

**FROM BURNOUT TO BROKEN BONDS: AN INTEGRATED STUDY OF
WORKPLACE VIOLENCE AND ITS CONSEQUENCES ON
DOCTORS' PRACTICE AND PATIENT
CARE IN INDIA**

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ABSTRACT

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Workplace violence (WPV) against doctors has become a serious concern in healthcare settings as the consequences are not limited to direct safety concerns. This study examined how WPV influences doctors' psychological well-being, clinical behaviour, doctor-patient relationship, and turnover intentions in Punjab and Chandigarh. The study further introduced Perceived Systemic Protection (PSP) as a newly integrated, context-specific construct including doctors' perceptions of organizational, legal, and societal protection against WPV.

A quantitative and cross-sectional research design was adopted for this study. Data was collected from 526 doctors through a structured questionnaire measuring WPV, burnout-related emotional exhaustion, job satisfaction, Risk Avoidance Behaviour (RAB), Changed Patient-Management Behaviour (CPMB), deterioration in the Doctor-Patient Relationship (DPR), turnover intentions, and PSP. The data was analyzed using descriptive statistics, regression, reliability analysis, confirmatory factor analysis, structural equation modeling, mediation analysis, moderation analysis, and moderated mediation analysis.

The findings showed that WPV significantly increased burnout-related emotional exhaustion and reduced job satisfaction among doctors. Burnout-related emotional exhaustion significantly predicted both RAB and CPMB, while job satisfaction significantly reduced RAB. However, the relationship between job satisfaction and CPMB was not significant. RAB significantly predicted

deterioration in the DPR, whereas CPMB did not significantly influence DPR, indicating that avoidance-based withdrawal had stronger relational consequences than protected clinical engagement. Deterioration in DPR significantly increased turnover intentions, confirming its role as an important relational and downstream mediator leading to attitudinal withdrawal. As RAB, CPMB, and PSP were exploratory constructs with limited convergent validity, findings involving these constructs are viewed as preliminary rather than conclusive and require further validation.

The mediation findings supported a layered and partially parallel model in which WPV influenced turnover intentions through psychological outcomes, behavioural adaptation, and relational deterioration. RAB emerged as a stronger behavioural mediator in this process. PSP was directly associated with lower burnout-related emotional exhaustion and higher job satisfaction, but it did not significantly moderate the effect of WPV on psychological outcomes or the indirect pathways leading to turnover intentions.

The study concludes that WPV against doctors is not an occasional but a constant occupational concern affecting doctors' emotional health, clinical decisions, patient relationships, and job stability. Strong institutional assistance, effective law enforcement, well-organized reporting mechanisms, and a comprehensive support system are essential for safer and more sustainable healthcare practice.

TABLE OF CONTENTS

List of Tables	vii
List of Figures.....	ix
CHAPTER 1 INTRODUCTION	1
1.1 Background	3
1.2 Statement of the problem	4
1.3 Significance of the problem	6
1.4 Research Questions	7
1.5 Research Objectives.....	8
1.6 Research Hypothesis	9
1.7 Limitations, delimitations, and assumptions.....	10
1.8 Definition of terms	13
CHAPTER 2 REVIEW OF THE LITERATURE	16
2.1 Introduction.....	16
2.2 Inclusion Criteria	17
2.3 Organizing Themes	18
2.4 Workplace Violence (WPV)	19
2.5 Psychological Outcomes of WPV	26
2.6 Behavioural Outcomes of WPV	34
2.7 Relational Outcomes of WPV	43
2.8 Attitudinal Outcome of WPV	47
2.9 Systemic Moderators of WPV	51
2.10 Integrated Conceptual Framework.....	55
2.11 Theoretical Framework.....	56
2.12 Research Gap	61
2.13 Conceptual Model	63

CHAPTER 3 METHODOLOGY	67
3.1 Introduction.....	67
3.2 Research Design.....	67
3.3 Population and Sampling	68
3.4 Data Collection and Instrumentation	71
3.5 Data Collection Procedures.....	78
3.6 Data Analysis	79
3.7 Ethics Related to Human Subject Participation	85
3.8 Methodology Summary	86
CHAPTER 4 RESULTS.....	87
4.1 Introduction.....	87
4.2 Organization of Data Analysis.....	87
4.3 Findings Regarding Hypothesis	135
4.4 Summary	146
CHAPTER 5 DISCUSSION, CONCLUSIONS, AND IMPLICATIONS	147
5.1 Introduction.....	147
5.2 Discussion of Findings.....	148
5.3 Summary of the Study and Findings.....	189
5.4 Conclusion	193
5.5 Implications and Applications	196
5.6 Limitation of the Study	207
5.7 Future Research	208
5.8 Chapter Summary	210
REFERENCES.....	211
APPENDIX A	238

LIST OF TABLES

Table 2.1 Alignment of Constructs with Theoretical Frameworks.....	59
Table 2.2 Theoretical Framework Linkages	60
Table 3.1 Summary of measurement of variables	75
Table 3.2 Conceptual Domain Mapping of PSP Items	78
Table 4.1 Descriptive Statistics of Variables used in the Study	89
Table 4.2 Correlation Matrix of Variables used in the Study	91
Table 4.3 Independent Samples t-test (WPV vs Non-WPV Groups)	93
Table 4.4 One-Way ANOVA results for Group Differences across Demographic and Contextual Variables.....	94
Table 4.5 Results of Two-Way ANOVA to assess the effects of WPV and Experience of doctors on Burnout-related Emotional Exhaustion.....	99
Table 4.6 Results of Regression-Based Interaction (Moderation) Effects	100
Table 4.7 Regression-Based Mediation Analysis Results	102
Table 4.8 Fit Indices for the Measurement Model.....	105
Table 4.9 Model specific Standardized Factor Loadings.....	107
Table 4.10 Construct-wise dropped Items and their Interpretation	109
Table 4.11 Internal Consistency Reliability with Cronbach's alpha (α) and Composite Reliability (CR) values	111
Table 4.12 AVE values for the measured constructs.....	113
Table 4.13 Discriminant Validity Assessment Using Fornell-Larcker Table of correlations.....	115
Table 4.14 Discriminant Validity Assessment Using the Heterotrait–Monotrait Ratio (HTMT).....	116

Table 4.15 Model Fit Indices for the Structural Model	119
Table 4.16 Direct Structural Path Estimates	121
Table 4.17 Bootstrapped Indirect Effects and Sequential Mediation Paths.....	124
Table 4.18 R ² Values for Endogenous Constructs.....	125
Table 4.19 Results of Moderation Analysis of PSP on the relationship between WPV and Burnout-related Emotional Exhaustion.....	129
Table 4.20 Results of Moderation Analysis of PSP on the relationship between WPV and Job Satisfaction	129
Table 4.21 Moderation Effects in the Burnout-related Emotional Exhaustion Moderated Mediation Model.....	132
Table 4.22 Moderation Effects in the Job Satisfaction Moderated Mediation Model....	132
Table 4.23 Conditional Indirect Effects through Burnout-related Emotional Exhaustion at various levels of PSP	133
Table 4.24 Conditional Indirect Effects through Job Satisfaction at various levels of PSP	133
Table 4.25 Hypothesis Testing Summary	142
Table 5.1 Policy and Administrative Recommendations Mapped to PSP.....	203

LIST OF FIGURES

Figure 2.1 Conceptual model illustrating psychological, behavioural, and relational pathways linking workplace violence (WPV) to turnover intentions, with perceived systemic protection (PSP) as a moderating variable.....	65
Figure 4.1 The figure shows the final SEM structural model estimated using standardized coefficients based on the study data. Latent constructs include workplace violence (WPV), perceived systemic protection (PSP), burnout-related emotional exhaustion (BO), job satisfaction (JS), risk-avoidance behaviour (RAB), changed patient-management behaviour (CPMB), deterioration in the doctor-patient relationship (DPR), and turnover intentions (TI)	126
Figure 4.2 Simple slope plot for PSP moderating the relationship between WPV and Burnout-related Emotional Exhaustion.....	130
Figure 4.3 Simple slope plot for PSP moderating the relationship between WPV and Job Satisfaction.....	131

CHAPTER 1

INTRODUCTION

Workplace violence (WPV) against doctors has emerged as a serious workplace-related and public health concern in India and globally. In India, the extent of the issue is reflected in a survey done by the Indian Medical Association (IMA), showing 82.7% of doctors felt stressed in the profession, 62.8% feared violence, and 46.3% identified violence as the main cause for their stress (Kala, 2023). WPV may occur in verbal, psychological, or physical forms and directly compromises doctors' safety. This compromises doctors' safety and shows serious concerns about the integrity of medical care (Pai et al., 2024). The impact of such incidents of violence against doctors is not confined to the psychological and social well-being of doctors but also extends to influence the clinical and relational behaviour of doctors towards their patients. This altered behaviour of doctors may initiate a cycle of mistrust among the community, followed by public dissatisfaction and, in turn, causing a further rise in violence against doctors and other medical professionals (Kaur et al., 2020).

Globally, violence against healthcare workers remains a serious concern, which can be estimated by available evidence from different types of sources. Data retrieved from the World Health Organization's (WHO) Surveillance System for Attacks on Health Care (SSA) dashboard, using calendar-year filters, showed 1,691 attacks on healthcare workers across 16 countries and territories in 2024, resulting in 945 deaths and 1,779 injuries. In 2025, the number of recorded attacks decreased to 1,385 across 19 countries and territories, while reported deaths increased abruptly to 1,984, and injuries declined to 1,187. However, these WHO SSA figures should be interpreted with caution, as the dashboard displays the data related to healthcare in countries with complex humanitarian emergencies rather than routine hospital-based WPV globally (World Health Organization, n.d.). Apart from the conflict-related settings, occupational and survey-based evidence also indicates the vulnerability of

healthcare workers. Wighton (2024) highlighted that violence in healthcare settings is a growing global concern affecting physicians and nurses, causing physical injury, psychological distress, fear, burnout, and underreporting. The U.S. Bureau of Labor Statistics (2023) documented more than half a million non-fatal injury cases among healthcare workers, the highest among all sectors. Peer-reviewed evidence demonstrates high WPV exposure among doctors, with Chen et al. (2024) reporting that 44% of doctors in China experienced WPV. Similarly, in Australia's workforce survey, healthcare and social assistance ranked second in serious compensation claims (Safe Work Australia, 2024) and in the UK, one in seven NHS staff experienced such violence (NHS Staff Survey, 2024).

In India, the rise in WPV against doctors has become a widespread concern, affecting the Indian healthcare system. Singh et al. (2023) found that 76% of healthcare workers had encountered WPV, with half experiencing such incidents every week, highlighting the alarming frequency of such incidents in hospitals across North India. Similarly, a study conducted by Debnath et al. (2023) in a tertiary care hospital in Delhi found that WPV was highly prevalent, with 80.4% of doctors experiencing verbal abuse, while 21.7% encountered physical assault. Likewise, as found by Paliwal et al. (2025), 96% of the 658 surveyed doctors faced verbal abuse, which led to reduced work motivation and adversely impacted their physical, social, and mental well-being. These statistics not only highlight the widespread occurrence of WPV against doctors within the Indian healthcare system but also strengthen the foundation for examining its psychological and attitudinal consequences, such as burnout, job satisfaction and turnover intentions, as well as its influence on doctors' professional behaviour and relationship with patients.

Recent events further illustrate the severity of the violence. Cases such as the assault of Dr. Amiya Suresh in Kerala, the attack on Dr. Revathy J. P. in Karnataka, and the tragic murder of Dr. Vandana Das in Kerala (News Karnataka, 2025; Onmanorama, 2025; The

Times of India, 2025) demonstrate the growing threat to medical professionals. The rape and murder of a trainee doctor in Kolkata led to nationwide protests, compelling the Indian judicial system to enforce strict and secure laws (DDNews, 2024). These events underscore the urgent need to study the severity of WPV against doctors in India and its impact on Indian doctors and the country's healthcare system.

1.1 Background

WPV against doctors has wide-ranging consequences beyond individual safety, as it can hamper the continuity and effectiveness of healthcare services of the country. Such incidents of violence against doctors may lead to temporary suspension of medical services, raging protests, indefinite strikes, or reduced engagement by healthcare professionals, thereby disturbing the patient care ecosystem of the country.

In addition to physical harm, exposure to WPV may contribute to psychological suffering among doctors, including stress, anxiety, burnout, and disturbed work-life balance. Such experiences can impact doctors' self-confidence and clinical decision-making, possibly affecting their clinical practices, interactions and relations within the healthcare settings.

Repeated exposure to such incidents may also create a sense of uncertainty and insecurity among doctors, leading to increased vigilance, defensive practices, and reduced willingness to engage in high-risk or complex cases. These consequences, which are intended for self-protection, may have long-term effects on the quality, approachability, and accessibility of patient care.

Despite growing recognition of WPV as a critical issue, there is an urgent need to thoroughly examine its broader impact on doctors' professional outcomes and on the healthcare system. Examining these consequences is essential for developing implementable strategies to improve both doctors' safety and patient care within the country's healthcare system.

1.2 Statement of the problem

Despite the increasing incidents of WPV against doctors, empirical research has been largely fragmented and primarily descriptive, particularly within the Indian healthcare context. Recent studies have primarily focused on the prevalence, manifestations, and immediate causes of WPV, neglecting its long-term effects on physicians' psychological health, professional behaviour, relationships with patients, and intentions to leave the profession. Therefore, the healthcare decision-makers should have an adequate, evidence-based understanding of the effects of WPV on long-term organizational and patient care outcomes.

The selection of Punjab and its capital, Chandigarh, as the empirical location for this study is justified by both circumstantial relevance and practical viability. Punjab has a considerable allopathic medical workforce, with 51,689 doctors registered with the Punjab Medical Council (PMC) out of 13,08,009 registered allopathic doctors in India as of June 2022 (Press Information Bureau, 2023). Thus, making it a suitable state for examining WPV among doctors. The state also includes important cities like Jalandhar, which has been reported as Asia's biggest healthcare hub with more than 800 super-specialty, multi-specialty hospitals, private nursing homes, and clinics, catering to patients from Punjab as well as neighbouring states such as Jammu & Kashmir and parts of Himachal Pradesh (Singh, 2019). Moreover, Chandigarh was included due to its administrative and healthcare relevance as the shared capital and a major referral centre for the region, having institutions like the Postgraduate Institute of Medical Education and Research (PGIMER) serving multiple northern states (Government of India, n.d.; PGIMER, n.d.). At the same time, Punjab has witnessed continuing safety concerns in healthcare facilities, with more than 50 cases of violence against doctors reportedly recorded in government hospitals within a year, leading to government intervention for security deployment, CCTV surveillance, and grievance

mechanisms (Kumar, 2025b). The recent deployment of 200 security guards across district hospitals further indicates that healthcare workers' safety has become a growing concern in the state (Kumar, 2026). Therefore, this study focuses on Punjab and Chandigarh as a contextually relevant and accessible state, without claiming them as representative of India.

Most existing research analyses individual outcomes such as burnout, job satisfaction, defensive medicine, or turnover intentions independently. This fragmented approach conceals the essential mechanisms through which WPV affects physicians' work attitudes and actions over time. In particular, there is a deficiency of empirical data clarifying how psychological pressure triggers defensive behavioural responses, how this behaviour compromises the doctor-patient relationship, and how this relational deterioration affects doctors' decisions to leave their profession. The absence of a unified conceptual framework impedes hospital administrators' and policymakers' ability to develop focused interventions to address workforce retention and improve patient care quality.

Furthermore, while organizational, legal, and societal protective mechanisms are frequently considered in policy discussions, doctors' perceptions of these protections have largely been overlooked in empirical research. No existing construct adequately integrates organizational, legal, and societal protection in the WPV context. In this study, a newly integrated and exploratory construct, Perceived Systemic Protection (PSP), is proposed to address this. This gap is particularly prominent in the Indian context, where the implementation of legislative protections and organizational support is inconsistent. This intensifies physicians' sense of vulnerability and lack of support.

In view of these gaps, the present study proposes an integrated framework that examines the impact of WPV on doctors' turnover intentions through interconnected psychological, behavioural, and relational pathways. Also, it investigates the moderating role of PSP in shaping the strength of these relationships. By theoretically developing and

empirically testing this framework, the study aims to provide a more comprehensive understanding of how WPV affects doctors' professional sustainability and the quality of patient care in the Indian healthcare system.

1.3 Significance of the problem

WPV against doctors not only threatens their personal safety but also produces long-lasting consequences for healthcare delivery and system performance. A recent study by Luo et al. (2025) confirmed that WPV reduced the probability that healthcare workers would achieve improved health outcomes by 12.9%. Moreover, conflict between doctors' professional ideals and harsh clinical realities can cause guilt, anxiety, and burnout, further deteriorating their mental well-being.

Even though WPV against healthcare workers, including doctors, in India is rising significantly, the issue remains under-researched. Besides physical injuries, WPV causes mental trauma, defensive clinical practices, migration from work, and deteriorated quality of patient care. This underscores the urgent need to draft uniform legislation and enforce it strictly to protect doctors from WPV across India. Beyond this, long-term prevention of WPV requires systemic reforms such as improved healthcare infrastructure, improved communication, and promoting a strong doctor-patient relationship, to protect doctors from the outcomes of WPV and to provide continued and quality patient care (Anil et al., 2025; Sachdeva et al., 2025; Sethi et al., 2025).

From both practical and academic perspectives, the present study addresses an important gap. Within healthcare settings, particularly in resource-constrained environments, exposure to WPV may influence not only doctors' psychological well-being but also their clinical behaviour and interactions with patients. While prior research in India has largely established the prevalence of WPV, limited studies have examined its combined effects on psychological outcomes (burnout-related emotional exhaustion and job satisfaction),

behavioural responses (risk-avoidance behaviour and changed patient-management behaviour), relational outcomes (doctor-patient relationship), and attitudinal withdrawal outcomes (turnover intentions) within a single framework.

Furthermore, existing research has not effectively explored the role of systemic support in shaping doctors' responses to WPV. The present study introduces PSP as a moderating construct that reflects doctors' perceptions of organizational, legal, and societal support mechanisms. By examining how PSP influences the relationships between WPV and its psychological, behavioural, relational, and attitudinal consequences, this study extends current understanding of WPV in healthcare. Therefore, it develops and empirically tests an integrated framework using structural modeling techniques, contributing both theoretically and practically within the Indian context.

The study is further strengthened by grounded and established theoretical perspectives, including the Job Demands-Resources (JD-R) Model theorized by Demerouti et al. (2001), Conservation of Resources (COR) Theory (Hobfoll, 1989), Affective Events Theory (AET) (Weiss & Cropanzano, 1996), and Social Exchange Theory (SET) (Blau, 1964), which together provide a strong framework to understand the psychological, behavioural, relational, and attitudinal consequences of WPV against doctors.

1.4 Research Questions

Based on the identified research gaps and the proposed conceptual framework, this study is directed by a set of research questions that aim to examine the psychological, behavioural, relational, and attitudinal withdrawal consequences of WPV against doctors. These questions are designed to systematically investigate the direct, indirect, mediating, and moderating relationships among the key constructs of the study. The present study aims to address the following research questions:

RQ1: How does WPV influence doctors' turnover intentions in the healthcare context of Punjab, India?

RQ2: To what extent do psychological outcomes (burnout-related emotional exhaustion and job satisfaction) mediate the relationship between WPV and doctors' turnover intentions?

RQ3: How does WPV affect doctors' behavioural responses, specifically Risk-Avoidance Behaviour (RAB) and Changed Patient-Management Behaviour (CPMB)?

RQ4: How do behavioural responses arising from WPV affect deterioration in the Doctor-Patient Relationship (DPR)?

RQ5: To what extent does deterioration in the DPR function as a downstream mediator linking psychological and behavioural responses to doctors' turnover intentions?

RQ6: To what extent does PSP moderate the effects of WPV on doctors' psychological outcomes?

1.5 Research Objectives

This study aims to examine the psychological, behavioural, relational, and attitudinal outcomes associated with WPV against doctors in India, and to examine how these relationships are systematically moderated by PSP, representing doctors' perceptions of organizational, legal, and societal support. Moreover, this study aims to develop an integrated framework, using Structural Equation Modeling (SEM) and established theories, to explain the impact of WPV on doctors' well-being, professional behaviour, and the quality of patient care in India.

To achieve this aim, the study seeks to:

1. Examine the impact of WPV on psychological outcomes, namely, burnout-related emotional exhaustion and job satisfaction.

2. Analyze the influence of psychological outcomes on doctors' behavioural responses, specifically RAB and CPMB.
3. Examine the effect of behavioural responses on deterioration in the DPR.
4. Evaluate the role of the deterioration in DPR in influencing doctors' turnover intentions.
5. Assess the indirect pathways linking WPV to turnover intentions through psychological, behavioural, and relational mechanisms.
6. Examine the moderating role of PSP in the relationship between WPV and psychological outcomes.

1.6 Research Hypothesis

The following are the research hypotheses aligned with the above-mentioned research objectives:

H1: WPV is positively associated with burnout-related emotional exhaustion among doctors.

H2: WPV is negatively associated with job satisfaction among doctors.

H3: Burnout-related emotional exhaustion is positively associated with RAB.

H4: Burnout-related emotional exhaustion is positively associated with CPMB.

H5: Job satisfaction is negatively associated with RAB.

H6: Job satisfaction is negatively associated with CPMB.

H7: RAB is positively associated with the deterioration in the DPR.

H8: CPMB is positively associated with the deterioration in the DPR.

H9: Deterioration in the DPR is positively associated with doctors' turnover intentions.

H10: The relationship between WPV and turnover intentions is mediated through a sequential multi-stage process, wherein parallel psychological outcomes (burnout-related

emotional exhaustion and job satisfaction) influence parallel behavioural responses (RAB and CPMB), which in turn affect the doctor-patient relationship (DPR), ultimately leading to turnover intentions.

To test this omnibus mediation hypothesis more evidently, H10 is decomposed into the following specific serial indirect pathways:

H10a: The relationship between WPV and turnover intentions is sequentially mediated through burnout-related emotional exhaustion, RAB, and deterioration in the DPR.

H10b: The relationship between WPV and turnover intentions is sequentially mediated through burnout-related emotional exhaustion, CPMB, and deterioration in the DPR.

H10c: The relationship between WPV and turnover intentions is sequentially mediated through job satisfaction, RAB, and deterioration in the DPR.

H10d: The relationship between WPV and turnover intentions is sequentially mediated through job satisfaction, CPMB, and deterioration in the DPR.

H11: PSP moderates the relationship between WPV and psychological outcomes, such that higher PSP weakens the positive association between WPV and burnout-related emotional exhaustion, and weakens the negative association between WPV and job satisfaction.

H12: PSP moderates the indirect relationship between WPV and turnover intentions by buffering its effect on psychological outcomes.

1.7 Limitations, delimitations, and assumptions

The present study has certain limitations and is bound by specific delimitations and underlying assumptions, as listed below.

1.7.1 Limitations

The present study is subject to certain anticipated limitations.

1. The study relies on self-reported data collected through structured questionnaires, which may be influenced by response bias, including social desirability and recall bias. Given the sensitive nature of WPV, respondents may underreport or even overreport their experiences.
2. The constructs in this study are based on well-established theoretical frameworks and previously validated scales; Confirmatory Factor Analysis (CFA) was considered appropriate for confirming the hypothesized model. However, future studies may incorporate Exploratory Factor Analysis (EFA) to examine certain variations, particularly in newly integrated constructs such as PSP.
3. The study measured burnout through its emotional exhaustion component only and did not include depersonalization or reduced personal accomplishment.
4. The cross-sectional design of the study does not allow to state definitive causal relationships among variables. While the proposed model examines theoretically sound sequential relationships using SEM, the findings are based on associations observed at a single point in time and do not confirm temporal causality.
5. The study employs a non-probability sampling approach combining convenience and snowball sampling techniques, without any formal sampling frame. While this approach enables access to a relevant, easily accessible population of practicing doctors, it may limit the representativeness of the sample and restrict the generalizability of the findings.
6. As the study uses snowball sampling and examines WPV among doctors, respondents who have personally experienced WPV may be more inclined to share the questionnaire with colleagues who have had similar experiences. This may create selection bias by extra representation of doctors exposed to WPV or those with more prevalent views about violence in healthcare settings. As a result,

the occurrence of WPV and the strength of its psychological, behavioural, relational, and attitudinal consequences may be inflated. Therefore, the findings should be considered as evidence from the sampled doctors rather than as generalized outcome estimates for all doctors in Punjab and Chandigarh.

7. The study focuses on perceived experiences and outcomes, which may not fully capture objective organisational or clinical indicators of performance and patient care quality.
8. Common method bias may arise due to the collection of data from a single source at a single point in time. Harman's single-factor test was used as an initial diagnostic check. However, this test is not a sole assessment of common method variance. A marker-variable approach was not possible because the questionnaire did not include a theoretically unrelated marker construct.

1.7.2 Delimitations

The present study is delimited in several ways.

1. The study focuses exclusively on doctors practising in Punjab, India, thereby limiting its geographical scope while allowing for contextual depth and significance.
2. The study examines selected psychological (burnout-related emotional exhaustion and job satisfaction), behavioural (RAB and CPMB), and relational (DPR) outcomes of WPV, rather than an exhaustive set of possible consequences.
3. The study is done using a quantitative approach comprising structured questionnaires and modeling techniques like SEM, without considering qualitative insights that may have provided in-depth contextual understanding.
4. The study conceptualises turnover intentions as an attitudinal withdrawal outcome and does not measure actual turnover behaviour.

5. The study introduces PSP as a specific moderating construct, focusing on doctors' perceptions of organizational, legal, and societal support mechanisms.

1.7.3 Assumptions

The study is based on several assumptions.

1. It is assumed that respondents provide honest and accurate responses that reflect their actual experiences and perceptions.
2. It is assumed that the measurement scales used in the study are valid and reliable in the context of Indian healthcare settings.
3. The study assumes that WPV is experienced and interpreted in a largely comparable manner among doctors, enabling meaningful and reliable collection and interpretation of data.
4. It is assumed that the relationships among WPV, psychological outcomes, behavioural responses, relational outcomes, and turnover intentions can be appropriately modelled using SEM.
5. It is assumed that PSP reflects a meaningful, measurable construct that influences doctors' reactions to WPV.

1.8 Definition of terms

The following terms, which have been used majorly in this study, are defined below.

1.8.1 Burnout-related emotional exhaustion

Burnout-related emotional exhaustion is a psychological state characterized by emotional fatigue, cognitive exhaustion, and reduced capacity to handle work-related stress resulting from constant exposure to challenging work conditions.

1.8.2 Changed Patient-Management Behaviour (CPMB)

CPMB refers to adjustments in clinical decision-making and patient care practices, such as ordering additional investigations, increasing documentation, documenting with greater precision, considering hospital resources before treatment, or adopting defensive medical approaches, to reduce potential legal or personal risk.

1.8.3 Doctor-Patient Relationship (DPR)

DPR refers to the quality of clinical or social interactions, trust, communication, cooperation, and mutual respect between doctors and patients, which affects treatment outcomes, patient care, and satisfaction, and the overall healthcare delivery system of the country.

1.8.4 Job Satisfaction

Job satisfaction refers to the extent to which doctors experience positive emotional and psychological aspects of their work, as well as feelings of accomplishment, enjoyment, enthusiasm, and overall satisfaction with their professional role.

1.8.5 Perceived Systemic Protection (PSP)

PSP refers to doctors' perception of the extent to which organizational, legal, and societal systems provide adequate support, safety, and protection against any form of WPV.

1.8.6 Risk-avoidance Behaviour (RAB)

Risk-avoidance behaviour (RAB) refers to the tendency of doctors to avoid high-risk, complicated, or potential conflict-prone clinical situations in order to minimise exposure to violence, disputes, complaints, or legal cases.

1.8.7 Turnover Intentions

Turnover intentions are defined as an attitudinal withdrawal outcome reflecting a doctor's conscious intent to leave their current workplace or medical practice. In the present study, turnover intentions are treated as distinct from actual turnover behaviour. The study measures doctors' self-reported intention to leave rather than confirmed resignation, job change, or migration. This distinction is acknowledged in the study's delimitations (Section 1.7.2), as the research does not longitudinally record whether doctors subsequently leave their jobs or profession.

1.8.8 Workplace Violence (WPV)

Workplace violence (WPV) refers to incidents where doctors are exposed to physical assault, verbal abuse, threats, or any form of aggressive behaviour by patients, attendants, or others during their duties within the healthcare settings.

CHAPTER 2

REVIEW OF THE LITERATURE

2.1 Introduction

Workplace violence (WPV) against doctors and other healthcare professionals has emerged as a life-threatening concern across healthcare systems globally. Although earlier research has largely focused on the prevalence and consequences of WPV, there is limited understanding of its broader implications for the healthcare system, professional well-being, and organizational stability. In particular, the impact of WPV on doctors is not limited to physical harm; it also influences their psychological state, professional behaviour, relations with patients, and attitudes towards their work.

Existing literature has scrutinized various consequences of WPV, including burnout, job dissatisfaction, defensive medical practices, and turnover intentions. However, these outcomes have often been studied in isolation, limiting the understanding of how WPV influences doctors through interconnected pathways. The absence of an integrated framework restricts the ability to fully understand the collective and long-term effects of WPV within healthcare settings.

Furthermore, while institutional and general responses to WPV have been widely discussed, little attention has been paid to how doctors perceive these protective mechanisms. The concept of PSP offers an important perspective on how organizational, legal, and societal support systems may influence doctors' responses to WPV.

The present literature review is organised around main conceptual areas, including WPV, psychological outcomes (burnout-related emotional exhaustion and job satisfaction), behavioural responses (RAB and CPMB), relational outcomes (DPR), and attitudinal outcomes (turnover intentions). The review also examines the moderating role of PSP and

integrates relevant theoretical perspectives to develop a comprehensive conceptual framework. By integrating existing research from various parts of the world across these areas, this chapter aims to identify key gaps in the literature and establish the basis for the proposed empirical model.

2.2 Inclusion Criteria

The literature included in this review was selected using clearly defined criteria to ensure suitability, relevance, quality, and alignment with the study's objectives. The review primarily focuses on peer-reviewed journal articles, conference papers, and credible news articles and reports related to WPV in healthcare settings.

The literature review primarily searched for recent empirical studies and relevant literature published within the last 8 years to capture developments in WPV, burnout, job satisfaction, turnover intentions, RAB, CPMB, DPR, and PSP in healthcare settings. However, foundational and seminal works were also included where necessary to define key constructs, support established measurement tools, or explain the theoretical framework of the study. Therefore, the review combines recent empirical evidence with foundational theoretical and measurement literature. The literature was obtained from academic databases, including PubMed, Scopus, and Google Scholar, as well as academic repositories, such as ResearchGate, to ensure access to peer-reviewed and relevant scholarly work. In addition, related academic books and foundational texts were referred to, particularly for conceptual definitions and theoretical contexts to ensure a broader understanding of key constructs. Moreover, these earlier studies were referred to identify the validated measurement scales, ensuring that the reliable and widely accepted instruments are used in the study.

Keywords used for the literature search included combinations of workplace violence, hospital violence, violence among doctors, healthcare professionals, , burnout, emotional exhaustion, measurement scales, job satisfaction, defensive medicine, clinical decision-

making, risk-avoidance behaviour, risk-taking capacity of doctors, doctor-patient relationship, patient-management, systemic support, organizational support, legal support, and turnover intentions. Since the review was narrative and theory-driven rather than systematic, a PRISMA flow diagram and formal screening counts were not prepared.

The review primarily includes studies focusing on doctors and healthcare professionals, with particular attention to the Indian healthcare context wherever available. Studies examining psychological, behavioural, relational, attitudinal and organisational outcomes of WPV were included to align with the conceptual framework of the study. However, studies not directly related to healthcare settings or that did not address WPV and its related outcomes were excluded from the review.

2.3 Organizing Themes

The literature review is organised into key thematic areas to ensure a balanced and structured development of concepts aligned as per the objectives of this study. The review includes an overview of WPV in healthcare settings, its prevalence, forms, and underlying causes in both global and Indian contexts.

It then examines the psychological outcomes of WPV, with an emphasis on burnout-related emotional exhaustion and job satisfaction, highlighting how exposure to violence influences doctors' mental well-being and work attitudes. This is followed by an examination of behavioural outcomes, RAB and CPMB, which reflect practically adaptive and defensive ways adopted by doctors to avoid risk-prone situations.

The review further analyses relational outcomes of WPV, particularly the DPR, as a critical component affected by both psychological strain and behavioural changes. In the end, the impact of all the mediations, from WPV to DPR, is observed on the turnover intentions of doctors who have experienced WPV. Subsequently, the role of PSP is discussed

as a moderating construct, covering organizational, legal, and societal support mechanisms that may influence doctors' views about WPV.

The final section integrates relevant theories, including the Conservation of Resources (COR) Theory, the Job Demands-Resources (JD-R) Model, the Affective Events Theory (AET), and the Social Exchange Theory (SET), and then identifies research gaps and develops the conceptual model guiding the present study.

2.4 Workplace Violence (WPV)

Workplace Violence (WPV) is a concerning civic and occupational health issue encompassing verbal, physical, or psychological hostility that compromises employees' well-being and welfare. WPV encompasses behaviours such as intimidation, threats, harassment, or physical harm occurring within professional environments. The severity of WPV can range from verbal incivility to physical attacks, and in extreme cases, it may lead to homicide (OSHA, n.d.). This phenomenon is not country-specific but has become a global issue (Nagpal, 2017).

Even though healthcare workers underreport many such incidents, viewing them as an inevitable part of the job, approximately 70% of WPV incidents in the U.S. are confronted by healthcare workers, exposing them to a disproportionately high risk (Rossi et al., 2023).

According to a recent global review by Berger et al. (2024) analyzing the prevalence of WPV against healthcare workers across 75 studies in 32 countries, it was found that 97% of these workers narrated verbal violence and around 82% reported physical violence. Despite the underreporting figures of 80%, the average physical violence rate was 31%, while that of verbal violence was 57%, leading to more apprehension, burnout, and increased turnover intentions. However, these estimates differ considerably across studies due to differences in definitions, measurement tools, study design, and reporting practices, indicating inconsistencies in the empirical understanding of WPV.

Indian studies also reveal a similar pattern in the prevalence and nature of WPV against doctors. In India, as reported by recent studies, the prevalence of WPV among doctors ranges from 65% to 80% (Datta & Das, 2021; Debnath et al., 2023; Kunnath et al., 2023; Singh et al., 2023; Vinay et al., 2025). This variation may be explained by methodological differences across studies, including differences in sample structure and technique, hospital type, gender variation, doctors' experience, department or specialty, recall period, measurement method and instrument used, perception of WPV, and operational definition of WPV. Studies focusing on resident doctors, emergency departments, ICUs, or tertiary-care hospitals may report higher prevalence because these settings involve higher patient load, critical illness, emotional distress among attendants, and more frequent high-intensity exchanges. Prevalence estimates may also differ depending on whether WPV is measured as lifetime exposure or exposure during the previous 12 months. Similarly, a survey among 658 doctors reported that nearly 61% experienced WPV, predominantly verbal abuse, usually perpetrated by patients' attendants, with most incidents occurring in ICUs, OTs, and Emergency Departments due to poor communication and dissatisfaction with patient care. Doctors reported adverse psychosocial impacts and highlighted gaps in training, communication skills, grievance mechanisms, and reporting systems (Paliwal et al., 2025). However, most of these Indian studies use self-reported data and cross-sectional designs, restricting causal interpretations and raising concerns regarding recall and response bias. Additionally, variations in institutional settings, reporting systems, and awareness levels further influence the observed prevalence and patterns of WPV.

Once regarded as saviours, doctors are also feeling the impact of increasing violence against them due to rising intolerance and complaints among the patients (Singh, 2017). In India, such incidents are significantly higher among healthcare professionals than in any other sector (Paliwal et al., 2025). Kumar et al. (2025) observed that the occurrence of such

incidents has escalated to an extent that healthcare professionals have begun to consider this part of their standard work. Altogether, these figures suggest that WPV against doctors is now severely embedded in the healthcare systems rather than being limited to isolated incidents, implying that WPV prevalence is not only high but also gradually accepted as part of the healthcare work culture.

WPV against doctors manifests in multiple forms. Kunnath et al. (2023) identified various types of WPV, including verbal abuse, threats and blackmail, intimidating gestures, harassment by local or higher authorities, physical assaults, cyber-bullying, and mob attacks. Among these, verbal abuse emerges as the most prevalent, followed by physical and then psychological violence (Rehman et al., 2024). Ranjha et al. (2022) further reported that verbal violence was particularly common among medical officers and doctors with one to five years of work experience. Additionally, younger and male doctors were found to be at greater risk of exposure to WPV. This trend shows that within healthcare hierarchies, professional status and role play an important part in placing some groups at higher risk of being targeted.

Several factors, including poor communication, billing disputes, and dissatisfaction with services, significantly contribute to the increasing WPV against doctors (Kumar et al., 2019). In addition to this, Sharma et al. (2019) identified the other foremost factors leading to WPV against doctors as the unexpected death of the patient, sudden onset of any complication in the patient, lower chances of the patient getting improved, extended hospital stay, and staff shortage in the hospital. Likewise, a survey conducted by Singh et al. (2019) revealed that the non-availability of medicines was one of the chief reasons initiating the violence in hospitals, mainly in the emergency departments. Other key factors leading to WPV against doctors are deterioration or non-improvement in patient's condition, wrong treatment, lack of administration, negative role of media, patient's distrust, less security at

hospital, drunk visitors/ attendants, no respect for doctors, long waiting time (Datta & Das, 2021; Dora et al., 2020; Kaur et al., 2020; Kumari et al., 2020). Collectively, these findings suggest that WPV is triggered mainly due to professional incompetencies, systemic flaws, unmet patient expectations, and external socio-cultural factors.

WPV has severe and substantial consequences for doctors. Considering psychological implications, depression, chronic anxiety, and post-traumatic stress are some of the outcomes of WPV against doctors. Unceasing hostile events, along with the stress involved in the clinical management of patients and long working hours, accelerate burnout, reduce productivity, cause job dissatisfaction, and increase the likelihood that doctors will leave their profession early. Eventually, this hampers the quality of patient care and weakens the DPR (Debnath et al., 2023; Sachdeva et al., 2025).

WPV negatively affects doctors' psychological, social, and family well-being. Çabuk and Menteş (2023) revealed that WPV in healthcare settings negatively impacts the quality of life, job performance, and productivity of healthcare professionals. Other frequently reported effects include loss of self-esteem, stress, depression, anxiety, sense of defeat, increased aggression towards patients, change of workplace, avoiding social gatherings, frustration, confusion at work, and difficulty in sleeping (Adhikari et al., 2023; Awooda, 2020; Kitaneh & Hamden, 2012). As claimed by Rusu et al. (2025) in a recent study, 42.7% doctors were extremely distressed by recurrent thoughts or memories of incidents involving verbal violence, whereas 34.9% doctors showed high tendencies of avoiding any discussion regarding the incidents. Overall, such consequences indicate that WPV causes physical harm, long-lasting psychological stress, and professional demoralisation, which in turn disturbs the well-being of doctors and hampers patient care.

Much empirical evidence supports the rising prevalence of WPV against doctors and their perception of it among doctors. Sharma et al. (2019) found that 83% of doctors believe

such incidents are more prevalent in the medical field than in any other field, and 95% perceive that awareness of such incidents remains low nationwide. Rusu et al. (2025) observed that 46% of doctors were highly concerned about WPV, while 27% were moderately concerned. On average, a doctor faces five incidents of violence in a year, resulting in reduced efficiency and motivation to work (Paliwal et al., 2025). The alarming issue of WPV has reached such an extent that 38.2% doctors in North India face verbal arguments nearly daily, resulting in decreased concentration at work and ultimately affecting their efficiency at work and reducing their motivation to work. As a result, 32% of the doctors considered opting for an alternative career (Mukta et al., 2025). These statistics demonstrate that the prevalence of WPV is very high in healthcare settings, making doctors more vulnerable and exposed to consistent risk. As a result, this diminishes their risk-bearing capabilities and fades their motivation to continue in the same profession.

Furthermore, circumstantial differences across healthcare systems significantly influence both the occurrence and impact of WPV. Most empirical evidence originates from developed or East Asian healthcare settings, where legal protections, institutional support systems, and patient expectations differ evidently from those in India (Chen et al., 2024; Luo et al., 2025; Schulz-Quach et al., 2025; Xiao et al., 2024). In contrast, the Indian healthcare context is characterised by high patient load, infrastructural restrictions, limited deployment of legal safeguards, and changing doctor-patient rapport, which may exaggerate both exposure to violence and its consequences.

Though WPV against doctors is a global phenomenon, its prevalence, causes and consequences differ across various countries, cultures, and healthcare settings. In India, the majority of WPV incidents are prompted by inadequate infrastructure, impaired communication systems, and weak medico-legal laws for the protection of doctors.

Punjab and Chandigarh were selected not as a statistically representative state for all of India, but as an analytically relevant state for examining WPV against doctors. First, the recent evidence suggests that violence against healthcare workers in Punjab is not confined to a single hospital or isolated city. Data compiled by the Punjab Civil Medical Services Association reported at least 60 incidents of severe hostile incidents in government healthcare facilities within one year, reported across various districts, namely Amritsar, Pathankot, Hoshiarpur, Kapurthala, Ludhiana, Muktsar, Moga, Gurdaspur, Jalandhar, SBS Nagar, Mohali, Bathinda, Patiala, Tarn Taran, Sangrur, Malerkotla, Ferozepur, Ropar, and Barnala. These incidents, including a lack of security, rural susceptibility, night-duty risk, and medico-legal work among healthcare workers, make Punjab relevant for studying WPV and its related consequences (Express News Service, 2025). Second, Punjab offers a mixed public-private healthcare context. Invest Punjab describes the state as a “Medical Destination for the World & Northern India” and reports 214 government hospitals and 1,734 private hospitals across the state, indicating a substantial and diversified healthcare delivery system (Invest Punjab, 2023). Third, from a legal perspective, Punjab is relevant to the study because it has had a special law protecting medical service personnel since 2008. However, its implementation in the state is weak, as the Punjab IMA claims that the law remained largely unused for years and that only a few police reports invoked the Act (HT Correspondent, 2019). More recent reporting indicates that the Punjab Clinical Establishments Act, notified in 2020, remains under finalization, highlighting continued regulatory and implementation gaps in healthcare governance in Punjab (Kumar, 2026). Though the Punjab Clinical Establishments Act is not a WPV-specific law, its delayed implementation reflects regulatory and governance lapses that affect doctors’ perceptions of systemic protection. Therefore, Punjab and Chandigarh provide a mixed healthcare context in which the psychological, behavioural, relational, and attitudinal consequences of WPV can be studied.

A critical examination of the existing literature on WPV against doctors reveals several important limitations. A major concern is the underreporting of incidents, which happens due to the normalization of violence, fear of retaliation, or lack of proper reporting mechanisms, further leading to an underestimation of its actual existence. Repeated exposure to such incidents leads to the standardization of violence within healthcare settings, where doctors begin to perceive it as an inevitable part of their profession. This alters their tolerance levels and professional responses. Furthermore, variations in definitions, measurement tools, and reporting practices across studies indicate inconsistent measurement of WPV, thereby limiting comparability and uniformity in findings. Additionally, most empirical evidence originates from developed healthcare systems or East Asian healthcare settings (Chen et al., 2024; Luo et al., 2025; Schulz-Quach et al., 2025; Xiao et al., 2024), making its applicability to the Indian context limited by differences in hospital infrastructure, healthcare settings, legal protections, and patient expectations. While only a few incidents of violence are documented, limited consideration has been given to doctors' individual views of safety and protection, thereby influencing their responses to WPV significantly. Moreover, existing studies predominantly assess WPV in terms of occurrence or frequency, with less emphasis on the perceived seriousness or intensity of such incidents. These limitations highlight the need for a more integrated, contextual, and sensitive measurement model to understand WPV in relation to doctors.

WPV against doctors can be aligned with various theoretical models. According to the JD-R model, WPV functions as a primary job demand, placing excessive emotional and psychological stress on doctors, draining their energy, and impairing their ability to perform (Demerouti et al., 2001). The COR theory further conceptualises WPV as an event, threatening the loss of valued resources for doctors (safety, energy, emotions, and respect), ultimately compelling doctors to adopt changed patient management practices (Hobfoll,

1989). From the perspective of AET, each episode of violence represents an adverse affective event that triggers emotional reactions influencing the subsequent work attitudes and behaviours of doctors (Weiss & Cropanzano, 1996).

Overall, the literature indicates that WPV is associated with important psychological and professional outcomes among doctors, including burnout, job dissatisfaction, and turnover intentions. However, much of the existing evidence examines these outcomes separately rather than as part of an integrated model. The broader research gap arising from these limitations is combined and discussed in Section 2.12.

In view of these widespread effects, WPV serves as a critical driver of several psychological consequences, such as burnout-related emotional exhaustion and job satisfaction, which are discussed in subsequent sections.

2.5 Psychological Outcomes of WPV

The purpose of this section is to examine the psychological consequences of WPV for doctors, focusing on burnout-related emotional exhaustion and job satisfaction. Psychological outcomes represent the immediate impact of violence, reflecting how repeated exposure to hostility exhausts emotional, cognitive, and motivational resources. These variables are critical because they mediate the relationship between WPV and broader professional or organizational outcomes, as explained using various theoretical models.

2.5.1 Burnout with a Focus on Emotional Exhaustion

Burnout is an emotional state that arises in response to prolonged occupational stress, characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Maslach et al., 1997). The World Health Organization (2019) recognizes burnout as a work-related phenomenon arising from continuous workplace strain that has not been effectively managed. Maslach's three-dimensional model conceptualizes burnout as emotional exhaustion (when employees feel emotionally drained and depleted);

depersonalization (when professionals develop detached or distrustful attitudes toward clients); and reduced personal accomplishment (when individuals experience dissatisfaction with their work performance and achievements).

For this study, burnout is assessed primarily through items reflecting emotional exhaustion, adapted from established burnout scales. Burnout is traditionally conceptualized as a multifaceted construct consisting of reduced personal accomplishment, depersonalization, and emotional exhaustion (Maslach et al., 1997). Amidst these dimensions, emotional exhaustion represents the core stress component of burnout and indicates the depletion of emotional resources triggered by prolonged workplace demands (Halbesleben & Demerouti, 2007; Lee & Ashforth, 1996; Maslach & Leiter, 2016; Schaufeli et al., 2008; Schaufeli & Taris, 2005; West et al., 2018). Emotional exhaustion was used as the operational indicator of burnout in the present study. This approach was adopted to reduce conceptual overlap and cross-loadings with other constructs included in the model. Depersonalization may overlap with DPR variables, while reduced personal accomplishment may intersect with job satisfaction measures. Focusing on burnout-related emotional exhaustion, therefore, enables clearer construct differentiation and improves discriminant validity in the SEM.

In the healthcare context, the presence of emotional exhaustion as the core burnout dimension among doctors has already been well-documented due to job-related factors like excessive job demands, length of training, extended duty hours, professional migration, suboptimal workplace conditions, employment instability, inadequate compensation, and ineffective managerial practices (Lu et al., 2025; Okeke et al., 2024; Shahi et al., 2022). In addition, the prevalence of external factors, such as WPV, increases the occurrence of burnout-related emotional exhaustion among doctors and other healthcare workers (Awooda, 2020; Çabuk & Menteş, 2023; Chen et al., 2024; Wu et al., 2021). A study by Hacer and Ali

(2019) revealed that the doctors who experienced verbal and physical violence showed significantly higher scores of emotional exhaustion. In the healthcare sector, mainly in high-intensity departments such as emergency or intensive care units, these stressors are exacerbated and make doctors more prone to burnout-related emotional exhaustion resulting from exposure to WPV.

The extent and severity of burnout among doctors is evident from recent studies. Maheshwari et al. (2025) found that 47% of doctors experienced personal burnout, 35% suffered patient-related burnout, 31% reported work-related burnout, and 24.9% of doctors experienced all three forms of burnout. A systematic review conducted by Ulaş and Seçer (2025) among 33,906 healthcare workers revealed that a significant positive correlation exists between secondary traumatic stress and burnout. Another recent survey of first-year interns found that nearly half were affected by burnout, characterized by high levels of emotional exhaustion (83.5%). This demonstrates the prevalence of burnout, as measured by emotional exhaustion, among doctors and the intensity of its increase (Surawattanasakul et al., 2025).

Numerous global and Indian studies have examined the prevalence of burnout and its correlates among doctors; however, very few have studied WPV, the emotional exhaustion dimension of burnout, and other consequences of WPV in an integrated model. A survey conducted by Li et al. (2024) among adult and paediatric doctors in Canada concluded that, on average, 44% of doctors tested positive for burnout, with higher rates among paediatric doctors. Another study, conducted by Ernes and Meilani (2023) among healthcare workers in Indonesia during the COVID-19 pandemic, found a significant negative correlation between burnout and job satisfaction. Additionally, job satisfaction negatively affects healthcare workers' turnover intentions. A study conducted among doctors in Japan indicated that sense of personal achievement was highly documented, followed by emotional exhaustion and depersonalisation. Around 5% of doctors had suicidal tendencies due to increased emotional

exhaustion and depersonalisation, which intensifies with an increase in working hours of doctors (Ishikawa, 2022). In China, a study done by Cao et al. (2022) found that 70% of the healthcare professionals who were subjected to WPV suffered high and moderate burnout. Moreover, it emphasised the negative correlation between emotional intelligence and burnout amongst healthcare professionals. Similarly, in India, a study in Pune's tertiary-care centre discovered that male doctors experienced higher emotional exhaustion than female doctors (Ghoshal et al., 2022). While these findings indicate a high prevalence of emotional exhaustion leading to burnout, variations across studies may arise due to differences in measurement scales, sample composition, and healthcare settings, suggesting inconsistencies in the reported extent of burnout.

WPV has severe and substantial consequences for doctors. Burnout is not only the consequence of WPV but also related to many other factors. Burnout is positively correlated with workplace incivility and turnover intentions among employees (Rahim & Cosby, 2016). Likewise, other studies have found that WPV against doctors is positively associated with burnout and doctors' intent to leave their organization (Duan et al., 2019; Kwon & Kim, 2024; Sinval et al., 2024). Burnout has major implications for doctors' psychological well-being. Recurrent burnout among doctors' results in stress, depression, anxiety, and sleep disorders (Lu et al., 2025). Considering psychological consequences, anxiety, depression, and stress are some of the outcomes of WPV against doctors. Unceasing hostile events, along with the stress involved in the clinical management of patients and long working hours, accelerate burnout, reduce productivity, cause job dissatisfaction, and increase the likelihood that doctors will leave their profession early. Eventually, this hampers the quality of patient care and weakens the DPR (Alzoubi et al., 2024; Debnath et al., 2023; Sachdeva et al., 2025). Therefore, professional and organisational outcomes are detrimentally affected by burnout. Moreover, a 2025 meta-analysis revealed that burnout prevention strategies and organised

interventions might yield a standardised mean difference in burnout scores for doctors (Krebs et al., 2025). Though reassuring, these interventions are never implemented properly in Indian hospitals.

Burnout, operationalized through emotional exhaustion, is best explained by the JD-R model and substantiated by the COR and AET theories. As theorized by the JD-R model, when job demands such as WPV exceed available resources, individuals experience emotional exhaustion (Demerouti et al., 2001). COR theory supports this by describing burnout-related emotional exhaustion as the outcome of continuous resource loss without suitable recovery or replacement, resulting in psychological exhaustion (Hobfoll, 1989). These frameworks together explain how persistent exposure to violence exhausts doctors' personal and professional resources, leading to burnout-related emotional exhaustion. Also, negative experiences at the workplace, such as violence, cause stress, burnout, and withdrawal intentions, as stated by AET (Weiss & Cropanzano, 1996). This focus on emotional exhaustion was adopted because it directly captures the psychological depletion expected after exposure to WPV and is theoretically aligned with the JD-R and COR perspectives used in this study.

In the context of WPV among doctors, burnout, operationalized through emotional exhaustion, acts as a crucial mediator and predictor of various outcomes. Doctors exposed to WPV feel threatened, suffer resource depletion, undergo emotional exhaustion, experience burnout, which decreases job satisfaction, increases turnover intentions, defensive behaviours, and weakens the DPR. These observations indicate that burnout has largely been examined in isolation or as a direct outcome, with restricted attention given to its integrative role in linking workplace stressors such as WPV to larger behavioural, relational, and attitudinal consequences. This highlights the need for a more structured and theory-driven examination of burnout-related emotional exhaustion within an integrated framework,

discussed as a research gap in Section 2.12. However, most studies use cross-sectional and self-reported data, thereby restricting the integration of the conceptual framework with grounded theoretical models (Hacer & Ali, 2019; Kulkarni et al., 2020; Lu et al., 2025; Maheshwari et al., 2025; Okeke et al., 2024; Shahi et al., 2022). Moreover, burnout is often measured as a static condition, with limited attention to its development over time in response to repeated exposure to WPV, highlighting an important direction for future research.

By examining emotional exhaustion, the core burnout dimension as both a consequence and a mediator of WPV, this research aims to investigate how systemic and interpersonal factors influence doctors' professional identity and performance in Punjab.

2.5.2 Impact on Job Satisfaction

Job satisfaction represents the degree to which an employee's expectations from their job correspond with the actual outcomes and rewards received (Locke, 1969). According to Locke, overall job satisfaction results from a holistic evaluation of distinct job facets such as pay, recognition, and workplace culture. These determinants can be classified into two categories: intrinsic factors (e.g., autonomy, achievement, respect, and participation in decision-making) and extrinsic factors (e.g., organisational climate, remuneration, job security, promotion opportunities, and managerial style) (Abdullah et al., 2023).

In the healthcare sector, particularly among doctors, job satisfaction is a vital element, as it affects hospital organizational efficiency, the quality of healthcare services, patients' satisfaction with the treatment process, and the DPR (Gyawali et al., 2024; Yu et al., 2018). Chellaiyan et al. (2022) stated that the most influential factor contributing to job satisfaction is the hospital working environment, whereas remuneration primarily motivates employees. Among healthcare professionals, job satisfaction is influenced by a combination of intrinsic and extrinsic factors. The intrinsic aspect can be attributed to factors such as current professional level or designation, training and educational opportunities, the doctor's

specialty, years of service, number of working hours, and type of employment. In contrast, the extrinsic attributes, particularly those related to conflict or violence, include exposure to threats, internal displacement, unsafe and insecure medical practices, patient behaviour, quality of care, doctor-patient relationships, and many more (Ahmad et al., 2016; Jadoo et al., 2018; Kumar & Khan, 2014; Stephen & Ibrahim, 2022).

WPV is among the most negatively evaluated factors influencing job satisfaction among doctors. Doctors often exposed to WPV report decreased job satisfaction, face high burnout, and have a greater tendency to leave their jobs. This leads doctors to feel less enthusiastic about their work, experience reduced respect and recognition from patients and family members, erode the doctor-patient trust relationship, and lack initiative (Duan et al., 2019). Yu et al. (2018) established that healthcare workers exposed to WPV reported markedly lower job satisfaction and reduced confidence in their profession. WPV triggers adverse emotions such as anger, fear, distress, and disgust, leading to emotional exhaustion and diminished job satisfaction. Inadequate organisational support, weak violence-reporting systems, and perceived bias further erode satisfaction, contributing to reduced work efficiency and concentration (Cao et al., 2023; Dursun & Aytac, 2021; Xu et al., 2023). Therefore, minimising WPV incidents and restoring a stable DPR are essential to enhancing job satisfaction and mitigating burnout.

Empirical studies have strengthened this linkage by examining the relationship between WPV and job satisfaction. According to a study done by Dursun and Aytac (2021) in Turkey, it can be observed that among the healthcare professionals, the job satisfaction of workers who experienced violence was lower than that of those who did not experience any such adverse event. In the Indian context, as surveyed by Ahamed et al. (2021), doctors who felt safe from WPV reported 2.5 times higher job satisfaction than those who did not. Low job satisfaction has severe consequences for individuals, professionals, and organizations.

Individual-level consequences include emotional fatigue, reduced motivation to work, disrupted work-life balance, and decreased personal fulfillment. Considering the occupation-related conclusions, compromised patient safety, erosion of doctor-patient trust, and deteriorated healthcare quality are the main outcomes of job dissatisfaction. From an organisational perspective, increased turnover intentions due to low job satisfaction have been observed among doctors (Ahamed et al., 2021; Cao et al., 2023; DiNçler et al., 2023; Gyawali et al., 2024; Kumari & Raghuramapatruni, 2023).

In this study, job satisfaction is conceptualized as a key outcome factor that mediates the relationship between WPV and other professional behaviours such as burnout, turnover intentions, and risk avoidance (Abate, 2018; Alkhraish et al., 2023; Far et al., 2022; Jadoo et al., 2018; Sabei et al., 2019; Zhang et al., 2021). Moreover, it has been observed that job satisfaction is the best predictor of emotional violence faced by doctors, which directs dissatisfied doctors to change the standards of patient care they provide, ultimately hampering the patient management behaviour of doctors (Berlanda et al., 2019; Lorenc et al., 2024).

Job satisfaction is shaped by the resource-based and emotional-relational theories, but is mainly supported by the JD-R theory and seconded by other theories. According to the JD-R and COR theoretical models, increased job demands and resource depletion, caused by WPV, lower the motivation and accomplishment, resulting in reduced job satisfaction among doctors (Demerouti et al., 2001; Hobfoll, 1989). Considering the AET, such violence-related incidents serve as negative emotional triggers that create a negative impact.

Despite considerable research on job satisfaction, gaps remain. Most Indian studies treat job satisfaction as an independent variable rather than considering a unified model, which is further discussed as a broader research gap in Section 2.12 (Berlanda et al., 2019; Chellaiyan et al., 2022; DiNçler et al., 2023; Gyawali et al., 2024; Jadoo et al., 2018; Yu et

al., 2018). Therefore, the present study focuses on job satisfaction in a broader and comprehensive context.

2.6 Behavioural Outcomes of WPV

This section explores how WPV translates into noticeable behavioural responses among doctors, including risk avoidance and changes in patient management such as defensive medicine. These actions reflect coping strategies by doctors intended to protect energy and avoid further conflict, which is supported by various theoretical models.

A note on construct provenance is warranted at this point. Whereas the psychological and attitudinal outcomes examined in this study (burnout-related emotional exhaustion, job satisfaction, turnover intentions) are measured using established, widely validated scales, three constructs central to the present framework, namely Risk Avoidance Behaviour (RAB), Changed Patient-Management Behaviour (CPMB), and Perceived Systemic Protection (PSP), were operationalised by the researcher for this study. Their items were generated from the qualitative and theoretical literature reviewed in Chapters 2.5 and 2.6, and their factorial structure, reliability, and convergent and discriminant validity were assessed empirically in the confirmatory factor analysis reported in Chapter 4. These constructs should therefore be treated as exploratory rather than established at the same evidentiary level as the validated scales used elsewhere in the model, and further psychometric replication in independent samples is recommended (see also Chapter 5, Limitations).

2.6.1 Emergence of Risk Avoidance Behaviour (RAB)

Risk Avoidance Behaviour (RAB) is defined as a proactive approach through which individuals deliberately avoid situations that are supposed to pose significant physical, emotional, or professional harm. Rather than responding to risks after they occur, RAB focuses on preventing exposure by refraining from participation in high-risk activities or decisions (Guevara, 2025). It is important to distinguish RAB from defensive medicine.

Although both may arise from exposure to WPV, they operate at different stages of the clinical engagement process. Defensive medicine refers to modifications made within ongoing patient care, such as excessive documentation, additional investigations, cautious referrals, or over-explanation of risks. Whereas, RAB refers to a prior or protective decision to avoid engaging in high-risk situations, such as refusing conflict-related cases, declining high-risk procedures, avoiding emergency duties, or referring serious patients to other hospitals. This distinction is important because RAB reflects professional withdrawal from risk exposure, whereas defensive medicine reflects altered clinical conduct while care is still being provided.

In the healthcare context, RAB refers to a deliberate, proactive strategy adopted by healthcare professionals to entirely avoid clinical situations or patient interactions perceived as high-risk, particularly those that may lead to violence, blame, litigation, or emotional distress. Rather than responding reactively after a threat has appeared, RAB emphasizes preventing exposure by consciously withdrawing from or refusing to engage in potentially volatile or high-stakes cases (Hu et al., 2025). This behaviour is especially prominent among doctors who have experienced or anticipate WPV, leading them to minimize involvement in emergency care, medico-legal cases, or complex procedures. The core aim is to safeguard their own physical safety, emotional well-being, and professional integrity by reducing exposure to perceived threats (Godinho & Cacodcar, 2024).

WPV has emerged as a critical driver of RAB development among healthcare professionals, particularly doctors. Exposure to verbal abuse, threats, and physical assault has been shown to significantly influence doctors' willingness to engage in high-risk clinical situations. Studies have indicated that doctors who experience WPV often resort to defensive medical practices, such as avoiding complex procedures, referring sick and serious patients, seeking consultation from other doctors, or refusing medico-legal and emergency cases, in

order to safeguard their own comprehensive well-being (Arafa et al., 2023; Kaur et al., 2020). Consequently, WPV jeopardizes doctors' safety and mental health and indirectly affects the quality of patient care, as physicians may limit their clinical exposure to mitigate future risks (Adhikari et al., 2023). This highlights the demanding need to study and address RAB as a coping outcome of WPV in healthcare settings.

Defensive medicine is a practice in which doctors avoid litigation arising from the treatment of their patients (Arafa et al., 2024). Numerous systematic reviews show that defensive medicine arises when doctors perceive a persistent litigation risk, even when the actual risk is lower. Doctors often showcase resentment to such legal adversities and pressure from patients by over-prescribing medicine, ordering additional lab tests and other investigations, increasing follow-up visits, over-documenting, or avoiding complicated cases, which ultimately hampers doctor-patient trust (Daneils & Marneffe, 2023; Eftekhari et al., 2023; Lorenc et al., 2024; Kakeman et al., 2022). However, unlike defensive medical practices, where clinicians may overprescribe or over investigate during the course of treatment, RAB is a proactive form of professional withdrawal, involving the choice not to engage in certain categories of patient care perceived as risky.

In the Indian context, various studies provide clear evidence of RAB being followed by doctors in the wake of increasing cases of WPV, rendering them vulnerable to risk exposure. As explored by Jith et al. (2024), 88.8% doctors feel that violence against them will force them to adopt RAB in the form of defensive medicine practices. Also, a study by Kunnath et al. (2023) in Kerala found that approximately 77% of doctors expressed a desire to relocate abroad. The study avoids such stressful incidents. Kaur et al. (2020), while examining the impact of WPV against doctors in India, found that 51% of doctors, who were exposed to verbal abuse only, decreased taking on complicated cases, and 40% of such doctors increased referring patients to other centres/hospitals. On the other hand, 69% of

doctors who faced verbal threats along with intimidation reduced handling severe patients and referred them to other healthcare institutes. Moreover, 69% of doctors who faced any sort of physical injury or experienced physical damage to hospital property increased their referrals or sought consultations with other doctors.

Empirical data and news reports from India increasingly highlight how WPV is leading to defensive shifts in doctors' clinical behaviour. For instance, a 2025 Times of India article reported that due to recurring violent incidents at hospitals in Punjab ranging from physical assaults to mob aggression, many doctors are opting out of night duties and avoiding high-pressure emergency cases, citing inadequate institutional safety measures (Kumar, 2025a). Similarly, in 2024, doctors in Delhi threatened to suspend emergency services unless the government enacted stronger protective mechanisms, demonstrating a joint withdrawal from duties involving risks, in response to workplace incivility (The Economic Times, 2024). These public demonstrations are not isolated; they align with findings from published studies like Kaur et al. (2020), which showed that exposure to violence significantly reduced doctors' willingness to manage critical patients or perform surgical interventions. The psychological impact of such violence creates a sense of insecurity among physicians, leading to their proactive avoidance of medico-legal cases or complicated treatments to minimize exposure to further threats or aggression (Arafa et al., 2023; Hu et al., 2025). Thus, both empirical and subjective evidence confirm that WPV in India not only compromises the morale and mental health of doctors but also promotes widespread RAB, which may inadvertently affect healthcare access and quality for high-risk patients in India.

RAB aligns with both the JD-R and COR frameworks, but primarily with the COR framework. COR theory interprets RAB as a resource-conservation strategy, where doctors limit exposure to potentially violent or emotionally tough cases to protect their well-being and preserve limited personal resources (Hobfoll, 1989). Under the JD-R model, it represents

a behavioural dealing mechanism initiated when job demands such as WPV exceed an individual's capacity to handle, leading to reduced engagement or selective avoidance (Demerouti et al., 2001).

Despite increasing recognition of defensive practices in healthcare, RAB remains conceptually underdeveloped and is often conflated with defensive medicine in the existing literature. Most studies focus on evident avoidance-based withdrawal behaviour of doctors along with defensive actions such as over-investigation or over-prescription, while relatively limited attention has been given to isolation of proactive clinical withdrawal behaviour, where doctors intentionally avoid high-risk patients or procedures altogether. Besides, RAB is frequently treated as a secondary or related coping response rather than a distinct behavioural outcome with direct implications for healthcare accessibility and quality (Eftekhari et al., 2023; Hu et al., 2025; Kakeman et al., 2022; Lorenc et al., 2024). In the Indian context, empirical research on RAB remains disjointed and largely descriptive, with minimal efforts to quantify it or examine its position within an integrated theoretical framework. Additionally, existing studies rarely examine how psychological factors, such as burnout, and systemic moderators, such as PSP, shape the emergence of RAB (Arafa et al., 2024; Debnath et al., 2023). This restricts a comprehensive understanding of how WPV translates into behavioural adaptations among doctors. Accordingly, the present study conceptualizes RAB as an independent behavioural construct and examines it within a structured model linking WPV to psychological, relational, and attitudinal outcomes.

2.6.2 Changed Patient-Management Behaviour (CPMB)

Patient management refers to the systematic coordination of clinical and administrative processes to ensure the delivery of effective, timely healthcare. It encompasses activities such as documentation, diagnosis, treatment planning, and patient follow-up. The ultimate objective is to guarantee safe, efficient, and patient-centred care (Softguide, n.d.).

However, with the increasing prevalence of WPV, physicians' management practices have undergone a marked transformation, shifting toward defensive and emotionally guarded approaches (Lafta et al., 2021).

Changed Patient-Management Behaviour (CPMB) refers to behavioural alterations among doctors in terms of patient care, communication style, doctor-patient interaction, and professionalism, which include attention, avoidance, or defensive practices that doctors adopt to protect themselves from hostile events or any such future occurrences (Hu et al., 2025; Karpinar et al., 2025).

WPV often triggers a cascade of effects leading to CPMB. WPV triggers severe emotional outcomes among doctors in the form of rage, distress, disgust, and anxiety. These influential emotions drain the psychological resources of doctors, causing emotional exhaustion, resulting in decreased concentration towards work, a professional identity crisis, and reduced motivation. As a result, they feel less confident in their professional capabilities and communication skills, leading to changed behaviour in patient management and a view of disbelief in the DPR. This blend of emotional trauma, decreased engagement, increased self-doubt, and stressed DPR gives rise to an altered way of managing patients, forming a foundation of CPMB (Cao et al., 2023).

This trend of shifting towards defensive clinical decision-making, commonly referred to as defensive medicine, involves selecting patients based on a fear of verbal, physical, or legal conflict, rather than following ideal clinical judgment. For instance, physicians exposed to violence may deliberately avoid performing complex surgeries, conducting critical interventions, or handling emotionally aggressive clinical cases, opting instead to advise unnecessary diagnostic tests or referring manageable cases to other institutions (Arafa et al., 2023). In India, Kaur et al. (2020) particularly highlighted this behaviour, noting that Indian doctors who are frequently exposed to any previous episodes of violence tend to restrict their

engagement with complicated clinical procedures and emergency care to protect themselves from such further incidents. Debnath et al. (2023) showed that WPV exposure leads to reactive clinical approaches, including reduced invasive interventions, increased investigations, and avoidance of complex emergencies, while Adhikari et al. (2023) found increased referrals and specialist consultations as the consequences of WPV.

Apart from defensive medicine, WPV also profoundly alters doctor-patient communication, another critical dimension of patient management. Effective communication, characterised by compassion, clarity, active listening, and trust-building, is essential to delivering quality healthcare. However, research clearly indicates that WPV leads to deteriorated communication behaviours among healthcare providers. In a survey conducted by Bayram et al. (2023), nurses who experienced verbal abuse reported feelings of sadness, insecurity, and worthlessness. Common coping behaviours included ignoring the abuse, becoming insensitive to it over time, and not involving themselves in the situation. These emotional responses often had prolonged repercussions, such as the use of non-curative communication, delays in patient care, or disengagement from care responsibilities altogether. Additionally, limited studies indicate altered communication patterns following WPV, including increased aggressiveness, more formal interactions, or emotional detachment (Anil et al., 2025).

The alteration in patient management behaviour resulting from WPV can have serious consequences for both healthcare delivery and patient outcomes. When doctors adopt defensive medical practices such as excessive referrals, unnecessary diagnostic tests, or refusal to treat high-risk patients, they compromise the principle of effective patient care (Arafa et al., 2023; Debnath et al., 2023; Islam & Awal, 2020). Additionally, WPV against healthcare professionals has a profound influence on medical decision-making and healthcare expenditures. It often leads to the adoption of defensive medical practices, marked by

conservative treatment strategies and reduced clinical intervention. Although such shifts may occasionally lower immediate costs for patients, they tend to compromise overall health outcomes. To ensure high-quality care and protect patient well-being, it is important to implement robust approaches to prevent WPV and to promote fair and appropriate treatment within healthcare institutions (Hu et al., 2025).

Besides conceptual reasoning, multiple empirical studies prove the concrete impact of WPV on doctors' clinical behaviour. For instance, Karpinar et al. (2021) reported that physicians subjected to verbal or physical violence exhibited reduced empathy, emotional disengagement, and a defensive communication style during patient interactions. In the Indian context, Kaur et al. (2020) reported that WPV against doctors significantly influenced various dimensions of clinical decision-making and patient management. The study found that 62% of doctors reduced the frequency of surgical procedures, 48% increased their reliance on diagnostic investigations, and 66% became less inclined to manage critically ill patients. Hence, CPMB becomes a measurable behavioural outcome relating doctors' stress and emotional trauma with consequences for patient safety and healthcare quality.

While WPV against doctors has been widely studied for its psychological and professional consequences, such as burnout-related emotional exhaustion, job satisfaction, turnover intentions, and risk avoidance, its impact on how doctors actually manage their patients remains underexplored. CPMB reflects a modification in clinical decision-making, often driven by emotional exhaustion, fear of litigation, or lack of systemic protection (Lafta et al., 2021; Pai et al., 2024). When doctors, as a result of violence, begin avoiding high-risk patients, over-prescribing diagnostics, or minimizing patient interaction, it compromises the quality of care delivered. It erodes the trust central to the doctor-patient relationship (DPR). This construct serves as a bridge between individual-level psychological responses (e.g., burnout, job satisfaction) and systemic consequences, such as poor patient outcomes and

increased healthcare costs. Studying CPMB in combination with constructs such as RAB and PSP provides a comprehensive understanding of how violence affects clinical conduct.

Theoretically, these clinical and interpersonal changes align primarily with the COR theory (Hobfoll, 1989), which postulates that doctors facing any sort of danger to their physical, mental or professional resources tend to limit or stop their involvement in order to preserve their valued resources. Thus, the rise in defensive clinical practices and in altered communication practices resulting from WPV highlights a crucial yet underexplored dimension of the healthcare sector. In terms of JD-R, it shows changed work behaviour of doctors resulting from a disparity between demands and resources (Demerouti et al., 2001).

Although many studies have stressed the psychological and organizational impacts of WPV, very few have addressed limited aspects of its behavioural outcomes, particularly CPMB (Adhikari et al., 2023; Fan et al., 2024; Hu et al., 2025; Kaur et al., 2020; Kaur et al., 2021; Ulku & Saracaloglu, 2024). Prevailing research has mainly emphasized burnout, job satisfaction, and turnover intentions, but the precise and detailed study of altered patient management and the corresponding communication practices of doctors remains unexplored. Also, most studies narrowly focus on isolated practices such as over-investigation or avoidance of complex procedures, without capturing the combined shift in clinical decision-making, communication patterns, legal documentation risks, and patient interaction styles that collectively define CPMB (Adhikari et al. 2023; Arafa et al., 2023; Debnath et al., 2023; Kaur et al., 2020). Moreover, no study has empirically and adequately examined CPMB in the Indian context and integrated it into a comprehensive model, indicating a gap in the literature, as discussed in Section 2.12.

In the present study, RAB and CPMB are conceptualized as distinct but related behavioural outcomes of WPV. RAB refers to doctors' tendency to reduce exposure to high-risk clinical responsibility by avoiding, declining, referring, or withdrawing from cases or

clinical procedures perceived as complicated or conflict-related. It therefore involves deciding whether to engage with certain high-risk patients or clinical situations. In contrast, CPMB refers to changes in doctors' patient-management or in-treatment behaviour after clinical engagement has already occurred. This generally involves additional testing, over-prescribing, cautious communication, proper documentation, detailed consent-taking, procedural caution, or other defensive patient-management modifications. Thus, RAB represents avoidance-based withdrawal from risk exposure, whereas CPMB represents modified clinical practice while continuing to provide clinical care.

Apart from changes in behaviour, WPV also impacts and deteriorates the everyday interactions of doctors and patients in healthcare. The effect of such practices on the DPR can be seen as hampering smooth patient care and effective healthcare delivery.

2.7 Relational Outcomes of WPV

The purpose of this section is to analyze how WPV changes the relationship between doctors and patients. Repeated aggression and violence against doctors decrease understanding, trust, and communication among them, weakening the quality of the doctor-patient relationship (DPR).

2.7.1 Deterioration of Doctor-Patient Relationship (DPR)

The DPR forms the ethical and professional backbone of medical practice. It enables accurate diagnosis, effective therapy, and compassionate, patient-oriented care. The chief drivers of a strong DPR are open communication, which improves loyalty and satisfaction; empathy, which builds mutual understanding and trust; and informed consent, which ensures transparency in treatment. Trust leads to better performance, thereby reducing stress among doctors and forming a solid foundation for DPR, whereas professional boundaries preserve the integrity of the DPR (Smith, 2019). Disturbances to these factors, such as those caused by WPV, may compromise both the doctor's emotional well-being and the quality of the

healthcare system. For the purposes of this study, DPR is operationalized as the doctor's perception of the relationship quality (trust, respect, communication, cooperation), not the patient's perception or any other objective measure.

DPR is a vital and multi-dimensional construct that begins with the first consultation and continues until the patient follows the doctor's advice and recommendations. An optimistic and sound DPR promotes healthy relationships, enhances trust, and reinforces patients' ability to cope with illness. Whereas a stressed DPR hampers the quality of patient care, increases emotional strain and anxiety, hinders loyalty towards treatment, and leads to seeking alternative treatment methods or remedies. Whenever doctors anticipate a potential disruption in such relationships, they may adopt defensive practices or change their behaviour towards patients (Qiao et al., 2019).

While studying the DPR from the doctor's perspective, many researchers have explored various aspects of this relationship. Qiao et al. (2019) found that the multiple factors that influence the doctor-patient relationship from the doctor's point of view are doctor-patient trust, hospital environment, negative media influence, type of hospital, waiting time for patients, income satisfaction of doctors, consultation time, expectation of treatment by patients, and medical dispute. Similarly, Liu et al. (2020) found that doctors generally held a negative perception of the DPR. Factors such as gender, age, region, hospital type, and income significantly shaped these perceptions. Doctors facing heavy workloads, involved in medical disputes, and those with limited time to communicate with patients were more likely to report strained relationships with patients. Conversely, physicians working in hospitals equipped with adequate safety protocols, dedicated security personnel, and institutional support such as medical liability insurance reported more favorable experiences in their interactions with patients. This implies that both individual-level and organizational-level factors impact the quality of DPR. In addition, the deterioration of DPR arises from rising

consumerism, media exaggeration, legal burdens, the government's negligence towards healthcare, and poor healthcare infrastructure, leading to further conflicts (Panday & Choudhary, 2020).

WPV has a substantial and detrimental effect on the DPR, leading to its deterioration. Doctors who experience violence perceive negativity in their relationships with patients, affecting trust, emotional connection, and communication, and indirectly influencing job satisfaction and turnover intentions. Feeling unsafe and threatened, doctors become more guarded and communicate less, leading patients to feel distant and inadequately supported. Over time, this vicious cycle erodes trust, reduces cooperation, and strains doctor-patient relationships, ultimately worsening service quality (Li et al., 2023; Mao et al., 2021; Milford & Lorenzini, 2024). Research done by Chen and Li (2022) indicates that doctors who have encountered verbal or physical abuse may become more self-protective, emotionally exhausted, or uncertain in their interactions with patients. This emotional disengagement, often an unconscious coping mechanism, leads to impaired communication, reduced empathetic engagement, and deteriorated therapeutic care, thereby impacting the fundamental aspects of a strong DPR (Hu et al., 2025). Patients, in turn, may perceive this behaviour as apathy or arrogance, reinforcing mistrust and frustration, thereby forming a vicious cycle that contributes to further conflicts and hostility.

A faded DPR not only impacts the healing and remedial association between a doctor and a patient but also hampers patient satisfaction, loyalty, and treatment outcomes. Compromised trust leads to a communication barrier between a doctor and a patient, resulting in non-consensual decisions by doctors and forcing them to adopt defensive medicine to avoid litigation and conflicts. Doctors tend to treat patients and focus on patient-care and quality of treatment while safeguarding themselves and handling the inappropriate and hostile behaviour of patients and their attendants efficiently. A harmonious and respectable DPR is

always driven by respect, empathy, and effective communication between doctors and patients; essential for a strong foundation of a patient-centric approach of healthcare delivery (Tao et al., 2022).

The deterioration of DPR can be explained through Affective Events Theory (AET) and Social Exchange Theory (SET). AET, which principally supports DPR, states that any violent event leads to adverse emotional reactions that diminish empathy, hamper patient care, and thereby destroy a trustworthy relationship between doctors and patients (Weiss & Cropanzano, 1996). SET posits that all social relationships are based on reciprocal exchanges and any violation of trust leads to an unbalanced relationship, creating mistrust and disaffection between the doctors and patients (Blau, 1964). These theories together describe how such hostile events cause emotional exhaustion and result in withdrawal tendencies among doctors.

In the context of rising WPV, it becomes essential to evaluate how these experiences shift doctors' attitudes, communication, and readiness to engage with their patients. A study in China by Li et al. (2023) found the association between WPV, job satisfaction, and turnover intentions among Chinese doctors and other healthcare professionals, with a specific focus on how they perceive the DPR. The study found that WPV influenced turnover intentions indirectly, mediated by DPR perception and, in turn, by a serial mediation involving both DPR perception and job satisfaction. Furthermore, in a study conducted in Bangladesh, Rashid (2025) explored doctors' perceptions of their patients and how these perceptions influence their clinical management. Consequently, it was observed that, especially in remote areas, the DPR is moulded not only by clinical efficiencies but also by cultural outlooks, institutional challenges, and emotional stress.

Despite being the backbone of healthcare delivery, DPR remains inadequately theorised in the context of WPV. Existing literature largely examines DPR from a patient-

centric or perception-based perspective, with limited attention to how doctors themselves experience and interpret the deterioration of relationships following violent encounters (Amin, 2025; Finkelstein, 2025; Rashid, 2025; Su et al., 2026). Furthermore, studies often treat DPR as an isolated outcome, without integrating it with underlying psychological states such as burnout or behavioural adaptations such as defensive practices and risk avoidance. In addition, empirical research rarely captures DPR as a dynamic and evolving construct influenced by repeated exposure to conflict and emotional exhaustion. In the Indian context, although rising distrust and strained interactions have been widely acknowledged, there is a lack of theory-driven, empirically validated models that situate DPR within a broader framework. Thus, examining the changed DPR from the doctor's perspective is crucial in understanding how WPV affects healthcare quality and the emotional extent of clinical practices.

2.8 Attitudinal Outcome of WPV

Attitudinal outcomes reflect doctors' own decisions and future-oriented plans about their profession and workplace. In the context of WPV, they capture how adverse WPV-related experiences influence their willingness to continue in medical practice or even the profession, particularly through turnover intentions.

2.8.1 Impact on Turnover Intentions

Employee turnover is referred to as a separation of an individual from an organization, which may occur either voluntarily or through employer-driven decisions (Holtom et al., 2008). Turnover intention, in contrast, denotes a worker's deliberate contemplation or idea to leave the organization or profession within a defined timeframe, generally driven by personal motivations. In order to maintain organisational continuity and achieve sustained success, sustaining skilled and experienced employees is crucial for an organization (Lazzari et al., 2022).

In the healthcare sector, particularly among doctors, various factors can be considered as antecedents of increased turnover intentions. These include job satisfaction, availability of alternate employment opportunities, workload, work pressure, work engagement, compensation satisfaction, organizational commitment, organizational culture, type of hospital, contentment with promotions, gender, speciality, age, professional title and designation of doctors (Chen et al., 2014; Duan et al., 2019; Li et al., 2020; Li et al., 2024; Luz et al., 2016; Oh & Kim, 2019; Xiao et al., 2024). Apart from these, numerous additional factors influence the turnover intentions of doctors, including organisational support, doctor-patient relationships, work-family conflict, interpersonal conflict, self-perceived staff shortages, and other psychological factors associated with doctors (Feng et al., 2022; Nikkhah-Farkhani & Soltani, 2021). A systematic review by Wang and Surienty (2025) further identified WPV, low job satisfaction, poor DPR, institutional shortcomings, occupational stress, burnout, and demographic factors as key influences, while a meta-analysis by Wang et al. (2025) reported a high existence of turnover intentions, with low job satisfaction emerging as the primary risk factor.

WPV has emerged as a recent and crucial contributor to doctors' turnover intentions, which are mediated by job burnout (Chen et al., 2022; Rahim & Cosby, 2016). A study by Debnath et al. (2023) concluded that the doctors who encountered WPV reported decreased motivation to work, which in turn led to a higher tendency to change their occupation. Additionally, a survey revealed that 59% of doctors who faced WPV were actively planning to move abroad, while 86% had explored migration for safety, dignity, and better working conditions (Al-Shimari et al., 2024). Similarly, research done by Al-Mousawi and Lafta (2024) in Iraq showed that 85% of doctors who suffered WPV expressed their intent to change their job, workplace, or simply leave the country to avoid such incidents.

The increase in turnover intentions among doctors and other healthcare professionals has become an alarming concern. Yen et al. (2021) expressed concern over the shortage in the medical system across various nations due to increased turnover intentions caused by WPV. A recent study by Xiao et al. (2024) in China found that as WPV levels increased, healthcare workers exhibited a reduced inclination to remain in the healthcare sector. Moreover, 91.7% of workers disagreed with the notion that their children should pursue a profession in the healthcare sector. Additionally, among the workers who experienced high levels of WPV, only 11% expressed interest in continuing in the same profession, and only 2% encouraged their children to follow them into their occupation.

Burnout, operationalized through emotional exhaustion, acts as a key factor intervening in this framework. Psychological stress triggered by WPV drains emotional resources, reduces morale, and lowers job satisfaction, which then leads to greater intention to quit. In high-intensity environments such as casualty or emergency departments, burnout, along with frequent violence, accelerates the intent to exit the profession completely (Chen et al., 2022; Li et al., 2020). Thus, showing how burnout-related emotional exhaustion and job satisfaction act as mediators in the relationship between burnout and turnover intentions.

Many global and Indian studies have strengthened the connection between WPV and doctors' turnover intentions. A 2025 meta-analysis, covering 97,000 doctors worldwide, found that approximately 39% reported intentions to leave their profession (Wang et al., 2025). Notably, burnout and job dissatisfaction arising from WPV in ICUs, emergency departments, and public hospitals contribute substantially to these figures. A national survey conducted by Shi et al. (2024) in China exhibited a high turnover intention rate of 55.45% amongst doctors. In India, a review done by Ahamed et al. (2021) revealed that 23.2% of doctors expressed an intention to leave their jobs, with perceived safety from WPV as the primary determinant. Similarly, other authors examined turnover intentions as a key outcome

variable, influenced by WPV and mediated through burnout, job satisfaction, professional identity, and emotional well-being (Chen et al., 2022; Zhang et al., 2021).

To conceptualise the mechanisms and position the constructs in the system, theoretical models such as JD-R, COR, AET and SET align with the increasing drift of turnover intentions among doctors. Corresponding to the JD-R model, once job demands such as WPV lead to stress and demotivation among doctors, and these demands are not backed by resources like social or organisational support, it leads to emotional fatigue and burnout, which in turn intensifies turnover intentions (Demerouti et al., 2001). Supported by COR theory, repeated exposure to violence leads to a perceived or actual loss of personal and professional resources, instigating doctors to consider exit in order to preserve their resources (Hobfoll, 1989). Likewise, AET states that any negative workplace experiences, like WPV, trigger negative emotional reactions leading to withdrawal intentions (Weiss & Cropanzano, 1996). SET also supports this view by signifying that when doctors feel that their efforts and risks are not reciprocated by organizational protection or recognition, they disengage themselves from work and consider leaving the organisation (Blau, 1964).

As has been demonstrated, the literature collectively implies that WPV triggers a sequence of psychological effects among doctors. Doctors, when they encounter such events, undergo emotional exhaustion and stress, leading to burnout instigating a state of demoralisation and disinterest in work. As burnout worsens, it erodes job satisfaction, undermining the sense of professional motivation and encouragement derived from medical practice. Eventually, this dissatisfaction and resentment lead to stronger turnover intentions, instigating doctors to leave unsafe and stressful professional and work atmospheres. This sequential relationship from WPV to burnout-related emotional exhaustion, then to eroded job satisfaction, and finally to turnover intentions, demonstrates a ripple effect grounded in theoretical models of JD-R, COR, and SET. Existing studies do not incorporate intermediary

factors, such as defensive medicine practices by doctors and the changing relationship between doctors and patients, when considering the overall impact of WPV on doctors' turnover intentions.

Despite the significance of turnover intentions for the sustainability of the healthcare system, most Indian studies remain descriptive and do not integrate turnover intentions into a comprehensive theoretical framework. Furthermore, turnover intentions are often examined as an independent outcome rather than as part of a broader model, a research gap that will be discussed further in Section 2.12. This fragmented approach limits the understanding of how WPV gradually translates into workforce withdrawal. Thus, the present study treats turnover intentions as a key attitudinal outcome influenced by WPV, both directly and indirectly through other WPV outcomes.

2.9 Systemic Moderators of WPV

The purpose of this section is to examine the systemic moderator, PSP, that shapes the relationship between WPV and doctors' outcomes, as conceptualized specifically for this study. Systemic moderators represent all the external factors that suppress or exaggerate the psychological, behavioural, relational and attitudinal effects of WPV.

2.9.1 Perceived Systemic Protection (PSP)

Perceived Systemic Protection (PSP), a newly integrated, context-specific exploratory construct in this study, which refers to the level of doctors feeling that organizational, legal, and societal factors safeguard them against WPV, preventing violent encounters and providing a fair and transparent environment in healthcare settings. In contrast to physical protection, PSP denotes a psychological state of safety, in which doctors believe they will receive protective support from involved institutions, legal frameworks, and relevant authorities in the event of such an occurrence. Higher degrees of PSP instill a sense of trust and safety, whereas, low PSP leads to feelings of neglect and rejection among doctors.

PSP incorporates multiple dimensions of safety and organizational support that doctors expect from the broader healthcare ecosystem in response to WPV. One of the foremost components of PSP is legal protection, wherein doctors feel secure knowing that there are specific laws designed to discourage violent behaviour through strict penalties and to provide fair judicial remedies for sufferers of such assaults. Complementing this are hospital-level administrative safeguards, such as formal anti-violence protocols, transparent grievance mechanisms, empathetic and fair supervision, and trained guards that help neutralize potential conflicts (Chen et al., 2024; Ranjha et al., 2022; Sharma & Gupta, 2023). Another essential layer is policy-level protection, which reflects doctors' trust in government regulations, various medical acts, health ministry guidelines, and institutional accreditation agencies such as the National Accreditation Board for Hospitals (NABH) or Medical Council of India (MCI) that mandate safety protocols for healthcare staff (Haldar & Chandrashekhar, 2024; Nanda et al., 2025).

In the healthcare sector, existing constructs such as Perceived Organizational Support (POS) and workplace safety climate offer valuable insights into employees' perceptions of safety and support, but their applicability remains limited. The safety climate reflects shared opinions about safety practices within a particular organizational environment. Moreover, PSP differs from POS in that it extends beyond doctors' perceptions of support from their employing organization. While POS primarily concerns whether the organization values employees and attends to their well-being, PSP captures doctors' broader perceptions of protection from legal, organizational, and societal safety in response to WPV (Chadhar et al., 2024; Eisenberger et al., 1986; Sorensen et al., 2018). Thus, PSP includes organizational-level support, as well as government regulation, legal enforcement, punishment of perpetrators, safety reporting, and media/societal responsibility. Since WPV-related attacks against doctors are not limited to organizational borders and are frequently influenced by

external variables such as public opinion, media narratives, the legal system, and broader societal conduct, organizational-level explanations are inadequate to account for doctors' perceptions of protection in the context of WPV.

By viewing protection as a multi-level, system-oriented phenomenon, PSP goes beyond these conventional conceptions. It incorporates three interconnected dimensions: (1) legal protection (e.g., the efficacy of laws, enforcement mechanisms, and accountability of offenders); (2) organizational protection (e.g., hospital security systems, administrative support, reporting mechanisms); and (3) societal protection (e.g., public trust, media responsibility, and societal respect for the medical profession). Together, these factors affect how doctors perceive safety in general and how they understand and handle WPV (Al-Mousawi & Lafta, 2024; Chen et al., 2024; Mahani & Zadu, 2024; Pai et al., 2024; Samant et al., 2024; Yücel et al., 2024).

Theoretically, PSP is based on both SET and COR theory. According to COR theory, people prioritize safeguarding themselves and building resources to cope with stress (Hobfoll, 1989). In this situation, perceived protection in the legal, social, and organisational spheres serves as a composite resource that protects against the psychological stress brought on by WPV. Greater perceived availability of protective resources is indicated by higher PSP levels, which reduce resource depletion and negative psychological effects such as burnout. Low PSP, on the other hand, increases perceived vulnerability and speeds up resource depletion.

Concurrently, SET gives PSP a relational explanation. Doctors are more likely to build trust, uphold their professional commitment, and interact well with patients when they believe that organisations, legal systems, and society as a whole support and protect them. Weak or inconsistent protection, on the other hand, indicates a breakdown in reciprocal trade, which results in diminished trust, defensive actions, and withdrawal intentions. As a result,

PSP functions as a signal of systemic justice and reciprocity in addition to serving as a resource buffer (Blau, 1964).

Crucially, PSP is conceptualized in this study as a system-level perception rather than as a narrow organizational-level support variable. Doctors consider a comprehensive sense of whether the system protects them, rather than experiencing organizational, legal, and societal protections separately. In places like India, where disparities in organizational support, legal enforcement, and public conduct interact to influence experiences of WPV, this system-level impression is especially pertinent. However, in this study, PSP was operationalized as a first-order exploratory and reflective construct, and its structure was not tested as a higher-order or multidimensional model. Therefore, findings involving PSP are interpreted cautiously, and future research should examine whether PSP is better represented as a formative, multidimensional, higher-order, or three-factor correlated construct.

PSP is positioned in this study as a moderating buffer that affects the strength of links between WPV and its psychological, behavioral, and relational effects due to its comprehensive nature. In particular, by buffering psychological pressure, lowering defensive behavioral reactions, and maintaining the DPR, higher levels of PSP are predicted to reduce the adverse effects of WPV. Low PSP, on the other hand, is predicted to intensify these negative consequences and hasten the transition from WPV to desire to leave.

The present study fulfills a major gap in the existing literature by presenting PSP as a unified, system-level construct. Previous research has mostly ignored how doctors' perceptions of protection across various organizational, legal, and societal layers influence their responses to WPV. This conceptualization offers a fresh perspective on the larger systemic issues affecting physician retention and well-being, as well as a more thorough and contextually grounded knowledge of safety in healthcare settings.

2.10 Integrated Conceptual Framework

WPV against doctors is conceptualized in the present study as a main job-related stress-inducing variable that initiates a chain reaction of psychological, behavioral, relational, and attitudinal consequences. As a job demand, WPV disrupts the professional environment, weakens doctors' sense of safety, and creates emotional strain, which impacts various aspects of their work and clinical practice.

At the psychological level, repeated exposure to WPV contributes to emotional exhaustion and burnout, while simultaneously weakening job satisfaction. These internal changes among the doctors shape the way they consider their work and professional accomplishment, forming the immediate impact of such violent workplace experiences. As burnout-related emotional exhaustion exaggerates and job satisfaction declines, doctors experience reduced motivation, emotional detachment, and a diminishing sense of professional commitment.

These psychological changes further turn into behavioral adaptations. Doctors, in response to such apparent violent threats, turmoil, and uncertainty, may engage in RAB and altered clinical decision-making patterns, referred to as CPMB. Such behaviors include avoiding high-risk cases, increased referrals, excessive investigations, and defensive medical practices intended to reduce or prevent potential conflict or litigation risks. These behavioral shifts represent situation-handling mechanisms adopted to retain personal and professional safety in high-risk and challenging environments.

Simultaneously, the impact of WPV extends to the relational dimension of medical practice, particularly the DPR. Exposure to violence leads to emotional withdrawal, reduced empathy, distressed coordination, disturbed interactions, risk avoidance, reformed clinical decision-making, and guarded communication, thereby weakening trust and transparency

between doctors and patients. This deterioration in DPR not only affects the quality of healthcare but also infuses a chain of mistrust and conflict within healthcare settings.

At the attitudinal level, these psychological, behavioral, and relational disruptions jointly shape doctors' long-term professional insights, particularly their intention to continue in the profession. Turnover intentions emerge as a critical outcome, reflecting doctors' consideration of leaving their current workplace or even the medical profession due to unsafe and tense working conditions.

The relationship between WPV and its outcomes is inconsistent and moderated by how doctors perceive the availability and effectiveness of systemic support. PSP, a newly introduced construct that buffers the adverse effects of WPV, is conceptualized as a moderating variable in the present study. When doctors perceive strong legal, organizational, and societal support, the negative impact of WPV on burnout-related emotional exhaustion, job satisfaction, behavioral responses, DPR, and turnover intentions is expected to weaken. Conversely, low PSP intensifies these relationships, amplifying the detrimental consequences of violence.

The proposed framework thus presents WPV as a central premise that triggers a sequential and interrelated process across psychological, behavioural, relational, and attitudinal outcomes, with PSP acting as an essential moderator. This integrated approach moves beyond isolated analysis of each WPV outcome and provides a comprehensive understanding of how WPV reforms doctors' experiences, behaviours, professional life and occupational decisions within the healthcare system.

2.11 Theoretical Framework

The theoretical model supporting this study comprises four complementary organisational and emotional theories: the Job Demands-Resources (JD-R) Model, the Conservation of Resources (COR) Theory, the Affective Events Theory (AET), and the

Social Exchange Theory (SET). These theories help elucidate how WPV impacts psychological, behavioural, relational, and attitudinal outcomes among doctors. Together, these theories provide a coherent foundation for the proposed structural model, illustrating how WPV acts as a stressor, depletes valued resources, triggers emotional and behavioural responses, and disrupts professional and social relationships.

2.11.1 Job Demands-Resources (JD-R) Model

According to the JD-R framework (Demerouti et al., 2001), the interaction between job demands and available resources results in employees' stress and motivation. In the present study, WPV is conceptualized as a job demand that leads to burnout and dissatisfaction among doctors. PSP and social support mechanisms are considered buffering job resources that can mitigate these negative effects. The JD-R model thus supports the mediation and moderation mechanisms proposed in this research, particularly in how WPV leads to professional withdrawal behaviours such as turnover intentions.

2.11.2 Conservation of Resources (COR) Theory

Hobfoll (1989) argues that people try to preserve valuable individual and related resources against any loss or threat. WPV threatens these resources, resulting in stress, burnout, and defensive responses. To protect their limited emotional and cognitive resources, doctors may reduce their engagement in emotionally draining tasks, leading to risk-averse behaviours and detachment from patients. This theory effectively explains the turnover intentions and defensive practices that doctors may develop after experiencing violence. Moreover, PSP can serve as an external resource that helps reduce the perceived threat, thereby enhancing resilience and mitigating the psychological and behavioural impact of WPV.

2.11.3 Affective Events Theory (AET)

AET by Weiss and Cropanzano (1996) argues that specific incidents at the workplace trigger emotions, which then influence attitudes and behaviour. WPV is a highly adverse affective event, provoking emotions like fear, frustration, and helplessness. These affective experiences can diminish job satisfaction, increase tendencies toward burnout and turnover, and damage the DPR. AET supports the argument that emotional experiences mediate the link between WPV and outcomes such as job satisfaction, burnout, and turnover intentions (Li et al., 2023).

2.11.4 Social Exchange Theory (SET)

SET by Blau (1964) emphasized that professional relationships operate through mutual reciprocity and the perceived fairness in give-and-take interactions. When doctors face violence and receive no organizational support, they may feel the exchange is unfair and biased, leading to withdrawal from professional commitments. This explains reduced patient-centered communication, RAB, and deteriorated DPR. Conversely, PSP may reinstate the balance in the exchange by reinforcing the organization's commitment to the physician, potentially leading to improved outcomes (Gbobaniyi et al., 2023).

2.11.5 Synthesis of Theoretical Perspectives

Collectively, these four frameworks explain how WPV generates stress and shapes psychological, behavioral, relational, and attitudinal outcomes among doctors. While each theoretical model has a distinctive characteristic, they jointly explain different dimensions of the same phenomenon. The resource-based theories, JD-R and COR models, highlight the depletion and replenishment of professional resources; AET explicates the emotional mechanisms linking violent incidents to attitudinal, behavioral, and relational changes; and SET explains the relational and reciprocal dimensions underpinning trust and withdrawal

behaviors. Hence, some constructs are aligned with multiple theories, reflecting the multifaceted nature of WPV in healthcare.

Table 2.1: Alignment of Constructs with Theoretical Frameworks

Construct/ Variable	Primary Theory	Supporting Theories
Workplace Violence (WPV)	JD-R	COR, AET
Burnout-related Emotional Exhaustion	JD-R	COR, AET
Job Satisfaction	JD-R	COR, AET
Risk Avoidance Behaviour (RAB)	COR	JD-R
Changed Patient Management Behaviour (CPMB)	COR	JD-R
Doctor-Patient Relationship (DPR)	AET	SET
Perceived Systemic Protection (PSP)	SET	JD-R, COR
Turnover Intentions	JD-R	COR, AET, SET

Source: Authors' compilation based on prior empirical studies including Demerouti et al. (2001), Hobfoll (1989), Weiss & Cropanzano (1996) and Blau (1964).

Table 2.1 presents the alignment of each construct with its primary and supporting theoretical models. While the JD-R and COR frameworks explain the stress and its coping mechanisms resulting from WPV, AET, and SET, AET and SET provide emotional and relational perspectives, respectively, together offering an organized and interconnected theoretical basis for the study.

Table 2.2 illustrates how the four theoretical frameworks collectively explain the relationships among the study constructs. The pathways presented are indicative of dominant theoretical linkages and do not imply strict sequential relationships, as the proposed model

conceptualizes psychological and behavioural constructs as parallel mediators within a layered framework.

Table 2.2: Theoretical Framework Linkages

Theory	Explains Pathway
JD-R Model by Demerouti et al. (2001)	WPV → Burnout-related Emotional Exhaustion, Job Satisfaction → Turnover Intentions; PSP acts as a moderating job resource
COR Theory by Hobfoll (1989)	WPV → Resource loss → Defensive behavioural outcomes → RAB, CPMB; PSP acts as a buffer to protect loss of valued resources
AET by Weiss and Cropanzano (1996)	WPV → Reduced Job Satisfaction → Deteriorated DPR
SET by Blau (1964)	Low PSP and WPV → Reduced Job Satisfaction → Turnover Intentions → Weakened DPR

Source: Authors' compilation based on prior empirical studies including Demerouti et al. (2001), Hobfoll (1989), Weiss & Cropanzano (1996) and Blau (1964).

While several alternative theoretical perspectives such as the Theory of Planned Behaviour, Organisational Justice Theory, and Stress-Strain-Outcome Model could be considered relevant, they offer inadequate applicability to the present study. Theory of Planned Behaviour primarily focuses on intention formation based on attitudes, norms, and perceived control, but does not effectively capture the emotional and mental resource depletion triggered by WPV (Ajzen, 1991). Organisational Justice Theory explains perceptions of fairness within organisations but remains limited to internal structures and does not account for external, legal and societal influences that are vital in WPV contexts (Greenberg, 1987). Similarly, the Stress-Strain-Outcome model by Koeske and Koeske (1993), provides an overview of stress responses but lacks precision in explaining

behavioural adaptation and relational dynamics in complex healthcare environments.

Whereas, the JD-R model, COR theory, AET, and SET collectively offer a more comprehensive, multi-level, and contextually relevant framework to explain the psychological, behavioural, relational, and attitudinal consequences of WPV, justifying their selection in the present study.

2.12 Research Gap

Despite the growing body of literature on WPV against doctors, several critical gaps remain in understanding its broader and long-term repercussions. Existing research has predominantly focused on the prevalence, forms, and immediate effects of WPV, with limited attention to its continued psychological, behavioural, relational, and attitudinal implications, particularly in the Indian healthcare context. Most studies adopt a disjointed, isolated, fragmented approach, examining isolated outcomes individually, such as burnout-related emotional exhaustion or job satisfaction, rather than placing WPV within an integrated framework that captures its sequential and combined impact on professional aspects and on the healthcare system in India.

In spite of the increasing prevalence of WPV against doctors, the literature mostly shows descriptive studies, lacking a conceptual and integrated study aligned with theoretical framework, examining the model through which WPV impacts the psychological, behavioural, relational, and attitudinal outcomes of doctors (Ahluwalia et al., 2024; Anil et al., 2025; Kunnath et al., 2023; Mukta et al., 2025; Nayanar et al., 2024; Rossi et al., 2023; Sachdeva et al., 2025; Singh et al., 2023; Vinay et al., 2025). Not only this, very few empirical studies have examined the multidimensional systemic protection, including organizational, legal, and societal-level safeguards, and how it changes doctors' perceptions towards WPV (Carter et al., 2024; Jith et al., 2024; Paliwal et al., 2025; Rusu et al., 2025; Yücel et al., 2024). The growing prevalence of WPV against doctors emphasizes an urgent need for a comprehensive

academic analysis of this ever-increasing phenomenon. WPV, ranging from verbal abuse to physical assault, endangers the safety and well-being of doctors and, at the same time, poses a threat to the integrity of healthcare delivery. Despite increasing media coverage and policy discussions, empirical research exploring the multidimensional impact of WPV remains limited, especially within the Indian healthcare context. A deeper understanding of how WPV influences serious psychological consequences like job satisfaction and burnout-related emotional exhaustion, and altered workplace behaviour is essential. Moreover, there is a demanding need to investigate how such violence may deteriorate doctor-patient relationships, initiate risk-avoidance behaviour among doctors, and erode long-term trust between doctors and patients in the healthcare system. These gaps underscore the need for such an empirical study, to construct an integrative, theory-driven model incorporated within a SEM framework. By integrating these variables into a structured model, the current study purposes to fill a significant research gap and contribute reliable insights for healthcare policy and institutional reform.

A significant theoretical gap is also evident, as although frameworks such as the Job Demands-Resources (JD-R) model, Conservation of Resources (COR) theory, Affective Events Theory (AET), and Social Exchange Theory (SET) offer strong explanatory potential, their collective application in empirically testing WPV related outcomes remains limited. Consequently, the dynamic pathways through which WPV translates into psychological strain, behavioural adaptations, relational deterioration, and eventual attitudinal withdrawal are insufficiently theorised and validated.

Further, behavioural constructs such as RAB and CPMB remain underdeveloped and lack standardised measurement tools, especially in the Indian context. Similarly, relational outcomes, like the deterioration of the DPR, have received relatively less attention and are rarely examined as part of a broader logical and causal system. Moreover, attitudinal

consequences, such as turnover intentions, are often studied independently, without suitably capturing their relationship with preceding psychological and behavioural processes.

Another crucial gap lies in the absence of a system-level perspective. Though issues such as weak legal enforcement, inadequate organizational support, over-sensitization by media and societal mistrust are frequently reported, no study has systematically conceptualised or empirically examined PSP as a unified construct. The lack of validated instruments and theoretical integration of PSP restricts the understanding of how systemic factors may buffer or intensify the effects of WPV.

Considering methodological point of view, there is lack of studies employing advanced analytical techniques such as SEM to examine these complex, multi-layered relationships simultaneously. Existing Indian research remains largely descriptive, thereby confining its ability to capture mediation, moderation, and sequential pathways.

Overall, these gaps emphasize the need for a comprehensive, theory-driven, and empirically validated, unified model that integrates psychological (burnout-related emotional exhaustion, job satisfaction), behavioural (RAB, CPMB), relational (DPR), and attitudinal (turnover intentions) outcomes of WPV, while incorporating PSP as a moderating construct. Addressing these gaps will provide theoretical understanding along with implementable policies for strengthening healthcare systems, and improving doctors' well-being and patient-care in India. Thus, this study responds to an essential need to move from descriptive documentation of WPV to an integrated, theory-driven explanation of its systemic consequences.

2.13 Conceptual Model

The conceptual model guiding this study integrates insights from the Job Demands-Resources (JD-R) model, Conservation of Resources (COR) theory, Affective Events Theory (AET), and Social Exchange Theory (SET) to explain how workplace violence (WPV)

influences doctors' psychological, behavioural, relational, and attitudinal outcomes. WPV is conceptualised as a critical job demand and a negative affective event that triggers emotional strain, resource depletion, and perceived withdrawal of systemic support.

Within this framework, psychological outcomes, namely burnout-related emotional exhaustion and job satisfaction, constitute the first stage of WPV outcomes. Burnout reflects emotional exhaustion arising from frequent or continuous exposure to violence, while job satisfaction results from the positive and appraising work experiences. These two psychological states are positioned as parallel mediators that initiate the downstream process. Burnout-related emotional exhaustion and job satisfaction are conceptualized as parallel psychological responses to WPV.

Building on these psychological responses, the model conceptualises behavioural adaptations in the form of RAB and CPMB. As perceived from the COR theory, these behaviours represent defensive strategies adopted by doctors to conserve remaining emotional, cognitive, and professional resources in response to perceived threats and uncertainty due to hostility.

Subsequently, these behavioural adaptations, along with continued psychological strain, contribute to the deterioration of the DPR, which is positioned as a relational outcome. In line with AET and SET, DPR reflects the erosion of trust, respect, communication, and reciprocal exchange between doctors and patients, resulting from repeated exposure to adverse workplace events and defensive clinical practices.

Turnover intentions is conceptualised as the concluding attitudinal withdrawal outcome of this sequential model. Rather than emerging directly from WPV, it develops as a cumulative response to psychological exhaustion, behavioural adaptations, and relational deterioration, representing a withdrawal-oriented professional attitudinal outcome.

The model, as shown in Figure 2.1, follows a layered sequential structure, wherein psychological outcomes (burnout-related emotional exhaustion and job satisfaction) form the first stage, behavioural responses (RAB and CPMB) form the second stage, and relational outcomes (DPR) form the third stage, ultimately leading to attitudinal outcomes (turnover intentions). Within each stage, constructs operate in parallel, while across stages, relationships follow a directional sequence.

In addition, PSP is introduced as a moderating construct that reflects doctors' perceptions of organizational, legal, and societal support. PSP is theorised to buffer or intensify the effects of WPV across psychological, behavioural, and relational pathways. Higher PSP levels are likely to weaken the adverse impact of WPV, whereas lower levels may amplify its negative consequences.

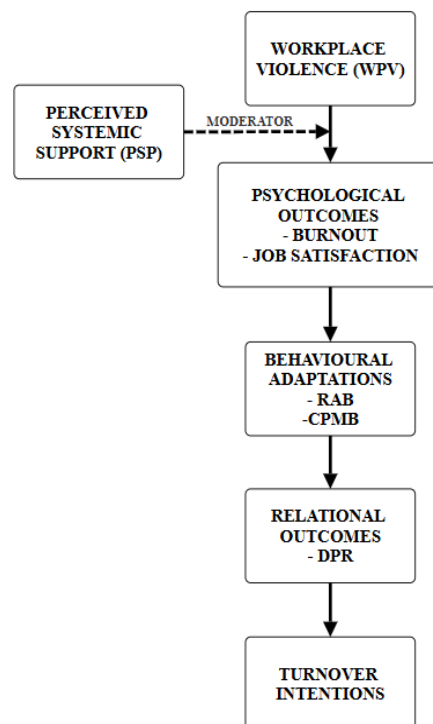


Figure 2.1

Conceptual model illustrating psychological, behavioural, and relational pathways linking workplace violence (WPV) to turnover intentions, with perceived systemic protection (PSP) as a moderating latent variable

The proposed conceptual framework thus provides a structured and theory-driven model to study the chained effect of WPV on doctors, capturing the association between psychological strain, behavioural adaptation, relational dynamics, and attitudinal withdrawal within a single integrated system.

CHAPTER 3

METHODOLOGY

3.1 Introduction

The chapter outlines the structured approach employed to study the impact of WPV on doctors and their subsequent psychological, behavioural, relational, and attitudinal outcomes. It explains the research design, sampling techniques, data instrumentation procedures, and data collection and analysis procedures used in the study. The chapter also describes the analytical techniques employed, including CFA to examine the model reliability and validity, followed by SEM to test the proposed relationships among constructs.

3.2 Research Design

This study adopted a theory-driven, quantitative and cross-sectional research design to observe the impact of WPV on doctors' psychological, behavioural, relational, and attitudinal outcomes. Quantitative research is appropriate for validating objective theories by studying relationships among variables through systematic measurement and statistical analysis (Creswell, 2018). The design is grounded in established theoretical frameworks, which also guide the order of relationships among the study constructs.

According to the established research methodology, quantitative studies derive relationships among variables from prior theory and translate them into testable hypotheses. Similarly, the present study utilised a structured conceptual model that defines the directional relationships between WPV, burnout-related emotional exhaustion, job satisfaction, RAB, CPMB, DPR, and turnover intentions (Bryman, 2016; Sekaran & Bougie, 2016).

The research used a cross-sectional design, in which data were collected from respondents at one point in time. This approach is suitable for analysing patterns and relationships among multiple constructs within a defined population and is widely used in quantitative research settings (Bryman, 2016).

A survey method was followed using a structured questionnaire, which was deployed to practising doctors. Survey research is considered a quantitative method as it involves the organized collection of measurable data to examine relationships among variables (Creswell, 2018). The instrument comprises validated and adapted scales measured on Likert-type responses, helping the quantification of latent constructs such as burnout-related emotional exhaustion, job satisfaction, and behavioural responses. This ensures consistency and suitability for statistical analysis (Sekaran & Bougie, 2016).

To analyse the proposed relationships, the study used SEM, a multivariate statistical method that enables synchronized and simultaneous examination of various dependent and independent associations among latent constructs within an integrated framework. SEM is particularly appropriate for theory-driven research, where relationships among variables are specified a priori based on theoretical justification, ensuring conceptual validity and meaningful interpretation of results (Hair et al., 2019).

The research design incorporated both measurement and structural components, wherein CFA is first conducted to validate the measurement model, followed by SEM to test the hypothesised relationships among constructs. This organized and sequential process strengthens the reliability and validity of the results.

Overall, the selected research design provided a comprehensive and methodologically robust framework for empirically testing the integrated conceptual and theoretical model and examining the multidimensional impact of WPV on doctors' professional outcomes.

3.3 Population and Sampling

The present study was conducted among registered medical doctors (MBBS and above) currently practicing in the state of Punjab and Chandigarh, India, who have witnessed the increasing number of such WPV cases against them and their overall impact on the healthcare sector in the state. Such doctors serve as an essential source of information and aid

in assessing the psychological, behavioural, relational, and attitudinal impacts of WPV, which are examined in this research. This study excludes medical interns, trainees, medical students, non-clinical and administrative medical officers, AYUSH practitioners, and doctors not directly involved with patients, such as pathologists and microbiologists. Doctors in Punjab and Chandigarh work across a variety of settings, including single-doctor clinics, private single- and multi-specialty hospitals, government hospitals, and nursing homes. Each type of setup has varied levels of patient workload, available resources and infrastructure, management support, and WPV exposures. Thus, the variety of respondents helped enhance the generalizability and severity of the findings, and this population is suitable for exploring the multidimensional effects of WPV and for testing the anticipated conceptual model using CFA and SEM.

3.3.1 Sampling Technique

Given the practical constraints associated with comprehensive sampling frame of doctors across Punjab, the study adopted a non-probability convenience sampling technique. This approach enabled data to be collected from respondents who were easily approachable and ready to participate. Convenience sampling is commonly used in social science and healthcare research studies, particularly when the population is difficult to access or when time and resource limitations are present (Bryman, 2016). The study primarily employed convenience sampling, supplemented by a snowball approach, wherein initial respondents were requested to share the questionnaire with other eligible participants to enhance sample reach and early completion of the targeted number of samples required for this study.

This hybrid sampling approach supports diversity while increasing reach and access to participants across different types of healthcare institutions. The present study employed a non-random or non-probability sampling approach, acknowledging the potential for sampling bias in such methods. Probability-based sampling was not feasible due to the absence of a

complete sampling frame of doctors, difficulties in approaching corporate and institutional doctors, time constraints, and the sensitivity of WPV as a research topic, which restricts random participation. The primary objective of the study is theory testing instead of population estimation; therefore, the emphasis is on obtaining a sufficiently large, information-rich sample to examine theoretically grounded relationships among constructs using SEM. This approach is consistent with established procedures followed in organizational and healthcare research, where non-probability sampling is frequently adopted due to feasibility and access constraints, particularly in the absence of a comprehensive sampling frame (Bryman, 2016; Polit & Beck, 2017; Sekaran & Bougie, 2016). While probability sampling enhances the generalizability of findings, non-probability sampling remains a practical alternative in such contexts, with emphasis placed on examining theoretically grounded relationships among constructs rather than making population-level estimations (Bryman, 2016; Hair et al., 2019; Sekaran & Bougie, 2016).

3.3.2 Sample Size

Considering the present study, there are eight latent variables (WPV, Burnout-related Emotional Exhaustion, Job Satisfaction, Turnover Intentions, RAB, CPMB, DPR and PSP) having approximately a total of 50-55 observed indicators along with mediation and moderation pathways. When using SEM, the most critical factor is to set an appropriate sample size to achieve model stability and accurate statistical power.

According to the conventional norms for CFA and SEM, the current study aimed to obtain a usable sample of at least 400 respondents. Hair et al. (2019) recommended a minimum sample of 300 for complex SEM models involving multiple latent constructs and moderation effects, while Kline (2016) noted that samples above 300 yield more stable parameter estimates. In the context of business research, Bajpai (2019) further suggests a minimum sample size of 200 for simple models and at least 400 for multivariate models with

multiple constructs. To allow for incomplete or invalid responses, the study targeted 500–600 distributed responses to obtain at least 400 usable cases, ensuring a strong model and obtaining reliable results.

Efforts were made to ensure diversity in the sample by including doctors from different practice settings, such as private hospitals, government institutions, and clinics, as well as varying levels of experience and specialisations. This enhances response variability and strengthens the findings.

Overall, the selected population and sampling strategy align with the objectives of the study and provide a practical and methodologically acceptable approach, for assessing the consequences of WPV on doctors within the specified settings.

3.3.3 Recruitment Channels and Sample Access Points

Since the study adopted a non-probability convenience and snowball sampling approach, no formal sampling frame was considered. A complete list of all eligible allopathic doctors practicing in Punjab and Chandigarh was not available for the research. Therefore, participants were enlisted through professional and personal networks, doctors' WhatsApp groups, Indian Medical Association (IMA) groups, referrals from participating doctors, and other professional contact points. These recruitment channels served as sample access points rather than a formal sampling frame. Eligible participants were screened based on the inclusion criteria, being an MBBS or allopathic doctor practicing in Punjab or Chandigarh.

3.4 Data Collection and Instrumentation

To collect data for the present study, a structured questionnaire was administered to practising medical doctors. A survey-based approach was adopted to obtain standardised responses across participants, enabling the quantitative measurement of constructs and simplifying statistical analysis of relationships among variables (Creswell, 2018).

The questionnaire was prepared using a comprehensive review of existing literature, theoretical models, and previously validated scales, with necessary adaptations made to suit the context of WPV against doctors in India. The instrument comprised multiple sections covering demographic information, WPV experiences, psychological outcomes, behavioural responses, relational outcomes, attitudinal outcomes and PSP. Minor wording changes were made to enhance contextual relevance without altering the original meaning of the items.

During the questionnaire design process, particular attention was given to ensuring conceptual clarity and construct uniqueness. Items that appeared to overlap across constructs or had the potential to create cross-loadings were carefully reviewed and, where necessary, excluded from inclusion within specific constructs. This was done to maintain discriminant validity and to ensure that each item accurately reflected its intended latent construct, thereby strengthening the measurement model. Items from established and validated scales in existing literature were cautiously adapted to ensure face validity of the measurement instrument

Prior to finalization, the questionnaire was reviewed for face validity by 22 practicing doctors. This was not conducted as a formal pilot study; rather, the purpose was to assess item clarity, wording, contextual significance, and practical appropriateness. Feedback from this stage was used to refine ambiguous wording and improve comprehension. For example, one of the DPR items was modified from “I generally trust my patients or attendants” to “I generally trust the information provided by patients or their attendants”. This change was incorporated because the original wording could be interpreted broadly as personal trust in patients, whereas the revised wording specifically focused on trust in clinical information provided by patients or their attendants, which was more relevant to the DPR construct in the present study. No responses from this review stage were used in the final statistical analysis.

An online survey platform (Google Forms) was used for data collection, enabling efficient distribution and broader reach across diverse healthcare settings. Data were collected

from doctors primarily through the Indian Medical Association (IMA), Punjab, and referral-based networks using calls and professional WhatsApp groups. A questionnaire link was shared through professional networks, personal contacts, and digital communication channels such as social media and messaging platforms. In addition, a snowball approach was employed, in which initial respondents were requested to forward the questionnaire to other eligible participants, thereby enhancing participation and coverage. As the data collection was conducted through professional networks, it led to a rapid accumulation of responses due to clustered participation patterns.

Respondents were informed about the research purpose, and their participation in the study was voluntary, while maintaining their confidentiality and anonymity.

3.4.1 Likert Scale

A five-point Likert scale was used to measure all the items, with response categories ranging from never (1) to very often (5) or strongly disagree (1) to strongly agree (5), depending on the nature of the construct. Likert scales are widely recognized as an appropriate method for measuring attitudes and perceptions in social and organizational research (Bryman, 2016; Hair et al., 2019; Sekaran & Bougie, 2016). A five-point scale was selected to ensure consistency and comparability across constructs, as many of the validated scales used in this study, particularly for job satisfaction, turnover intentions, and WPV, have been developed using five-point response formats. In addition, the scale balances respondent ease and measurement sensitivity, particularly in professional samples. The inclusion of a neutral midpoint allows respondents to express balanced or undecided views. Prior research indicates that increasing the number of response categories beyond a certain level results only in marginal improvements in reliability, while increasing response complexity and respondent fatigue. Moreover, prior research has reported that 5-point Likert scales yield comparable or higher data quality than 7- or 11-point scales (Dawes, 2008; Revilla et al.,

2014). Therefore, the five-point scale was considered appropriate for ensuring both response quality and analytical suitability.

3.4.2 Common Method Bias and Recall Bias

As the survey involved a cross-sectional and self-administered questionnaire, common method bias was considered during questionnaire design and analysis. Following the procedural recommendations of Podsakoff et al. (2003), several steps were taken to reduce common method bias. Participation was kept anonymous and voluntary, and respondents were informed that no answers were right or wrong. No personal details such as names, state council registration numbers, phone numbers, email addresses, or hospital names were collected. The questionnaire items were worded clearly, and the instrument was reviewed for face validity to reduce vagueness and improve contextual clarity. Some items were reverse-coded where appropriate to reduce the same-direction response bias. Positively worded items were reverse-coded prior to analysis to ensure the direction of measurement is consistent across all constructs. In addition to these procedural safeguards, Harman's single-factor test was applied as a preliminary diagnostic check, as reported in Chapter 4. However, because the study used single-source, cross-sectional self-reported data and did not include a conceptually unrelated marker variable, common method bias could not be completely eliminated.

Moreover, as the study relies on subjective data, there is a possibility of recall bias, particularly in reporting past WPV experiences. However, efforts were made to minimize this by using clearly defined, recent reference frames in the questionnaire.

3.4.3 Measurement of Variables

The instrument included both adapted and context-specific measurement scales. WPV was measured using items capturing the frequency of exposure to different forms of violence, adapted from healthcare-based WPV studies.

Table 3.1: Summary of measurement of variables

Construct	Role in the Model	Source of Scale Used	No. of Items	Scale Used
Workplace Violence (WPV)	Independent Variable	Adapted from WPV healthcare sector scales used by ILO, WHO, ICN, PSI and later empirical studies (e.g., Kumari et al., 2021)	10	5-point Likert Scale & Multiple-Choice Questions
Burnout-related Emotional Exhaustion	Psychological Mediator	Maslach Burnout Inventory - Emotional Exhaustion subscale (Maslach et al., 1997)	5	5-point Likert Scale
Job Satisfaction	Psychological Mediator	Brayfield & Rothe (1951) - Global Job Satisfaction scale	6	5-point Likert Scale
Risk-Avoidance Behaviour (RAB)	Behavioural Outcome & Mediator	Adapted from defensive medicine and risk-avoidance measures (Adhikari et al., 2023; Arafa et al., 2023; Debnath et al., 2023; Kaur et al., 2020)	5	5-point Likert Scale

Changed Patient-Management Behaviour (CPMB)	Behavioural Outcome & Mediator	Adapted from defensive practice and clinical-behavioural changes (Fan et al., 2024; Hu et al., 2025; Lorenc et al., 2024; Ulku & Saracaloglu, 2024; Ünal & Akbolat, 2024)	7	5-point Likert Scale
Doctor-Patient Relationship (DPR)	Relational Outcome & Downstream Mediator	Adapted from Doctor-Patient Relationship scales (Du et al., 2023; Tao et al., 2022)	7	5-point Likert Scale
Perceived Systemic Protection (PSP)	Moderator	Newly integrated construct based on existing literature, items adapted from organisational support and safety studies (e.g., Chen et al., 2024; Pai et al., 2024; Ranjha et al., 2023)	8	5-point Likert Scale
Turnover Intentions	Final Dependent Variable	Mobley Turnover Intention Scale (Mobley et al., 1978), Turnover Intention Scale (Bothma & Roodt, 2004)	4	5-point Likert Scale

Source: Authors' compilation based on validated instruments and prior empirical studies including ILO et al. (2002), Maslach et al. (1997), Brayfield & Rothe (1951), Mobley et al. (1978), Bothma & Roodt (2004), and recent healthcare violence literature (2020–2024).

For each construct, Table 3.1 shows its role in the conceptual model, the existing scale from which it will be adapted, the number of items, and the response format to be used.

The different types of WPV were taken into consideration by grouping relevant questionnaire items into categories, including verbal, physical, threat-based, and clinical pressure-related forms of violence.

For the purpose of group-based analysis, experience was categorized into three levels: junior (0–5 years), mid-level (6–10 years), and senior (above 10 years), to enable meaningful comparisons across different professional stages.

Behavioural constructs, including RAB and CPMB, were operationalised through items reflecting defensive clinical practices and changes in decision-making, based on relevant literature and contextual adaptation. The DPR was measured using items that capture perceived changes in trust, mutual respect, communication, and interaction quality, drawing on existing studies.

Overall, the data collection method and instrumentation were designed to ensure content relevance, conceptual clarity, and suitability for measuring latent constructs, thereby supporting reliable and valid analysis of complex relationships within the proposed theoretical framework.

3.4.4 PSP Measurement

PSP was introduced in the present study as a newly integrated, literature-adapted exploratory construct rather than as a fully validated new scale. PSP refers to doctors' perception of a system that provides adequate protection against WPV through legal, organizational, and societal support.

Since no adequate single existing instrument was available that comprehensively measured doctors' perceived protection of legal, organizational, and societal systems in the Indian WPV context. Therefore, an 8-item PSP construct was formulated for this study. The items were adapted from existing literature on WPV against doctors, medical protection laws, hospital security systems, administrative responses, reporting mechanisms, law-enforcement

actions, punishment of perpetrators, and media/societal responsibility. The PSP items were measured on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree), where higher scores indicate stronger PSP. Table 3.2 shows the conceptual mapping of PSP items.

The initial PSP item set was revised during academic supervision and the proposal review process for its theoretical relevance, clarity, and conceptual alignment with the study objectives. However, a separate pilot study, an exploratory factor analysis, and a formal expert assessment were not conducted prior to the main survey. Therefore, PSP is not claimed as a fully developed or validated scale. Instead, PSP was treated as a first-order reflective exploratory construct, and its reliability properties were examined in this study through CFA, reliability analysis, AVE, and discriminant validity testing. Accordingly, PSP findings in the present study are interpreted as preliminary and context-specific, requiring further validation in future research, as mentioned as a limitation of the study.

Table 3.2: Conceptual Mapping of PSP Items

PSP item	Item focus	Domain	Source
PSP1	Government regulations and health ministry policies protect doctors against WPV	Legal protection	Al-Mousawi & Lafta, 2024
PSP2	Guards, CCTV, administrative assistance, and support mechanisms protect doctors	Organizational protection	Chen et al., 2024; Ranjha et al., 2023
PSP3	Existing laws along with legal mechanisms protect doctors from violence	Legal protection	Al-Shimari et al., 2024; Mahani & Zadu, 2024
PSP4	Law-enforcement authorities respond appropriately to violence against doctors	Legal protection	Sethi et al., 2025

PSP5	Perpetrators of violence against doctors are punished appropriately	Legal protection	Chen et al., 2024; Jith et al., 2024; Paliwal et al., 2025
PSP6	Media and society act responsibly when violence against doctors occurs	Societal protection	Ranjha et al., 2023; Samant et al., 2024; Yücel et al., 2024
PSP7	Hospital/clinic administration supports doctors after WPV incidents	Organizational protection	Pai et al., 2024; Ranjha et al., 2023
PSP8	Doctors feel safe reporting WPV to institutions or external authorities	Organizational protection	Mukta et al., 2025

Source: Authors' compilation based on prior empirical studies from 2023-2025

3.5 Data Collection Procedures

After the finalisation of the questionnaire, the data collection process was initiated. The survey was administered over a defined period, during which responses were collected from eligible participants. To enhance participation, reminders were periodically sent, and respondents were requested to share the questionnaire with other practising doctors, thereby capturing the broader sampling frame and getting wider reach. Data collection was continued until an acceptable sample size was achieved. Final analyses were conducted on the complete dataset to ensure stability of results.

Upon completion of the data collection phase, the responses were compiled and underwent screening to ensure data completeness and quality. Responses that were incomplete, inconsistent, or exhibited uniform answering patterns were excluded. Reverse-coded items were appropriately recoded before the analysis to maintain a consistent direction of measurement. The dataset was then organised and prepared for statistical analysis.

3.6 Data Analysis

In the present study, a structured, multi-stage approach was used for the data analysis to examine the relationships among the proposed constructs. The analysis involved preliminary data screening, measurement model validation, and structural model testing, in line with established practices in multivariate analysis (Hair et al., 2019).

3.6.1 Data Screening and Preparation

Initially, the dataset underwent preliminary screening to ensure its accuracy and suitability for statistical testing. This included checking for missing values, inconsistent responses, and outliers. The data were screened for outliers and normality. Boxplots and standardized scores indicated the presence of a small number of outliers. However, these values fell within the permissible response range and were considered as reflecting genuine variability in respondents' perceptions and behaviours rather than data entry errors. Therefore, no such cases were removed from the collected dataset. Moreover, the dataset was further checked for straight-lining patterns and duplicate responses. As such, no significant evidence of careless responding was observed.

Basic assumptions regarding normality and data distribution were also examined to ensure appropriateness for subsequent multivariate techniques. Assessment of normality using Skewness, Kurtosis, and Mardia's coefficients suggested deviations from multivariate normality. Given the sample size and the sensitivity of maximum likelihood estimation to non-normality, bootstrapping (5,000 resamples) was used to obtain statistically sound standard errors and confidence intervals. This approach is widely recommended in SEM to address non-normal data and enhance the stability of parameter estimates. A significance level of 0.05 was assumed for hypothesis testing, corresponding to a 95% confidence level.

3.6.2 Measurement Model Assessment (CFA)

CFA was performed to assess the reliability and validity of the measurement model.

CFA is appropriate for theory-driven research where the relationships between indicators and latent constructs are specified (Hair et al., 2019).

Multiple criteria were used to evaluate the measurement model (Hair et al., 2019):

- Factor Loadings: Standardised loadings were examined, with values above 0.50 considered acceptable. Items demonstrating poor factor loadings or cross-loadings were considered for removal while maintaining theoretical integrity.
- Internal Consistency Reliability: Assessed by Composite Reliability (CR), with CR > 0.70 indicating adequate reliability.
- Convergent Validity: Evaluated using Average Variance Extracted (AVE), with values > 0.50 indicating sufficient convergence.
- Discriminant Validity: Evaluated using both the Fornell-Larcker criterion ($\sqrt{\text{AVE}}$ > inter-construct correlations) and the Heterotrait-Monotrait ratio of correlations (HTMT). HTMT values below the recommended threshold of 0.85 indicate that constructs are empirically distinct and that discriminant validity is established.

Model fit was evaluated using commonly reported fit indices, which are mentioned below, along with their cut-off values:

- χ^2 / df – ratio ≤ 3 indicates acceptable model fit (≤ 2 indicates good fit)
- Comparative Fit Index (CFI) ≥ 0.90
- Tucker-Lewis Index (TLI) ≥ 0.90
- Goodness-of-Fit Index (GFI) > 0.90
- Adjusted Goodness-of-Fit Index (AGFI) > 0.90
- Standardised Root Mean Square Residual (SRMR) ≤ 0.08
- Root Mean Square Error of Approximation (RMSEA) ≤ 0.08

- Parsimony Normed Fit Index (PNFI) > 0.50

Where necessary, model refinement was considered based on modification indices to improve overall model fit. All modifications were made cautiously, guided by theoretical justification to avoid purely data-driven adjustments. Only conceptually meaningful correlations or adjustments were made between items within the same construct to ensure the validity and interpretability of the measurement model. Cross-loadings and cross-construct residual correlations were not included in order to prevent overfitting and preserve theoretical integrity and discriminant validity.

Since RAB and CPMB are conceptually related behavioural responses to WPV, discriminant validity assessment was considered particularly important. RAB was defined as avoidance, rejection, referral, or withdrawal from high-risk clinical engagement, whereas CPMB was defined as modification of clinical behaviour during ongoing patient management. Discriminant validity was therefore assessed using Fornell-Larcker criteria and HTMT to ensure that these constructs were empirically distinguishable.

EFA was not conducted for the adapted constructs because the measurement model was theory-driven and the items were derived from established literature. However, PSP was conceptualized as a context-specific, newly integrated exploratory measure rather than a fully established scale. Since no separate pilot study or EFA was conducted for PSP prior to the main survey, PSP is not considered a fully developed or independently validated scale. However, it was assessed within the main CFA study using reliability analysis, AVE, and tests of discriminant validity. Findings involving PSP are therefore interpreted as preliminary and may require further validation.

3.6.3 Structural Model Assessment (SEM)

SEM was used to test the hypothesised relationships among constructs and to examine the overall model structure. SEM allows simultaneous estimation of multiple relationships

between latent constructs and is particularly suitable for complex, theory-driven models (Hair et al., 2019).

The structural model was assessed based on:

- Path Coefficients (β values): To assess the strength and direction of relationships.
- Statistical Significance (p-values / confidence intervals): To determine hypothesis support.
- Coefficient of Determination (R^2): To measure the explanatory power of endogenous constructs.

The structural model was evaluated using the direction and magnitude of standardized coefficients (β values) and significance levels (p-values). Hypotheses were considered supported when the path coefficient was significant ($p < 0.05$) and in the hypothesized direction. Moreover, the analysis focused on theory validation rather than model exploration, consistent with the study's confirmatory nature.

3.6.4 Preliminary Statistical Analysis

In addition to CFA and SEM, descriptive statistical analyses were performed to examine demographic characteristics and preliminary relationships among the constructs. To summarise the data, descriptive statistics like percentages, means, medians, and standard deviations were used.

Group differences were analyzed using independent sample t-tests and one-way and two-way ANOVA, where appropriate.

3.6.5 Mediation Analysis

Mediation effects were examined to understand the indirect relationships between WPV and turnover intentions through psychological, behavioural, and relational constructs. Indirect effects were assessed using bootstrapping techniques, which provide robust estimates

of mediation without assuming normality of the sampling distribution (Sekaran & Bougie, 2016). Bias-corrected and accelerated bootstrap confidence intervals (5000 resamples) were used to assess indirect effects, as they provide more accurate estimates than the percentile method under conditions of non-normality (Hair et al., 2019).

Both direct and indirect effects were analysed to identify significant mediation pathways within the model.

3.6.6 Moderation Analysis and Moderated Mediation Analysis

The moderating role of PSP was examined to assess whether it influences the relationship between WPV and the corresponding outcome variables within the proposed structural model. Moderation was tested by creating interaction terms between the independent variable (WPV) and the moderator (PSP), and analysing these interaction effects using regression-based approaches. Similarly, moderated mediation was performed using the jAMM GLM Mediation Model in Jamovi to assess the moderating effect of PSP across various mediated paths.

Given the conceptualisation of PSP as a systemic resource showing organizational, legal, and societal support, the moderation analysis was primarily focused on the psychological outcomes, where such buffering effects are theoretically expected to occur. Accordingly, interaction effects between WPV and psychological constructs were tested to determine whether PSP alters the strength of these relationships.

For moderation analysis, interaction terms were computed by multiplying the independent variable by the moderator. All continuous variables were mean-centered prior to creating interaction terms to minimize multicollinearity and enhance the interpretability of regression coefficients.

The significance of the interaction terms was evaluated to assess the presence of moderation effects. The primary moderation analysis examined whether PSP moderated the

effect of WPV on burnout-related emotional exhaustion and job satisfaction. Downstream moderation tests involving behavioural and relational outcomes were treated as exploratory robustness checks and were conducted only if moderation was statistically significant at the psychological stage. This approach is in line with the JD-R model and conceptual positioning of PSP, where its influence is expected to operate at the stage of initial stress evaluation rather than at downstream behavioral or relational stages.

3.6.7 Software and Tools

Data analysis was conducted using Jamovi version 2.7.24. CFA and SEM were performed using the SEMLj module. Descriptive statistics, reliability analysis, correlation analysis, t-tests, ANOVA, and regression-based diagnostic checks were conducted using Jamovi's standard analysis functions (jmv package). Moderation analysis was conducted using the medmod module, which supported regression-based interaction testing and simple bootstrap procedures. Moderated mediation analysis was handled using the jAMM GLM Mediation Model, which permitted testing of moderation-based indirect effects using bias-corrected bootstrap confidence intervals. Composite Reliability (CR) was manually verified using standardized CFA loadings to ensure consistency with the final measurement model. R/lavaan was not used as a separate complementary platform; SEMLj uses lavaan as its backend for CFA and SEM estimation.

3.7 Ethics Related to Human Subject Participation

The present study involved the voluntary participation of human subjects, specifically practicing medical doctors. To ensure the dignity, rights, and comfort of all participants, ethical considerations were carefully addressed throughout the research process. The study involved voluntary participation, and respondents were pre-informed about the purpose and nature of the research. Informed consent was obtained from all eligible participants, and they were free to withdraw from the study at any time without restriction.

No personal or patient-related information was collected, and all responses were recorded anonymously. The collected data were used solely for academic research and handled with strict confidentiality. Access to the data was restricted, and the information was not shared with any third party. The study did not involve any physical or psychological harm to participants. Proper care was taken to ensure that questions were framed appropriately and did not cause undue distress to the participants, as WPV is a sensitive topic.

The approved DBA research proposal itself constituted IRB or ethics committee approval. The study was considered low-risk research and did not involve clinical or high-risk human subject research.

Overall, the study followed ethical principles of voluntary participation, informed consent, anonymity, and confidentiality in accordance with standard research practices.

3.8 Methodology Summary

This chapter presented the methodological framework implemented for the study. It outlined the research design, sampling approach, and data collection procedures employed to examine the proposed relationships among WPV and its outcomes among doctors. The development of the research instrument, including the use of validated and context-specific measurement scales, was also discussed.

The chapter further detailed the analytical techniques used for data analysis, including CFA for measurement model validation and SEM for examining the hypothesised relationships. Mediation analysis was performed to assess the relationships along the suggested indirect paths. Additionally, a moderation analysis was performed to evaluate the role of PSP. Ethical considerations related to human subject participation were also addressed.

Overall, the systematic and methodological approach was formulated to ensure reliability, consistency, and alignment with the theoretical framework of the study. The subsequent chapter exhibits the results of the data analysis.

CHAPTER 4

RESULTS

4.1 Introduction

This chapter presents the results of the empirical analysis performed to assess the relationships between WPV and its psychological outcomes (burnout-related emotional exhaustion and job satisfaction), behavioural responses (RAB and CPMB), relational outcomes (DPR), and turnover intentions among doctors.

The analysis follows a structured and sequential approach. It begins with data screening to ensure data quality and appropriateness for multivariate techniques. This is followed by the assessment of common method bias and descriptive statistics. The reliability and validity of the measurement instruments are then evaluated using reliability analysis and CFA. Subsequently, SEM is used to test the proposed relationships among constructs.

Further, mediation effects are examined using bootstrapping techniques to evaluate the indirect pathways through psychological, behavioural, and relational variables. In order to evaluate the role of PSP in influencing key relationships, moderation analysis and moderated mediation analysis are conducted. Moreover, the strength of the model is measured through the coefficient of determination (R^2).

The chapter systematically presents the findings of the analysis, followed by results related to each hypothesis and a summary of important outcomes.

4.2 Organization of Data Analysis

This section presents the results of the statistical analyses which were conducted to test the proposed model. The findings begin with preliminary analysis, then develop the model testing and finally towards the hypothesis evaluation.

4.2.1 Data Screening

As outlined in Chapter 3, the data were screened to ensure accuracy and completeness. A total of 561 responses were initially collected; after excluding incomplete and duplicate responses, 526 valid responses were retained for further analysis.

The complete dataset was examined for inconsistencies and abnormal response patterns, and no major issues such as extreme outliers or systematic response bias were identified. Boxplot analysis indicated a small number of mild outliers in certain variables, but no extreme outliers were observed. These observations were retained as they did not significantly affect the distribution of the data. Composite scores for all constructs were computed based on their respective items and were used for subsequent analyses.

4.2.2 Common Method Bias

As a single self-reported questionnaire was used to collect data for the study, the possibility of common method bias was assessed. A statistical diagnostic check was performed using Harman's single-factor test with unrotated exploratory factor analysis in Jamovi. The results showed that the first factor accounted for approximately 23% of the total variance, well below the 50% threshold, indicating that common method bias was not a concern for the model.

Therefore, the results showed that no individual factor accounted for more variance, suggesting that common method bias is unlikely to have significantly affected the results.

4.2.3. Descriptive Statistics and Preliminary Analysis

This section presents the descriptive statistics and preliminary analyses conducted to understand the characteristics and initial relationships among the constructs. These analyses provide a foundational insight into the collected survey data and ensure its appropriateness for further advanced techniques, including CFA and SEM. These analyses serve as analytic, diagnostic and exploratory procedures to support the validity of core model-based analyses.

4.2.3.1 Descriptive Statistics of Study Variables

Descriptive statistics were used to analyse and summarise the central tendency measures and distribution of the key constructs in the study. The reported minimum and maximum values correspond to composite scores computed as the mean of the corresponding scale indicators for each respondent.

Table 4.1: Descriptive Statistics of Variables used in the Study

Variable	Mean	SD	Min	Max
Workplace Violence (WPV)	1.73	0.510	1.00	3.70
Burnout-related Emotional Exhaustion (BO)	2.92	0.879	1.00	5.00
Job Satisfaction (JS)	3.18	0.857	1.00	5.00
Risk Avoidance Behaviour (RAB)	3.79	0.632	1.00	5.00
Changed Patient Management Behaviour (CPMB)	3.93	0.469	1.86	5.00
Doctor-Patient Relationship (DPR)	3.55	0.518	2.14	4.86
Perceived Systemic Protection (PSP)	2.49	0.531	1.00	4.38
Turnover Intentions (TI)	2.95	1.03	1.00	5.00

Source: Author's computation based on primary data

The figures as calculated are as presented in Table 4.1, which show that WPV was reported at relatively low frequency levels on average ($M = 1.73$ on a 1–5 scale, well below the midpoint of 3), although 83.7% of respondents reported some exposure (Section 4.2.3.1). Burnout-related emotional exhaustion was at moderate levels ($M = 2.92$, just below the midpoint), while job satisfaction was slightly above the midpoint ($M = 3.18$), together suggesting a mixed psychological profile in which exposure is widespread but typically infrequent in occurrence.

Behavioural responses showed a prominent pattern, with both RAB ($M = 3.79$) and CPMB ($M = 3.93$) reported at relatively high levels. This suggests that doctors tend to adopt adaptive or defensive strategies in response to WPV.

The deterioration in the DPR revealed moderate levels ($M = 3.55$), indicating some degree of relational strain. PSP was relatively lower ($M = 2.49$), reflecting limited assurance in organizational or systemic support mechanisms. Turnover intentions remained moderate ($M = 2.95$), indicating that while dissatisfaction exists, it does not completely translate into strong intentions to leave the medical practice or profession.

A considerable proportion of respondents (83.7%) reported experiencing WPV, indicating that exposure to WPV is highly prevalent among doctors in the sample.

Among different forms of WPV, verbal abuse was the most prevalent (90.9%), followed by threats (81.4%), clinical pressure (47.3%), and physical violence (41.6%). This indicates that non-physical forms of aggression are more commonly experienced in healthcare settings.

The proportion of respondents reporting verbal WPV (90.9%) exceeded the overall WPV prevalence (83.7%). This discrepancy may reflect a perceptual gap in how WPV is understood. Some respondents answered that they have not experienced WPV but reported instances of verbal aggression. This suggests that behaviours such as shouting or verbal abuse may be normalised or not recognised as WPV by some doctors, leading to probable under-reporting in the overall WPV measure.

4.2.3.2 Correlation Analysis

Pearson correlation analysis was used to examine the relationships among the key constructs and the corresponding results are shown in Table 4.2.

As evident from the results, there is a positive and significant association between WPV and burnout-related emotional exhaustion ($r = 0.574$, $p < 0.001$) and a negative

association between WPV and job satisfaction ($r = -0.390$, $p < 0.001$). This suggests that higher exposure to WPV is connected to increased psychological strain and reduced job satisfaction among doctors.

Burnout-related emotional exhaustion was positively associated with RAB ($r = 0.354$, $p < 0.001$) and CPMB ($r = 0.292$, $p < 0.001$), indicating that higher burnout-related emotional exhaustion is associated with greater adoption of defensive or avoidant behavioral practices. In contrast, job satisfaction showed negative correlations with both behavioral responses (RAB: $r = -0.418$; CPMB: $r = -0.200$; $p < 0.001$), suggesting that more satisfied doctors are less likely to engage in such behaviors.

Table 4.2: Correlation Matrix of Variables used in the Study

Variable	WPV	BO	JS	RAB	CPMB	DPR	PSP	TI
WPV	1							
BO	0.574***	1						
JS	-0.390***	-0.595***	1					
RAB	0.254***	0.354***	-0.418***	1				
CPMB	0.226***	0.292***	-0.200***	0.378***	1			
DPR	0.460***	0.497***	-0.598***	0.453***	0.353***	1		
PSP	-0.259***	-0.275***	0.247***	-0.357***	-0.068	-0.367***	1	
TI	0.419***	0.562***	-0.686***	0.337***	0.331***	0.593***	-0.156***	1
* $p < .05$, ** $p < .01$, *** $p < 0.001$								

Source: Author's computation based on primary data

With respect to relational outcomes, both RAB ($r = 0.453$, $p < 0.001$) and CPMB ($r = 0.353$, $p < 0.001$) were positively associated with deterioration in the DPR. Burnout-related emotional exhaustion also showed a positive relationship with deterioration in the DPR ($r = 0.497$, $p < 0.001$), while job satisfaction was negatively related ($r = -0.598$, $p < 0.001$), suggesting that psychological factors play a pivotal role in forming relational outcomes.

Turnover intentions demonstrated strong positive correlations with burnout-related emotional exhaustion ($r = 0.562$) and deterioration in the DPR ($r = 0.593$), and a strong negative correlation with job satisfaction ($r = -0.686$) ($p < 0.001$), highlighting the dominant role of these variables in influencing doctors' intention to leave.

PSP was negatively associated with WPV ($r = -0.259$) and burnout-related emotional exhaustion ($r = -0.275$), and positively associated with job satisfaction ($r = 0.247$) ($p < 0.001$), indicating that higher perceived protection is linked to better psychological outcomes. However, its relationship with CPMB was not statistically significant.

Overall, this preliminary analysis shows that the correlation results provide sustenance for the proposed relationships among variables and are consistent with the hypothesised directions in the study. None of the correlations exceeded the conventional threshold of $r = 0.80$, indicating no multicollinearity concerns.

4.2.3.3 Group Differences Analysis

To examine key differences in study variables across demographic and related factors, independent samples t-tests and one-way ANOVA were conducted. The results are presented in the following subsections.

a) Independent Samples t-test

Independent samples t-tests were conducted to examine differences in the variables between doctors who reported experiencing WPV and those who did not. The results are presented in Table 4.3.

The results indicate significant differences between doctors who experienced WPV and those who did not across all key variables ($p < 0.001$). Wherever the assumed condition of homogeneity of variances was met, Student's t-test was used; otherwise, Welch's t-test was considered in cases where this assumption was violated.

Doctors exposed to WPV reported significantly higher levels of burnout-related emotional exhaustion ($M = 3.07$, $SD = 0.79$) compared to those not exposed ($M = 2.16$, $SD = 0.90$), and lower job satisfaction ($M = 3.04$, $SD = 0.82$) compared to their counterparts ($M = 3.91$, $SD = 0.63$), representing a significant negative psychological impact. They also demonstrated higher levels of RAB ($M = 3.85$, $SD = 0.60$) compared to those not exposed ($M = 3.53$, $SD = 0.73$), and CPMB ($M = 3.96$, $SD = 0.44$) compared to ($M = 3.75$, $SD = 0.55$), signifying changed behaviour among doctors resulting in defensive or adaptive clinical strategies.

Table 4.3: Independent Samples t-test (WPV vs Non-WPV Groups)

Variable	WPV(Yes) Mean $\pm$ SD	WPV(No) Mean $\pm$ SD	t-value	p-value	Cohen's d
BO	3.07 $\pm$ 0.79	2.16 $\pm$ 0.90	9.52	< 0.001	1.123
JS	3.04 $\pm$ 0.82	3.91 $\pm$ 0.63	-10.96	< 0.001	-1.175
RAB	3.85 $\pm$ 0.60	3.53 $\pm$ 0.73	3.86	< 0.001	0.483
CPMB	3.96 $\pm$ 0.44	3.75 $\pm$ 0.55	3.97	< 0.001	0.468
DPR	3.65 $\pm$ 0.49	3.09 $\pm$ 0.42	9.97	< 0.001	1.175
PSP	2.43 $\pm$ 0.50	2.76 $\pm$ 0.59	-5.31	< 0.001	-0.625
TI	3.10 $\pm$ 1.02	2.17 $\pm$ 0.71	10.19	< 0.001	1.053
Note: Values are presented as mean $\pm$ standard deviation. Welch's t-test is reported where the assumption of homogeneity of variances was violated.					

Source: Author's computation based on primary data

In terms of relational outcomes, doctors who experienced WPV reported greater deterioration in the DPR ($M = 3.65$, $SD = 0.49$) than those who did not ($M = 3.09$, $SD = 0.42$). Additionally, turnover intentions were significantly higher among those exposed to WPV ($M = 3.10$, $SD = 1.02$) than among those who remained unaffected ($M = 2.17$, $SD = 0.71$), highlighting the probable long-term repercussions of such experiences.

Conversely, PSP was significantly lower among doctors who experienced WPV ($M = 2.43$, $SD = 0.50$) than among those who did not ($M = 2.76$, $SD = 0.59$), suggesting that exposure to WPV is associated with reduced assurance in organizational, legal, and societal support mechanisms.

Cohen's d effect size estimates further show that WPV has a substantial impact on psychological, relational, and attitudinal outcomes. Large effect sizes were observed for burnout-related emotional exhaustion, job satisfaction, DPR, and turnover intentions, suggesting strong differences between groups. On the other hand, the effect sizes for behavioural responses, such as RAB and CPMB, were comparatively moderate, signifying that these behaviours are influenced by WPV, but the extent of their change is minor.

b) One-way ANOVA

One-way ANOVA was conducted to examine differences across various demographic and contextual variables. The results are presented in Table 4.4. The interpretation of results will be based on various demographic group differences, i.e., experience-based, hospital-type-based, gender-based, WPV-seriousness-based, and specialty-based.

Table 4.4: One-Way ANOVA results for Group Differences across Demographic and Contextual Variables

Independent Variable	Dependent Variable	F-value	p-value	Post Hoc (Tukey's)	Result
Experience	Burnout-related Emotional Exhaustion	4.03	0.019	Senior > Junior; Mid > Junior	Significant
Experience	DPR	4.00	0.020	Senior > Junior; Mid > Junior	Significant

Experience	Turnover Intentions	3.86	0.022	Mid > Senior	Significant
Hospital Type	Turnover Intentions	9.00	<0.01	Government > Corporate; Government > Private	Significant
Hospital Type	PSP	3.89	0.007	Medical College > Government; Medical College > Private; Trust > Government	Significant
Gender	BO	0.195	0.659	Not Significant	Not Significant
Seriousness	DPR	36.4	<0.001	Life-threatening > Minor; Severe > Minor; Moderate > Minor	Significant
Speciality	WPV	1.62	0.068	Not Significant	Not Significant
Speciality	BO	4.50	<0.001	High-burnout specialties (Emergency, ICU, Cardiology, Surgery) > Low-burnout specialties (Dermatology,	Significant

				Pathology, General Practice)	
Note: Welch's ANOVA is reported where the supposition of homogeneity of variances was not supported. Post hoc comparisons were conducted using Tukey's test where applicable. Significance is assessed at $p < .05$.					

Source: Author's computation based on primary data

(i) Experience-based differences

To examine differences in burnout-related emotional exhaustion across experience groups, a one-way ANOVA was conducted. The results indicate a statistically significant difference in burnout-related emotional exhaustion levels across experience groups ($F = 4.03$, $p = 0.019$). Post hoc analysis revealed that senior (above 10 years of experience) and mid-level doctors (6-10 years of experience) reported significantly higher burnout-related emotional exhaustion than junior doctors (0-5 years of experience), while no significant difference was observed between the senior and mid-level groups. These findings suggest that burnout-related emotional exhaustion tends to increase with experience, possibly reflecting the overloading of responsibilities with time and the collective experience of various work-related stress factors and violence over time.

Similarly, one-way ANOVA results revealed differences in deterioration in the DPR across experience groups. The results indicate a statistically significant difference in deterioration in the DPR across experience groups ($F = 4.00$, $p = 0.020$). Post-hoc analysis revealed that senior and mid-level doctors reported significantly higher levels of deterioration in the DPR than junior doctors, whereas no significant difference was observed between the senior and mid-level groups. These findings suggest that relational stress tends to be greater among more experienced doctors, possibly due to prolonged exposure to strained patient interactions and tough workplace stressors.

Likewise, differences in turnover intentions across various experience groups were analysed using one-way ANOVA. The results showed a statistically significant difference (F

= 3.86, $p = 0.022$). Post hoc analysis revealed that mid-level doctors reported significantly higher turnover intentions than senior doctors, whereas no noteworthy differences were observed between junior and other studied groups. These findings suggest that turnover intentions may be high at mid-career stages, possibly due to career uncertainty, job-related pressures, or intermediate professional opportunities.

(ii) Hospital Type-based differences

The effect of hospital type on turnover intentions was examined using a one-way ANOVA test. The results exhibited a statistically significant difference ($F = 9.00$, $p < 0.001$). Post hoc analysis revealed that doctors working in government hospitals reported significantly higher turnover intentions than those in corporate and private hospitals, whereas no significant differences were observed across other groups. These findings recommend that organisational constitution has an important role in shaping doctors' turnover intentions, with government hospital settings possibly having more administrative pressure, higher work-related stress, excessive patient-load, inappropriate infrastructure, low remuneration, or high exposure to WPV.

Moreover, one-way ANOVA results revealed differences in PSP across hospital types. The analysis indicated a statistically significant difference ($F = 3.89$, $p = 0.007$). Post hoc comparisons showed that doctors working in medical colleges reported significantly higher PSP than those in government and private hospitals, while trust-based hospitals also reported higher PSP than government hospitals. No other significant differences were observed across groups. These findings suggest that well-established institutional set-ups impact perceptions of systemic support, with academic and trust-based environments probably providing comparatively robust perceived protection mechanisms.

(iii) Gender-based differences

The effect of gender on burnout-related emotional exhaustion was examined using one-way ANOVA. The results indicated no statistically significant difference in burnout-related emotional exhaustion levels between male and female doctors ($F = 0.20$, $p = 0.659$). Post hoc analysis also confirmed the absence of significant pairwise differences. These findings suggest that burnout-related emotional exhaustion levels are similar across genders within the collected sample.

(iv) Seriousness-based differences

Differences in deterioration in the DPR across levels of incident seriousness were analyzed using a one-way ANOVA test. The results evidenced a high statistically significant difference ($F = 36.40$, $p < 0.001$). Post hoc analysis revealed that higher levels of incident seriousness, including life-threatening, severe, and moderate cases, were associated with significantly greater deterioration in the DPR compared to minor incidents. These findings suggest a clear gradient in which increasing WPV severity is linked to progressively greater strain in the DPR.

(v) Specialty-based differences

The effect of WPV across various medical specialties was analyzed using one-way ANOVA. The outcome indicated a statistically non-significant difference ($F = 1.62$, $p = 0.068$). Given the non-significant overall effect, post hoc comparisons were not interpreted. These findings suggest that exposure to WPV is relatively uniform across specialties, indicating that such experiences are widely prevalent and not confined to specific clinical fields.

As well, the effect of medical specialty on burnout-related emotional exhaustion was examined using a one-way ANOVA test. The results exhibited a statistically significant difference ($F = 4.50$, $p < 0.001$). Post hoc analysis revealed that certain high-intensity

specialties, such as emergency medicine, critical care, cardiology, and surgical disciplines, reported higher levels of burnout-related emotional exhaustion than relatively lower-intensity specialties such as dermatology, pathology, and general practice. These findings indicate that the nature and intensity of clinical efforts vary across specialties, with critical and high-pressure environments associated with greater burnout-related emotional exhaustion among doctors.

4.2.3.4 Interaction Effects (Two-Way ANOVA)

Interaction effects were examined using a two-way ANOVA, with both independent variables categorical. Accordingly, the interaction between WPV and experience on burnout-related emotional exhaustion was analyzed using this approach. For interaction effects involving continuous variables, such as PSP and behavioural responses, regression-based methods were employed. The results for Two-Way ANOVA are presented in Table 4.5.

Table 4.5: Results of Two-Way ANOVA to assess the effects of WPV and Experience of doctors on Burnout-related Emotional Exhaustion

Dependent Variable	Factor 1	Factor 2	Effect	F-value	p-value	Result
Burnout-related Emotional Exhaustion	WPV	Experience	WPV	77.76	<0.001	Significant
			Experience	4.44	0.012	Significant
			WPV x Experience	5.04	0.007	Significant

Source: Author's computation based on primary data

A two-way ANOVA statistical test was performed to analyse the effects of WPV and experience on burnout-related emotional exhaustion, including their interaction. The results indicated a significant main effect of WPV ($F = 77.76$, $p < 0.001$), suggesting that doctors exposed to WPV reported higher burnout-related emotional exhaustion levels. A significant main effect of experience was also observed ($F = 4.44$, $p = 0.012$), indicating differences in

burnout-related emotional exhaustion across experience groups. Also, WPV $\times$ experience interaction was found to be statistically significant ($F = 5.04$, $p = 0.007$). This suggests that the impact of WPV on burnout-related emotional exhaustion varies across levels of experience.

Furthermore, the assessment of estimated marginal means indicates that while burnout-related emotional exhaustion is steadily higher among doctors exposed to WPV across all experience groups, the extent of this difference is predominantly noticeable among junior doctors, indicating that less experienced doctors may be more susceptible to the psychological impact of WPV.

4.2.3.5 Preliminary Regression Analysis (Interaction/Moderation Tests)

Preliminary regression analyses were conducted to examine interaction effects involving continuous variables, which could not be assessed using two-way ANOVA. Specifically, moderation effects were tested using interaction terms within linear regression models to determine whether the relationship between WPV and outcome variables varies across levels of PSP and behavioural outcomes. Interaction terms were created using mean-centered variables. The results of regression analysis are presented in Table 4.6.

Table 4.6: Results of Regression-Based Interaction (Moderation) Effects

Dependent Variable	Predictor	Moderator	Interaction Term	β (Interaction)	p-value	Result
Turnover Intentions	WPV	PSP	WPV $\times$ PSP	0.186	0.357	Not Significant
DPR	WPV	RAB	WPV $\times$ RAB	0.107	0.146	Not Significant

DPR	WPV	CPMB	WPV x CPMB	0.149	0.143	Not Significant
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Source: Author's computation based on primary data

(i) WPV × PSP → Turnover Intentions

To examine the interaction effect of WPV and PSP on turnover intentions, a linear regression analysis was conducted. The results indicated a significant main effect of WPV ($\beta = -0.836$, $p < 0.001$), demonstrating that the high occurrence of WPV is associated with higher turnover intentions. However, the main effect of PSP on turnover intentions was not statistically significant ($p = .082$).

Also, the WPV x PSP interaction was statistically non-significant ($\beta = 0.186$, $p = 0.357$), showing that the relationship between WPV and turnover intention was not significantly moderated by PSP. The model accounted for 11.8% of the variation in turnover intentions ($R^2 = 0.118$).

(ii) WPV × RAB → DPR

To assess the interaction effect of WPV and RAB on worsening of the DPR, a linear regression analysis was used. The results manifested that WPV had a significant impact on deterioration in the DPR ($p < 0.001$), and RAB was also significantly related to deterioration in the DPR ($p < 0.001$).

However, the interaction term WPV x RAB did not yield a statistically significant effect ($\beta = 0.107$, $p = .146$), indicating that the relationship between WPV and the DPR was not significantly moderated by RAB. The model captured 31.1% of the variance in deterioration in the DPR ($R^2 = 0.311$).

(iii) WPV × CPMB → DPR

To examine the interaction effect of WPV and CPMB on deterioration in the DPR, a linear regression analysis was performed. The outcomes showed that WPV had a significant

influence on deterioration in the DPR ($p < 0.001$), and CPMB was also significantly connected with deterioration in the DPR ($p = 0.020$).

However, the interaction term WPV x CPMB was statistically non-significant ($\beta = 0.149$, $p = 0.143$), indicating that the relationship between WPV and deterioration in the DPR was not significantly moderated by CPMB. The model accounted for 24.6% of the variance in deterioration in the DPR ($R^2 = 0.246$).

Overall, the results show that while the moderators examined in this study have direct effects on outcome variables, none significantly affect the relationship between WPV and its related consequences.

4.2.3.6 Preliminary Mediation Analysis (Regression-based)

Preliminary mediation analyses were conducted using regression-based approaches to investigate whether psychological constructs mediate the relationship between WPV and turnover intentions. Burnout-related emotional exhaustion and job satisfaction were tested as mediators to assess their role in explaining how WPV influences doctors' turnover intentions. These analyses provide early evidence and initial validation of mediation, which is further examined using SEM. The results of regression-based mediation are shown in Table 4.7.

Table 4.7: Regression-Based Mediation Analysis Results

Independent Variable	Mediator	Dependent variable	Direct Effect (c')	Indirect Effect	Result
WPV	Burnout-related Emotional Exhaustion	Turnover Intentions	Significant	Significant	Partial Mediation

WPV	Job Satisfaction	Turnover Intentions	Significant	Significant	Partial Mediation
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Source: Author's computation based on primary data

(i) WPV → Burnout-related Emotional Exhaustion → Turnover Intentions

A regression-based mediation analysis was conducted to examine whether the relationship between WPV and turnover intentions of doctors is mediated by burnout-related emotional exhaustion. The results exhibited that WPV had a significant effect on burnout-related emotional exhaustion ($p < 0.001$), and burnout, in turn, had a significant positive effect on turnover intentions ($p < 0.001$).

The indirect pathway from WPV to turnover intentions through burnout-related emotional exhaustion was statistically significant ($\beta = +0.547$, $p < 0.001$), indicating mediation. Since the direct WPV → turnover intentions path also remained significant ($p < 0.001$), burnout-related emotional exhaustion was interpreted as a partial mediator.

(ii) WPV → Job Satisfaction → Turnover Intentions

To further understand the underlying mechanism related to psychological outcomes of WPV, a regression-based mediation analysis was performed to check if job satisfaction mediates the relationship between WPV and turnover intentions. As seen in the results, doctors reporting higher WPV also reported lower job satisfaction due to significant negative effect of WPV on job satisfaction ($p < .001$). In turn, lower job satisfaction was linked with higher turnover intentions, as reflected by the significant negative JS → turnover intentions path ($p < .001$).

The indirect path from WPV to turnover intentions through job satisfaction was found to be statistically significant ($\beta = +0.680$, $p < .001$), indicating the existence of mediation. Since the direct WPV → turnover intentions path also remained significant ($p = .010$), indicated that job satisfaction acts as a partial mediator.

These findings suggest that burnout-related emotional exhaustion and job satisfaction play an important role as psychological outcomes through which WPV influences doctors' turnover intentions.

4.2.4 Measurement Model (CFA)

After completing the preliminary analyses, the emphasis shifts to evaluating the measurement model using CFA. This is an important step to ascertain that the constructs are measured reliably before examining the relationships between them.

4.2.4.1 Introduction to Measurement Model

To assess the reliability and validity of the study constructs and evaluate the measurement model, CFA was conducted. The analysis examined factor loadings, internal consistency, model fit, and measures of convergent and discriminant validity. Before proceeding with the structural model analysis, this step was crucial to ensure that the constructs were measured accurately.

4.2.4.2 Model Specification

The latent constructs included in the measurement model were WPV, burnout-related emotional exhaustion, job satisfaction, RAB, CPMB, DPR, PSP, and turnover intentions. These constructs covered multiple observed indicators used to capture all the related aspects. PSP was included in the CFA as a latent construct to assess its reliability and validity. Although PSP was conceptualized as a moderating variable in the structural model, its measurement properties were assessed alongside those of other constructs to ensure construct reliability and validity prior to hypothesis testing.

While the initial model encompassed all items from the questionnaire, subsequent refinement was carried out based on factor loadings and model fit indices. Items which were

below the suggested threshold levels were dropped from the initial model, resulting in a refined, well-fitting measurement model.

4.2.4.3 Model Fit Assessment

The fitness of the measurement model was evaluated using various model fit indices. The measurement model results indicate an acceptable fit to the data. The Tucker-Lewis Index (TLI) was 0.889, slightly below the suggested cut-off but just below the conventional ≥ 0.90 cutoff (Hu & Bentler, 1999), indicating marginal fit, whereas the Comparative Fit Index (CFI) was 0.901, meeting the threshold criteria.

The Adjusted Goodness-of-Fit Index (AGFI) was 0.986, and the Goodness-of-Fit Index (GFI) was 0.989, both exceeding the required threshold. In addition, the Root Mean Square Error of Approximation (RMSEA) was 0.055, with a 95% confidence interval ranging from 0.051 to 0.058, and the Standardized Root Mean Square Residual (SRMR) for this model was 0.057.

Table 4.8: Fit Indices for the Measurement Model

Fit Index	Value	Cut-off	Interpretation
CFI	0.901	≥ 0.90	Good
RMSEA	0.055	≤ 0.08	Adequate
SRMR	0.057	≤ 0.08	Acceptable
TLI	0.889	≥ 0.90	Marginal
GFI	0.989	> 0.90	Good
AGFI	0.986	> 0.90	Good

Source: Author's computation based on primary data

As the above values fall within acceptable limits, it suggests a good fit of the given model. The measurement model fit indices that are being used in the present study, along with their cut-off values are shown in Table 4.8.

Overall, the fit indices show that the measurement model offers an acceptable representation of the available data and is appropriate for further analysis.

4.2.4.4 Indicator Reliability (Factor Loadings)

To evaluate the indicator reliability, standardized factor loadings (β) of the observed items for their respective constructs were considered. Most items for the study constructs had satisfactory loadings above the recommended cut-off of 0.50, indicating that the indicators were appropriate for representing their underlying constructs. Although theoretically relevant, some items did not load strongly in this sample, possibly due to generalization of certain behaviours or contextual and circumstantial differences in interpretation among doctors.

Given the sensitive, context-specific nature of WPV in Indian healthcare settings, certain items may not have been understood consistently by respondents, necessitating refinement for accurate measurement. The goal was not to discard the scale in its current form, but to preserve its conceptual meaning while improving its empirical validity.

As all the factor loadings were statistically significant ($p < 0.001$), this further supported the reliability of the measurement model. While a few items showed relatively lower loadings than others, they were retained because they remained within an acceptable range and contributed meaningfully to the model's overall construct validity. The standardized loadings ranged from approximately 0.45 to 0.90 across constructs. Although factor loadings above 0.50 are generally preferred, items with loadings between 0.45 and 0.50 were not automatically removed, as they were theoretically important and contributed to the construct's content validity. Loadings around 0.40 are considered important by Hair et al. (2019), while Tabachnick & Fidell (2007) describe loadings around 0.45 as fair. Further, given the large sample size of the present study ($N = 526$), loadings in this range may still be statistically meaningful. Therefore, borderline items ($\beta = 0.45$ to 0.50) were retained where

their removal would narrow the conceptual exposure of newly developed or context-specific constructs, provided that the overall reliability and model fit remained acceptable.

This approach was particularly relevant for newly integrated and adapted behavioural constructs such as RAB, CPMB, and PSP, where some items captured conceptually important but context-specific extents. Therefore, item retention was based on the loading value but also considered theoretical relevance, construct coverage, reliability indices, fitness of the measurement model, and the overall interpretability. Table 4.9 presents the standardized factor loadings for all retained items in the model.

Table 4.9: Model specific Standardized Factor Loadings

Construct	Indicator	Factor Loading (β)
WPV	WPV1	0.842
	WPV2	0.833
	WPV3	0.690
	WPV5	0.608
	WPV10	0.637
Burnout-related Emotional Exhaustion (BO)	BO1	0.830
	BO2	0.796
	BO3	0.629
	BO4	0.660
	BO5	0.639
Job Satisfaction	JS1	0.844
	JS2	0.822
	JS3	0.788
	JS4	0.839
	JS5	0.681

	JS6	0.692
RAB	RAB1	0.805
	RAB2	0.580
	RAB3	0.490
	RAB5	0.482
CPMB	CPMB3	0.596
	CPMB4	0.562
	CPMB5	0.639
	CPMB6	0.536
	CPMB7	0.452
DPR	DPR3	0.743
	DPR5	0.528
	DPR6	0.609
	DPR7	0.744
PSP	PSP1	0.536
	PSP3	0.533
	PSP4	0.477
	PSP5	0.623
	PSP6	0.618
Turnover Intentions	TI1	0.906
	TI2	0.805
	TI3	0.879
	TI4	0.813

Source: Author's computation based on primary data

During CFA-based measurement refinement, selected items with weak loadings or poor contribution to the measurement model were dropped. The final interpretation of each construct in a SEM was based on the retained items instead of the original items. This was particularly important for CPMB and PSP. Since the over-investigation and additional or aggressive treatment indicators were not retained, CPMB was interpreted as cautious or defensive patient-management modification rather than as a complete defensive-medicine construct. Similarly, because the organizational protection indicators were not retained in the final PSP model, PSP was interpreted as an exploratory measure, mainly reflecting legal and societal protection based on the retained indicators. Table 4.10 shows how these refinements narrowed the empirical scope of the constructs and were taken into account when interpreting the findings.

Table 4.10: Construct-wise *dropped Items and their Interpretation*

Construct	Dropped item(s)	What was removed conceptually	Effect on final interpretation
WPV	WPV4, WPV6, WPV7, WPV8, WPV9	Pressure against clinical judgment, direct physical assault, vandalism, restriction of movement, repeated aggressive calls/messages	WPV becomes narrower and is recognised more by verbal aggression, threat, attempted physical aggression, and complaint, legal or media intimidation.
RAB	RAB4	Specialist consultation to avoid full responsibility	Final RAB focuses more clearly on avoidance, referral, refusal to risk-exposure rather than consultation-seeking. This actually helps sharpen

			RAB as engagement-avoidance behaviour.
CPMB	CPMB1, CPMB2	Additional investigations and additional or aggressive treatment	Final CPMB does not capture basic over-treatment defensive medicine. It should be framed as cautious, defensive patient-management modification rather than full defensive medicine.
DPR	DPR1, DPR2, DPR4	Emotional reactions, difficult demands of patients, difficulty maintaining cooperative relationship	Final DPR is narrower and reflects perceived respect, trust in patient information, communication quality, and comfort in interaction.
PSP	PSP2, PSP7, PSP8	Security/support mechanisms, post-incident hospital support, incident reporting safety	Final PSP does not fully capture organizational protection. It mainly reflects legal protection and societal responsibility.

Source: Author's computation based on primary data

Moreover, the removal of items during CFA refinement may not be interpreted as indicating that these issues were less important to doctors. The dropped items did not work as strong reflective indicators of their respective latent constructs in the present model. Some items may have represented important but less frequently experienced events, such as severe physical violence or vandalism, while others may have been interpreted differently by respondents. For example, seeking specialist consultation may have reflected as safe clinical collaboration rather than risk avoidance, and additional investigations or over-prescribing

may be viewed as misconduct rather than clinical thoroughness or defensive patient-management behaviour. Therefore, item deletion was treated as a measurement refinement decision, and the final interpretation of each construct was done accordingly.

4.2.4.5 Internal Consistency Reliability

Cronbach's alpha (α) and composite reliability (CR) for each construct were used to assess the internal consistency reliability. The results show that most constructs met satisfactory levels of reliability, with Cronbach's alpha and CR values above or nearly meeting the recommended thresholds. Table 4.11 shows Cronbach's alpha and CR values for all the study constructs.

Table 4.11: Internal Consistency Reliability with Cronbach's alpha (α) and Composite Reliability (CR) values

Construct	α	CR	Interpretation
WPV	0.831	0.847	Good
Burnout-related Emotional Exhaustion	0.860	0.838	Good
Job Satisfaction	0.901	0.903	Excellent
Turnover Intentions	0.912	0.913	Excellent
RAB	0.720	0.686	Marginal
CPMB	0.719	0.693	Acceptable
DPR	0.752	0.754	Acceptable
PSP	0.716	0.694	Acceptable

Source: Author's computation based on primary data

Cronbach's alpha (α) and CR were both reported because they are based on different assumptions. Cronbach's alpha was calculated from the retained items, whereas CR was manually computed from the standardized CFA loadings. The CFA model incorporated refinements and included theoretically justified correlations among selected items. Therefore,

the α may remain slightly higher because it captures the total observed item covariance, whereas CR is based mainly on the proportion of indicator variance explained by the latent construct. These model refinements are further discussed in Section 4.2.4.8.

Cronbach's alpha (α) was more than 0.70 for all the latent constructs, and CR values for constructs such as WPV, burnout-related emotional exhaustion, job satisfaction, and turnover intentions exhibited strong reliability, with values well above the acceptable limits. Although majority of the constructs met the recommended cut-off value of 0.70, some constructs showed slightly lower CR values. However, these exceeded 0.60, which has been suggested as an acceptable level of reliability (Bagozzi & Yi, 1988). For a few constructs, including RAB, CPMB, and PSP, the CR values were comparatively lower but remained within the aforementioned acceptable ranges (>0.60), particularly given the exploratory nature of the research.

Overall, the results imply that the study constructs demonstrate adequate internal consistency and are fit for further analysis.

4.2.4.6 Convergent Validity

Average Variance Extracted (AVE) was used to assess convergent validity for each construct, along with composite reliability. According to Hair et al. (2019), a higher AVE value (>0.50) indicates acceptable convergent validity, as it suggests that at least half of the variance of that construct is explained through its indicators. Whereas a lower AVE value (<0.50) indicates that, on average, a greater proportion of variance is assigned to measurement error than to the fundamental construct.

However, convergent validity should not be assessed solely on the basis of AVE. Hair et al. (2019) also highlighted that reliability serves as an important complementary criterion, as it reflects the construct's internal consistency. Considering this study, while several

constructs achieved AVE values (>0.50) above the suggested threshold, a few constructs showed AVE values slightly below 0.50.

In such cases, the corresponding composite reliability values were checked and found to exceed 0.60, which is considered acceptable (Bagozzi & Yi, 1988). This indicates that the indicators reliably represent their underlying constructs despite the relatively lower AVE values. Furthermore, Fornell and Larcker (1981) and Bagozzi and Yi (1988) suggest that when CR exceeds 0.60, convergent validity is partially supported even if AVE values are marginally below 0.50. AVE values for all the latent constructs are shown in Table 4.12.

Table 4.12: AVE values for the measured constructs

Construct	AVE
WPV	0.545
Burnout-related Emotional Exhaustion	0.516
Job Satisfaction	0.600
Turnover Intentions	0.726
RAB	0.380
CPMB	0.336
DPR	0.455
PSP	0.310

Source: Author's computation based on primary data

It is important to acknowledge that lower AVE values indicate a relatively higher proportion of measurement error in the indicators. Therefore, these constructs were retained with attention, particularly considering the exploratory nature of behavioural constructs and the acceptable reliability levels observed in this study. Overall, the results indicate that the given measurement model has acceptable convergent validity and is suitable for further study.

The constructs RAB, CPMB, DPR, and PSP had AVE values < 0.50 , which are below the recommended cut-off. Further, item reduction checks were performed to assess whether deleting low-factor-loading indicators would meaningfully improve AVE. However, deleting the weakest PSP indicator slightly improved AVE and reduced CR. Similar checks for RAB and CPMB also did not yield an appropriate measurement solution and narrowed the theoretical content of the constructs. Therefore, the retained CFA structure was considered for further analysis. Hence, RAB, CPMB, and PSP were treated as first-order reflective exploratory constructs, and the findings regarding these constructs were interpreted as preliminary rather than conclusive.

Moreover, PSP was retained because it was theoretically important for the study's emphasis on systemic protection in the WPV context. However, its AVE remained below the recommended threshold, indicating limited convergent validity under its reflective form. Thus, PSP was not treated as a fully validated scale. Instead, it was treated as a literature-adapted, newly integrated exploratory measure based on the indicators used. Since the retained PSP items mainly represented legal protection and societal or media responsibility, some organizational-level indicators were removed during CFA refinement. So, claims involving PSP were restricted and interpreted accordingly.

4.2.4.7 Discriminant Validity

The Fornell-Larcker criterion and the Heterotrait-Monotrait (HTMT) ratio of correlations were used to assess the discriminant validity. Both methods showed different outputs. The Fornell-Larcker criterion evaluates whether $\sqrt{\text{AVE}}$ for each latent construct is greater than its correlations with other latent constructs. The results showed that the criterion was satisfied for several construct pairs. However, the criterion was not fully satisfied for the selected pairs (Burnout-related emotional exhaustion - Job Satisfaction, DPR-Turnover Intentions, Job Satisfaction-DPR). These findings suggest substantial conceptual overlap

between psychological, relational, and attitudinal withdrawal outcomes. This overlap is theoretically reasonable, as burnout-related emotional exhaustion, reduced job satisfaction, deteriorated DPR, and turnover intention may represent closely connected consequences of WPV. Table 4.13 exhibits Fornell-Larcker values for the constructs representing WPV, Burnout-related Emotional Exhaustion (BO), Job Satisfaction (JS), Turnover Intentions (TI), RAB, CPMB, DRP, and PSP.

Table 4.13
Discriminant Validity Assessment Using the Fornell-Larcker Table of Correlations

Construct	WPV	BO	JS	TI	RAB	CPMB	DPR	PSP
WPV	0.738	0.717	-0.51	0.57	0.363	0.267	0.643	-0.386
BO	0.717	0.718	-0.719	0.696	0.475	0.326	0.604	-0.474
JS	-0.51	-0.719	0.775	-0.761	-0.563	-0.133	-0.755	0.362
TI	0.57	0.696	-0.761	0.852	0.49	0.339	0.702	-0.371
RAB	0.363	0.475	-0.563	0.49	0.616	0.364	0.548	-0.458
CPMB	0.267	0.326	-0.133	0.339	0.364	0.58	0.178	-0.231
DPR	0.643	0.604	-0.755	0.702	0.548	0.178	0.675	-0.511
PSP	-0.386	-0.474	0.362	-0.371	-0.458	-0.231	-0.511	0.557
Note: Diagonal = $\sqrt{\text{AVE}}$, Off-diagonal = inter-construct correlations								

Source: Author's computation based on primary data

Besides, the HTMT ratio was observed as a more sensitive and modern measure of discriminant validity. All HTMT values were below the recommended threshold of 0.85, thereby confirming that the constructs are empirically discrete despite some correlations. Table 4.14 presents the Heterotrait-Monotrait (HTMT) ratio of correlations for the variables representing WPV, Burnout-related Emotional Exhaustion (BO), Job Satisfaction (JS), Turnover Intentions (TI), RAB, CPMB, DRP, and PSP.

This approach is supported by Henseler et al. (2015), who demonstrated that the Fornell-Larcker criterion may not be a robust method and may lack responsiveness to detecting discriminant validity issues, particularly for models studying closely associated constructs. Therefore, the HTMT ratio is considered a more reliable and precise measure for assessing discriminant validity.

Table 4.14
Discriminant Validity Assessment Using the Heterotrait–Monotrait Ratio (HTMT)

Construct	WPV	BO	JS	TI	RAB	CPMB	DPR	PSP
WPV	1	0.678	0.478	0.528	0.321	0.18	0.654	0.399
BO	0.678	1	0.65	0.621	0.428	0.182	0.526	0.453
JS	0.478	0.65	1	0.744	0.48	0.108	0.715	0.349
TI	0.528	0.621	0.744	1	0.368	0.205	0.655	0.304
RAB	0.321	0.428	0.48	0.368	1	0.307	0.483	0.454
CPMB	0.18	0.182	0.108	0.205	0.307	1	0.156	0.167
DPR	0.654	0.526	0.715	0.655	0.483	0.156	1	0.514
PSP	0.399	0.453	0.349	0.304	0.454	0.167	0.514	1

Source: Author's computation based on primary data

Overall, while the Fornell-Larcker results reveal partial overlap among certain constructs, the HTMT findings offer convincing evidence of discriminant validity. So, the measurement model is deemed acceptable for discriminant validity and is used for further structural analysis.

4.2.4.8 Model Refinement

The initial measurement model was assessed using CFA, and thereafter, some refinements were made to improve model fit. This step was performed to ensure the

reliability and validity of the constructs. The refinement process was iterative and guided by both statistical factors and theoretical considerations.

Items with relatively low factor loadings were carefully studied, and those that did not contribute implicitly to their corresponding constructs were removed. This step helped improve the overall measurement fit and internal consistency of the constructs.

In addition, modification indices were examined to identify possible areas of model misfit. Wherever theoretically reasonable, covariance paths between the error terms of certain indicators were introduced, specifically within the same construct. These modifications were based on the idea that some items may have similar wording or measurement context, leading to correlated measurement errors.

During CFA refinement, modification indices were checked to identify closely related item pairs within the same construct that shared wording or content overlap. Residual covariances were included only for item pairs with relatively high modification indices and clear theoretical or wording-based overlap within the same construct. No cross-construct residual covariances were added. For example, covariance was allowed between items that showed closely related aspects of the same latent construct, such as exhaustion and burnout within the burnout-related emotional exhaustion construct, enthusiasm and enjoyment within job satisfaction, dispute avoidance and conflict-related referral within RAB, legal mechanisms and law enforcement response within PSP, and detailed documentation and risk explanation within CPMB. These refinements were based on theoretical justification rather than purely statistical adjustments.

All the above-mentioned refinements were applied carefully to avoid overfitting and to ensure that the changes keep the model conceptually meaningful and theoretically aligned with the study. The primary objective was not to attain a superior statistical fit, but to improve the overall validity of the given measurement model.

After making the improvements, the measurement model exhibited improved model fit indices along with acceptable levels of convergent validity, construct reliability, and discriminant validity. The refined final model was therefore considered suitable for SEM.

4.2.4.9 Final Measurement Model

The final measurement model, after iterative refinements, demonstrated an overall acceptable fit to the data and suitable measurement properties across constructs. All retained items showed adequate factor loadings, and the constructs exhibited acceptable and satisfactory levels of internal consistency reliability, which was assessed using Cronbach's alpha and CR values.

Convergent validity was also assessed for all constructs, with several meeting the suggested AVE threshold, while others showed acceptable validity given adequate reliability levels. Discriminant validity was evaluated using both the HTMT ratio of correlations and the Fornell-Larcker criterion. Although minor overlaps were detected by the Fornell-Larcker criterion, the HTMT results confirmed that all constructs were empirically different.

Overall, the final measurement model was found to be both consistent and valid, providing a thorough basis for implementing structural model analysis.

4.2.5 Structural Model (SEM)

The structural model was assessed using SEM to observe the relationships among the constructs, after the validation of the measurement model was done through CFA. The evaluation of the structural model was done by overall model fit and the proposed relationships between latent variables.

4.2.5.1 Introduction to the Structural Model

After assessing the adequacy of the measurement model, the SEM was used to examine the relationships among the latent constructs in the framework. It was used to assess

the direct relationships between WPV, psychological outcomes, behavioural responses, DPR, PSP, and turnover intentions of doctors.

The structural model was analysed using bootstrapping procedures to obtain reliable estimates of path coefficients, standard errors, and significance levels. The complete structural model included assessing the path estimates and its statistical significance, the overall model fit, and the explanatory power of the endogenous constructs.

4.2.5.2 Structural Model Fit Assessment

The study-specific structural model was examined to check the degree to which the proposed theoretical framework adequately fits the observed data. Overall model fit was assessed using various indices, including the Comparative Fit Index (CFI), Goodness-of-Fit Index (GFI), Adjusted Goodness-of-Fit Index (AGFI), Tucker-Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA), Standardized Root Mean Square Residual (SRMR) and Parsimony Normed Fit Index (PNFI).

Table 4.15: Model Fit Indices for the Structural Model

Fit Index	Value	Cut-off	Interpretation
χ^2 / df	3.19	2-3	Marginal
RMSEA	0.065	≤ 0.08	Adequate
CFI	0.858	≥ 0.90	Marginal
SRMR	0.077	≤ 0.08	Acceptable
TLI	0.845	≥ 0.90	Marginal
GFI	0.984	> 0.90	Good
AGFI	0.981	> 0.90	Good
PNFI	0.741	> 0.50	Acceptable

Source: Author's computation based on primary data

The structural model exhibited mixed overall fit, with strong absolute indices but incremental indices below the conventional cutoff. Although some incremental fitness, namely CFI and TLI, were slightly below the required threshold values, the other absolute fit indices, particularly RMSEA, SRMR, GFI, and AGFI, were well within the acceptable limits. Table 4.15 shows resultant values of the structural model fit indices along with their cut-off values.

The above structural model demonstrated an overall adequate level of fit when evaluated using various fit indices. The strongest indication of acceptable fit model was shown by the RMSEA value of 0.065, which falls below the recommended 0.08 cut-off. The χ^2/df ratio was 3.19, slightly above the commonly accepted range of 2 to 3. The SRMR value of 0.077 was also below the 0.08 cut-off, supporting acceptable residual fit. However, the incremental fit indices were below the acceptable cut-off of 0.90, with CFI = 0.858 and TLI = 0.845, indicating marginal incremental fit. This was considerable due to the complexity of the model, which included multiple latent constructs, mediating pathways, and correlated residuals. The application of firm cutoff criteria for evaluating model fit in SEM has been widely argued in methodological literature. Although commonly recommended thresholds for indices such as CFI, TLI, and RMSEA are usually applicable, these guidelines have been criticized for their limited generalizability. Marsh et al. (2004) warned against the rigid use of universal cutoff values, stressing that model fit must be interpreted in relation to model complexity and contextual specification. Further, suggestion from Kenny and McCoach (2003) manifests that fit indices behave indifferent when the number of constructs in a model increases, as indices like RMSEA often improve while incremental fit indices like CFI and TLI may worsen, even in the presence of similar levels of model misspecification. This happens because incremental fit indices become more sensitive to minor model misspecifications in complex models and specifies that lower levels of incremental fit indices

may be a function of model complexity instead of poor model quality. In addition, the PNFI value of 0.741 indicated acceptable parsimony-adjusted fit, showing that the model retained its acceptance despite its complexity.

Therefore, the overall model evaluation adopted a holistic approach, considering theoretical justification along with the multiple fit indices, rather than strictly depending on rigid cut-off thresholds.

4.2.5.3 Direct Structural Path Estimates

The direct structural associations among the latent constructs were assessed using β values (standardized path coefficients) obtained through bootstrapping procedures. Table 4.16 shows the results of the structural path analysis, including standardized estimates (β), standard errors, z-values, and significance levels.

Table 4.16: Direct Structural Path Estimates

Structural Path	β	SE	z-value	p-value
WPV $\rightarrow$ BO	0.7904	0.0595	14.36	<0.001
WPV $\rightarrow$ Job Satisfaction	-0.5975	0.0594	-10.24	<0.001
BO $\rightarrow$ RAB	0.3125	0.0441	4.29	<0.001
Job Satisfaction $\rightarrow$ RAB	-0.7222	0.0479	-9.70	<0.001
BO $\rightarrow$ CPMB	0.4250	0.0404	4.39	<0.001
Job Satisfaction $\rightarrow$ CPMB	0.1203	0.0335	1.59	0.112
RAB $\rightarrow$ DPR	0.9333	0.1153	10.57	<0.001
CPMB $\rightarrow$ DPR	0.0546	0.0298	-1.83	0.276
DPR $\rightarrow$ Turnover Intentions	0.8167	0.0728	15.11	<0.001

Source: Author's computation based on primary data

The findings reveal that WPV demonstrated significant relationships with both burnout-related emotional exhaustion and job satisfaction. Burnout-related emotional

exhaustion further showed significant associations with behavioural responses, namely RAB and CPMB. While, job satisfaction showed significant relation with RAB only. In addition, deterioration in the DPR exhibited a significant relationship with turnover intentions.

Considering the final structural model, RAB showed a positive relationship with DPR which was statistically significant ($\beta = 0.9333$, $p < 0.001$). Although the coefficient remained within the standardized range, its magnitude was high. Therefore, the finding was interpreted cautiously as a strong model-related association rather than as an exact measure of causal impact. This caution is also relevant because DPR showed high explained variance in the model ($R^2 = 0.892$). Since RAB and CPMB were taken together as predictors of DPR, multicollinearity was assessed using VIF diagnostics. The VIF values for both predictors were 1.06, indicating no evidence of mean-score multicollinearity.

Most of the structural paths included in the proposed framework were found to be statistically significant. However, the relationships between CPMB and deterioration in the DPR, and job satisfaction and CPMB was found not to be statistically significant.

4.2.5.4 Indirect Effects and Sequential Path Analysis (Bootstrapping)

To examine the indirect and sequential mediation effects in the proposed model, bias-corrected and accelerated bootstrap confidence intervals (5000 resamples) were used in the SEM analysis. Bootstrapping was considered suitable because the assessment of multivariate normality exhibited deviations from normal distribution, as shown in the significant Mardia's multivariate skewness and kurtosis coefficients. The Mardia's multivariate skewness coefficient was 183 ($\chi^2 = 16085$, $p < 0.001$) and the multivariate kurtosis coefficient was 1719 ($z = 41.4$, $p < 0.001$), which indicated the presence of non-normality in the data. Therefore, bootstrapping is recommended as it provides more effective estimates of indirect effects, confidence intervals, and standard errors, without depending on strict normality assumptions (Hair et al., 2019).

Bootstrap estimation was used to study the strength of indirect effects in the SEM model. Out of 5,000 bootstrap resamples, 95 resulted in non-admissible solutions and the remaining 4,905 admissible bootstrap repetitions were considered for interpretation. The non-admissibility rate of 1.90% was considered acceptable as the SEM model is complex having multiple number of latent constructs including the serial indirect pathways. However, SEMLj did not provide a specific breakdown for each path of the non-admissible bootstrap repetitions. Therefore, the bootstrap results were retained, but the indirect effects were interpreted cautiously. Nevitt and Hancock (2001) accepted that bootstrap procedures in SEM may produce unstable or unusable samples. These unusable samples may arise due to estimation problems such as non-convergence or improper solutions. So, it is a common practice to discard such samples and make inferences based on admissible bootstrap estimates, depicting that the presence of a small proportion of non-admissible solutions is a characteristic limitation of the bootstrap method rather than an error in the model. Although bootstrapping is widely used for estimating sampling distributions, it does not perform uniformly across all resamples. As noted by Bollen & Stine (1992), the success of bootstrap procedures depends on the resemblance between empirical and population sampling behaviour. Also, in some situations this assumption may not hold which results in unstable or badly behaved estimates. Therefore, the small proportion of non-admissible bootstrap solutions (1.90%) as observed in the present study is consistent with the observed limitations of resampling-based bootstrapping methods in various studies and does not affect the overall strength of the model.

The bootstrapped indirect effects revealed multiple significant sequential mediation pathways linking WPV with turnover intentions through psychological, behavioural, and relational outcomes. Table 4.17 shows the indirect effects and their corresponding significance levels for the proposed model.

Table 4.17: Bootstrapped Indirect Effects and Sequential Mediation Paths

Indirect Path	β	SE	z-value	p-value
WPV → BO → RAB → DPR → Turnover Intentions	0.188	0.054	4.048	<0.001
WPV → BO → CPMB → DPR → Turnover Intentions	0.015	0.016	1.062	0.288
WPV → Job Satisfaction → RAB → DPR → Turnover Intentions	0.329	0.055	6.876	<0.001
WPV → Job Satisfaction → CPMB → DPR → Turnover Intentions	-0.003	0.005	-0.817	0.414
Total Indirect Effect	0.529	0.063	9.626	<0.001

Source: Author's computation based on primary data

The bootstrapped indirect effects revealed several statistically significant indirect pathways linking WPV with turnover intentions through psychological, behavioural, and relational variables. The indirect pathways involving burnout-related emotional exhaustion, RAB, deterioration in the DPR, and turnover intentions were statistically significant. Similarly, the serial indirect pathway passing through job satisfaction, RAB, deterioration in the DPR, and turnover intentions also showed statistical significance.

In contrast, the indirect pathway involving burnout-related emotional exhaustion, CPMB, deterioration in the DPR, and turnover intentions did not come out to be statistically significant. Moreover, the indirect path connecting job satisfaction, CPMB, deterioration in the DPR, and turnover intentions did not show statistical significance. The total indirect effect of WPV on turnover intentions was found to be statistically significant, representing the existence of significant indirect pathways among the constructs involved in the structural model.

4.2.5.5 Explanatory Power of the Structural Model (R^2)

The coefficient of determination (R^2) for each endogenous construct was used to evaluate the explanatory power of the structural model. The R^2 value represents the amount of variation in the dependent variable explained by its predictor variables within the structural model. Higher R^2 values indicate greater descriptive power of the proposed model.

The results show that the structural model demonstrated considerable explanatory power for the constructs included in this study. The given structural model explained 62.50% of the variance in burnout-related emotional exhaustion, 35.70% in job satisfaction, 83.20% in RAB, 89.20% in deterioration of the DPR, 14.90% in CPMB, and 66.70% in turnover intention. The construct, RAB and deterioration in RAB showed high values of R^2 , signifying strong explanatory abilities of these constructs. However, the explanatory power for CPMB was comparatively lower, with the model explaining 14.90% of its variance. Overall, the findings propose that the given structural framework adequately explains the major psychological, behavioural, and relational outcomes associated with WPV among doctors. Table 4.18 shows R^2 values for the endogenous variables used in the study.

Table 4.18: R^2 Values for Endogenous Constructs

Endogenous Construct	R^2	Variance Explained	Interpretation
Burnout-related Emotional Exhaustion	0.625	62.50%	Moderate
Job Satisfaction	0.357	35.70%	Weak
Turnover Intentions	0.667	66.70%	Substantial
RAB	0.832	83.20%	Substantial
CPMB	0.149	14.90%	Weak
DPR	0.892	89.20%	Substantial

Source: Author's computation based on primary data

4.2.5.6 Structural Model Diagram

The final structural model diagram visually presents the hypothesised relationships tested through SEM, including the pathways from WPV to psychological outcomes, behavioural responses, deterioration in the DPR, and turnover intentions. The diagram also displays the retained measurement indicators and standardised estimates for each construct, providing a consolidated view of the model tested in the present study. This visual representation supports the interpretation of the SEM results discussed in the preceding sections. The diagram of SEM model is shown in Figure 4.1

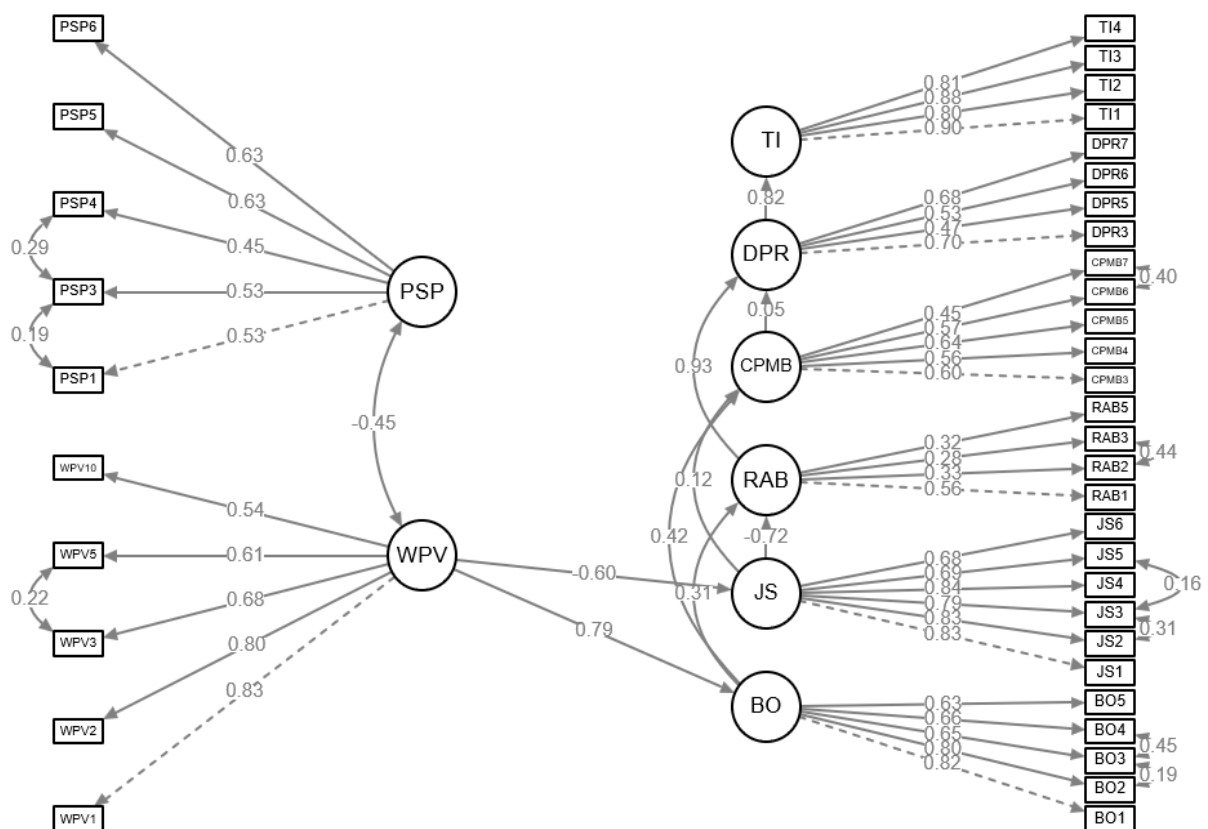


Figure 4.1 The figure shows the final SEM structural model estimated using standardized coefficients based on the study data. Latent constructs include workplace violence (WPV), perceived systemic protection (PSP), burnout-related emotional exhaustion (BO), job satisfaction (JS), risk-avoidance behaviour (RAB), changed patient-management behaviour (CPMB), deterioration in the doctor-patient relationship (DPR), and turnover intentions (TI).

4.2.5.7 Summary of the Structural Model

To observe the proposed relationships among WPV, psychological outcomes, behavioural responses, relational dynamics, PSP, and turnover intentions, the structural model analysis was conducted. The present model showed an acceptable overall fit to the experimental data, indicating that the proposed theoretical framework satisfactorily represents the relationships among the constructs.

The analysis of direct structural paths discovered that most of the proposed relationships were statistically significant. In addition, the bootstrapped indirect effects analysis acknowledged several significant indirect pathways linking WPV with turnover intentions through psychological, behavioural, and relational variables. The structural model also proved significant explanatory power for the main endogenous constructs, particularly deterioration in the DPR, RAB, burnout-related emotional exhaustion, and turnover intentions.

Overall, the findings and analysis conclude that the projected structural framework provides an adequate explanation of the complex and multifaceted relationships associated with WPV among doctors.

4.2.6 Moderation Analysis of Perceived Systemic Protection (PSP)

After the structural model analysis, a moderation analysis was performed to check whether the relationship between WPV and its related outcomes, is influenced by PSP. Furthermore, it was examined whether the indirect influence of WPV on turnover intentions varies across different levels of PSP.

4.2.6.1 Introduction to Moderation Analysis

Moderation analysis was performed in order to study whether PSP influences the relationship between WPV and psychological outcomes among doctors. The main objective

of the analysis was to examine whether higher levels of PSP weaken the adverse effects of WPV on burnout-related emotional exhaustion and job satisfaction.

In addition, moderated mediation analysis was performed to examine whether the indirect relationship between WPV and turnover intentions varies across different levels of PSP. The analysis further studied whether the buffering influence of PSP on psychological outcomes conditionally impacts the downstream behavioural and relational pathways included in the proposed framework.

The analyses were carried out using regression-based general linear modeling (GLM) procedures with bootstrapping to get reliable estimates of indirect effects and confidence intervals.

4.2.6.2 Preliminary Assumption Assessment

Before performing moderation and moderated mediation analyses, the continuous predictor variables included in the interaction models were mean-centred to decrease the chances of multicollinearity and enhance the interpretability of interaction effects.

Since the analyses involved indirect effects and interaction terms, bootstrapping procedures (5000 samples) were used to get more stable estimates of regression coefficients, indirect effects, and confidence intervals.

Overall, the data were appropriate for conducting moderation and moderated mediation analyses using the regression-based GLM module.

4.2.6.3 Moderating Effect of PSP

Moderation analysis was performed to check whether the relationship between WPV and psychological outcomes, moderated by PSP. Isolated regression-based moderation models were estimated using WPV as the predictor, PSP as the moderator, and burnout-related emotional exhaustion and job satisfaction as dependent variables.

The results showed that WPV has positive and statistically significant association with burnout-related emotional exhaustion ($\beta = 0.670$, $p < 0.001$) and a negative and statistically significant association job satisfaction ($\beta = -0.490$, $p < 0.001$). In addition, PSP showed significant direct relationships with both psychological outcomes, exhibiting a positive association with job satisfaction ($\beta = 0.227$, $p < 0.001$) and a negative association with burnout-related emotional exhaustion ($\beta = -0.293$, $p < 0.001$).

Table 4.19: Results of Moderation Analysis of PSP on the relationship between WPV and Burnout-related Emotional Exhaustion

Predictor	β	SE	95% CI	z-value	p-value
WPV_C	0.670	0.048	0.572 to 0.762	13.866	<0.001
PSP_C	-0.293	0.060	-0.416 to -0.174	-4.858	<0.001
WPV_C $\times$ PSP_C	0.059	0.082	-0.102 to 0.218	0.719	0.472
WPV_C and PSP_C represent mean-centered variables. Interaction effects were estimated using regression-based moderation analysis.					

Source: Computation done by author based on primary data

Table 4.20: Results of Moderation Analysis of PSP on the relationship between WPV and Job Satisfaction

Predictor	β	SE	95% CI	z-value	p-value
WPV_C	-0.490	0.051	-0.593 to -0.395	-9.62	<0.001
PSP_C	0.227	0.068	0.091 to 0.360	3.33	<0.001
WPV_C $\times$ PSP_C	-0.118	0.089	-0.297 to 0.053	-1.31	0.189
WPV_C and PSP_C represent mean-centered variables. Interaction effects were estimated using regression-based moderation analysis.					

Source: Computation done by author based on primary data

However, the interaction effects between WPV and PSP were not statistically significant for either burnout-related emotional exhaustion ($\beta = 0.059$, $p = 0.472$) or job satisfaction ($\beta = -0.118$, $p = 0.189$). These findings indicate that PSP did not significantly change the relationship strength between WPV and the respective psychological outcome.

Tables 4.19 and 4.20 show the moderation results for burnout-related emotional exhaustion and job satisfaction as dependent variables, respectively.

Figure 4.2 and Figure 4.3 show the simple slope plots demonstrating PSP as a moderator, and its influence on the relationship between WPV and psychological outcomes at low, average, and high levels of PSP. The plots imply that the relationship between WPV and burnout-related emotional exhaustion remained positive across all levels of PSP, whereas the relationship between WPV and job satisfaction remained negative across all levels of PSP. Though minor variations in slope estimates were seen across different moderator levels, the regression lines remained mostly parallel. This manifests the negligible disparity in the strength of these relationships. Also, these results are consistent with the statistically non-significant moderation effect findings received in the regression analysis, suggesting that PSP did not significantly moderate the relationship between WPV and their corresponding psychological outcomes.

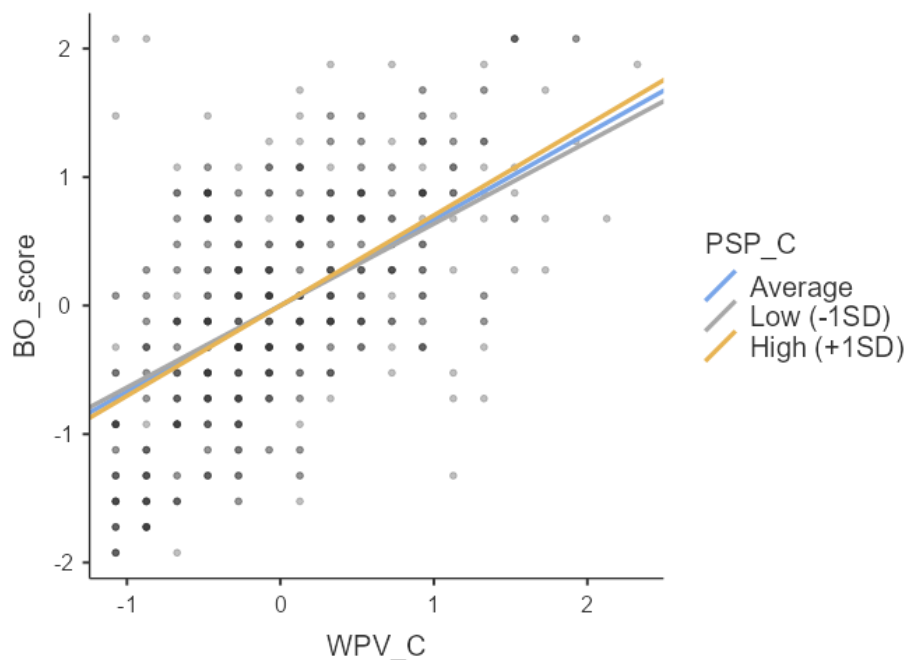


Figure 4.2
Simple slope plot for PSP moderating the relationship between WPV and Burnout-related Emotional Exhaustion (BO)

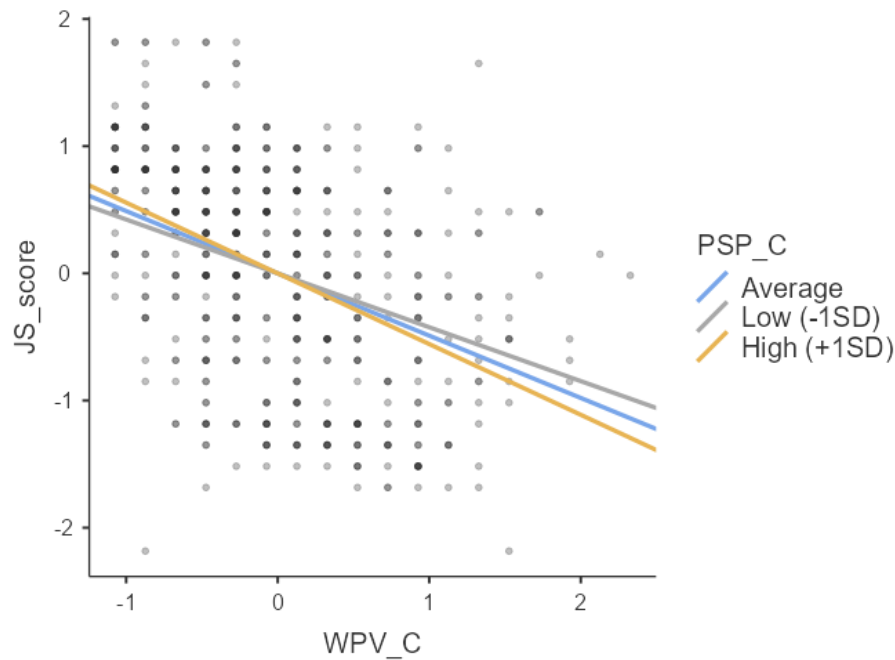


Figure 4.3
Simple slope plot for PSP moderating the relationship between WPV and Job Satisfaction

4.2.6.4 Moderated Mediation Analysis

Moderated mediation analysis was performed to assess the indirect pathways between WPV and turnover intentions (TI) through psychological outcomes and how it varies across different levels of PSP. Individual regression-based moderated mediation models were run for burnout-related emotional exhaustion and job satisfaction using bias-corrected bootstrapped confidence intervals (5000 sample repetitions).

The results indicated that the indirect pathways of WPV on turnover intentions through burnout-related emotional exhaustion remained statistically significant at low, average, and high levels of PSP. Similarly, the indirect effects facilitated by job satisfaction were also found to be statistically significant at all observed levels of PSP. These findings suggest that burnout-related emotional exhaustion and job satisfaction significantly mediate the WPV and turnover intentions relationships, at any level of PSP.

Table 4.21: Moderation Effects in the Burnout-related Emotional Exhaustion Moderated Mediation Model

Interaction Effect	β	SE	95% CI	z-value	p-value
WPV_C $\times$ PSP_C $\rightarrow$ BO	0.028	0.075	-0.110 to 0.218	0.783	0.434
WPV_C $\times$ PSP_C $\rightarrow$ TI	-0.018	0.121	-0.380 to 0.291	-0.368	0.713
PSP_C $\times$ BO $\rightarrow$ TI	-0.004	0.091	-0.242 to 0.235	-0.028	0.978
Note: WPV_C and PSP_C represent mean-centered variables. Confidence intervals were estimated using bias-corrected bootstrap procedures.					

Source: Author's computation based on primary data

However, the interaction effects predicted by the moderated mediation models were not statistically significant. Specifically, the interaction terms involving WPV and PSP, as well as those involving PSP and the mediators, did not reflect statistically significant effects in either model. This shows that PSP did not substantially moderate the indirect pathways between WPV and turnover intentions mediated through burnout-related emotional exhaustion or job satisfaction. Table 4.21 and Table 4.22 depict the moderation effects of PSP in the moderation mediation model of burnout-related emotional exhaustion and job satisfaction, respectively.

Table 4.22: Moderation Effects in the Job Satisfaction Moderated Mediation Model

Interaction Effect	β	SE	95% CI	z-value	p-value
WPV_C $\times$ PSP_C $\rightarrow$ Job Satisfaction	-0.057	0.082	-0.298 to 0.062	-1.433	0.152
WPV_C $\times$ PSP_C $\rightarrow$ TI	-0.022	0.089	-0.272 to 0.168	-0.626	0.531
PSP_C $\times$ Job Satisfaction $\rightarrow$ TI	0.156	0.075	-0.067 to 0.231	1.065	0.287
Note: WPV_C and PSP_C represent mean-centered variables. Confidence intervals were estimated using bias-corrected bootstrap procedures.					

Source: Author's computation based on primary data

Although the indirect effects showed marginal differences across different levels of PSP, the detected differences were relatively minor. Whereas, these conditional indirect relationships remained statistically significant across all levels of PSP moderation. Overall, the results suggest that the burnout-related emotional exhaustion and job satisfaction supported the mediation, whereas the moderated mediation effects involving PSP were not supported. Tables 4.23 and 4.24 show the conditional indirect effects of burnout-related emotional exhaustion and job satisfaction at different levels of PSP.

As the conceptual framework suggests that the moderated mediation of PSP may extend to downstream behavioural and relational pathways through psychological outcomes, the non-significant moderation effects at the psychological stage leave a limited likelihood of such conditional downstream influence in the present study.

Table 4.23: Conditional Indirect Effects through Burnout-related Emotional Exhaustion at various levels of PSP

PSP Level	Indirect Effect	SE	95% CI	β	p-value
Low (-1 SD)	0.311	0.044	0.179 to 0.460	0.212	<0.001
Mean	0.326	0.042	0.244 to 0.417	0.222	<0.001
High (+1 SD)	0.342	0.049	0.226 to 0.483	0.232	<0.001
Note: Confidence intervals were estimated using bias-corrected bootstrap procedures.					

Source: Computation done by author based on primary data

Table 4.24: Conditional Indirect Effects through Job Satisfaction at various levels of PSP

PSP Level	Indirect Effect	SE	95% CI	β	p-value
Low (-1 SD)	0.315	0.049	0.216 to 0.432	0.211	<0.001
Mean	0.342	0.041	0.265 to 0.425	0.233	<0.001
High (+1 SD)	0.363	0.054	0.256 to 0.502	0.251	<0.001
Note: Confidence intervals were estimated using bias-corrected bootstrap procedures.					

Source: Computation done by author based on primary data

4.2.6.5 Summary of Moderation Analysis

The moderation analysis assessed the role of PSP in affecting the relationship between WPV and the outcome variables. The findings indicated that WPV showed significant relationships with burnout-related emotional exhaustion, job satisfaction, and turnover intentions. PSP also revealed significant direct relationships with the psychological outcomes, namely, burnout-related emotional exhaustion and job satisfaction.

However, the WPV x PSP interaction effects were not found to be statistically significant in the moderation and moderated mediation models. Even though the indirect relationships between WPV and turnover intentions, through burnout-related emotional exhaustion and job satisfaction, remained significant across various levels of PSP, the strength of these relationships did not show much variance across moderator levels. This shows that moderation was not statistically supported.

Overall, the results suggest that PSP may behave more as an independent protective factor rather than as a crucial buffering moderator in the relationship between WPV and its psychological, behavioural, relational and attitudinal outcomes.

4.3 Findings Regarding Hypothesis

The findings related to each hypothesis proposed in the study are presented in this section. The hypotheses were assessed using the results from SEM, bootstrapped indirect effects analysis, and regression-based moderation and moderated mediation analyses.

4.3.1 H1: WPV is positively associated with burnout-related emotional exhaustion among doctors.

H1 proposed that WPV is positively associated with burnout-related emotional exhaustion among doctors. The results of the structural model analysis showed a statistically significant positive relationship between WPV and burnout-related emotional exhaustion ($\beta =$

0.7904, $p < 0.001$). The findings suggest that higher levels of WPV are related with increased levels of burnout-related emotional exhaustion among doctors.

The positive association and statistical significance of the relationship confirm support for H1. The findings state that exposure to WPV contributes considerably to emotional and psychological fatigue among doctors, thereby increasing burnout-related emotional exhaustion levels within hospitals.

4.3.2 H2: WPV is negatively associated with job satisfaction among doctors.

H2 hypothesized that WPV is negatively related to job satisfaction among doctors. The SEM results discovered a statistically significant negative relationship between WPV and job satisfaction ($\beta = -0.5975$, $p < 0.001$). The results show that higher WPV exposure is associated with lower job satisfaction among doctors.

The negative direction and statistical significance of the relationship implies that H2 is supported. The outcomes advocate that experiences of WPV adversely affect doctors' overall satisfaction with their occupational roles and working atmosphere.

4.3.3 H3: Burnout-related emotional exhaustion is positively associated with RAB.

H3 proposed that burnout-related emotional exhaustion is positively connected with RAB. The structural model results exhibited a statistically significant and positive relationship between burnout-related emotional exhaustion and RAB ($\beta = 0.3125$, $p < 0.001$). This indicates that doctors who experience more burnout-related emotional exhaustion are more likely to be involved in behaviours intended at avoiding professional or clinical risks.

The positive and significant association reinforces H3. The findings suggest that emotionally exhausted and psychologically stressed doctors may develop a habit of being highly careful in their clinical decision-making and professional conduct in order to minimise potential disputes, stress, or hostile outcomes.

4.3.4 H4: Burnout-related emotional exhaustion is positively associated with CPMB.

H4 intended that burnout-related emotional exhaustion is positively associated with CPMB. The SEM findings exposed a positive and statistically significant relationship between burnout-related emotional exhaustion and CPMB ($\beta = 0.4250$, $p < 0.001$). The results point to higher burnout-related emotional exhaustion levels among doctors being linked with more adjustments in patient-management practices.

Therefore, H4 was supported by the positive and significant outcome. The findings imply that burnout-related emotional exhaustion may encourage doctors to modify their clinical management methods by being more defensive and proactive in order to avoid psychological tension and occupational stress.

4.3.5 H5: Job satisfaction is negatively associated with RAB.

H5 proposed that job satisfaction is negatively associated with RAB. The output of SEM analysis established a statistically significant and negative relationship between job satisfaction and RAB ($\beta = -0.7222$, $p < 0.001$). The findings indicate that doctors with increased job satisfaction have less possibility to have behavioural changes intended at avoiding professional or clinical risks.

Therefore, H5 was supported. The findings suggest that professionally satisfied doctors may feel more confident, positive, and jobwise secure in their clinical tasks and roles. This decreases their tendency to adopt avoidance-oriented behavioural changes in their medical practice.

4.3.6 H6: Job satisfaction is negatively associated with CPMB.

As hypothesized, H6 states that job satisfaction is negatively associated with CPMB. However, the findings of the structural model analysis showed a statistically non-significant

and positive association between job satisfaction and CPMB ($\beta = 0.1203$, $p = 0.112$), opposite to the hypothesised path.

Therefore, H6 was not supported. The results suggest that job satisfaction did not significantly reduce CPMB in the present sample, indicating that CPMB may not be a primary outcome of job dissatisfaction but may reflect cautious or adaptive clinical practice.

4.3.7 H7: RAB is positively associated with the deterioration in the DPR.

H7 proposed that RAB is positively associated with the deterioration in the DPR. The structural model analysis exhibited a statistically significant and positive relationship between RAB and deterioration in the DPR ($\beta = 0.9333$, $p < 0.001$). Since higher RAB scores in the present study mean greater deterioration in the DPR, the findings indicate that increased RAB is related to worsening DPR consequences.

H7 was supported because of its positive direction and significance. This indicates that doctors reporting higher RAB also reported greater deterioration in the DPR. However, the magnitude of the standardized coefficient ($\beta = 0.9333$) was high, and therefore the result was interpreted cautiously. This should be considered as a strong model-dependent association rather than a literal effect size of RAB on DPR. The strong association may reflect that avoidance-based behavioural withdrawal and relational deterioration are conceptually related and may have strong empirical overlap in this sample. Although Fornell-Larcker criteria did not indicate the failure of discriminant validity between RAB and DPR, the high standardized coefficient (β) and high DPR R^2 (0.892) suggest that the RAB $\rightarrow$ DPR pathway should be analyzed cautiously. The findings advise that doctors who progressively adopt avoidance-based clinical behaviours may experience more communication hurdles, reduced trust, and less interactive relations with patients and their attendants.

4.3.8 H8: CPMB is positively associated with the deterioration in the DPR.

H8 projected that CPMB is positively associated with deterioration in the DPR. The structural modeling outcomes exposed a positive relationship between CPMB and deterioration in the DPR ($\beta = 0.0546$) but the relationship was not statistically significant ($p = 0.276$).

Hence, H8 was rejected. While the proposed relationship was likely to show that greater changes in patient-management behaviour would be associated with worsening DPR, the results did not offer sufficient statistical evidence to support this hypothesis within the present study.

4.3.9 H9: Deterioration in the DPR is positively associated with doctors' turnover intentions.

H9 stated that deterioration in the DPR is positively associated with doctors' turnover intention. The SEM result exhibited a statistically significant and positive relationship between deterioration in the DPR and turnover intentions ($\beta = 0.8167$, $p < 0.001$). The findings depict that more worsening in DPR is associated with higher levels of turnover intentions among doctors.

Hence, H9 was supported. The findings suggest that stressed doctor-patient interactions, reduced trust, communication difficulties, and deteriorating relational understandings may lead significantly to doctors' intentions to withdraw from or change their professional roles within healthcare settings.

4.3.10 H10: The relationship between WPV and turnover intentions is mediated through a sequential multi-stage process, wherein parallel psychological outcomes (burnout-related emotional exhaustion and job satisfaction) influence parallel behavioural responses (RAB and CPMB), which in turn affect the doctor-patient relationship, ultimately leading to turnover intentions.

H10 hypothesized that the pathway between WPV and turnover intentions is mediated through a sequential multi-stage process involving parallel psychological and behavioural pathways. The proposed conceptual model examined whether WPV influences turnover intentions through the parallel psychological outcomes of burnout-related emotional exhaustion and job satisfaction, further affecting the parallel behavioural responses of RAB and CPMB, and finally contributing to deterioration in the DPR and turnover intentions. H10 was treated as an omnibus serial mediation hypothesis and was tested through four hypotheses (H10a-H10d) having different serial mediation paths. The bootstrapped SEM analysis which included indirect effects, revealed several statistically significant sequential indirect pathways within the studied model.

H10a: The relationship between WPV and turnover intentions is sequentially mediated through burnout-related emotional exhaustion, RAB, and deterioration in the DPR.

The indirect pathway involving WPV, burnout, RAB, deterioration in the DPR, and turnover intentions was significant statistically ($\beta = 0.188$, $p < 0.001$).

H10b: The relationship between WPV and turnover intentions is sequentially mediated through burnout-related emotional exhaustion, CPMB, and deterioration in the DPR.

Moreover, the indirect pathway involving WPV, burnout-related emotional exhaustion, CPMB, deterioration in the DPR, and turnover intentions was statistically not significant ($\beta = 0.015$, $p = 0.288$).

H10c: The relationship between WPV and turnover intentions is sequentially mediated through job satisfaction, RAB, and deterioration in the DPR.

Similarly, the indirect pathway involving WPV, job satisfaction, RAB, deterioration in the DPR, and turnover intentions was significant statistically ($\beta = 0.329$, $p < 0.001$).

H10d: The relationship between WPV and turnover intentions is sequentially mediated through job satisfaction, CPMB, and deterioration in the DPR.

Whereas, the indirect pathway involving WPV, job satisfaction, CPMB, deterioration in the DPR, and turnover intentions was statistically insignificant ($\beta = -0.003$, $p = 0.414$).

Overall, the total indirect effect directed by the pathway from WPV to turnover intentions was statistically significant ($\beta = 0.529$, $p < 0.001$), indicating that WPV influences attitudinal outcomes (turnover intentions) through interconnected psychological, behavioural, and relational consequences within the sequential model.

The findings further support the framing of the proposed framework as a layered sequential model comprising multiple parallel mediating pathways rather than a strictly linear sequential model. Pathways involving RAB appeared as the leading and statistically significant ones, whereas pathways linking CPMB showed non-significant effects. This pattern suggests that psychological and behavioural responses to WPV may occur simultaneously, but the impact may not see a uniform progression through the sequence across all pathways.

Therefore, H10 was partially supported, as the paths connecting RAB within the proposed sequential indirect pathways were statistically significant, whereas the pathways including CPMB were not statistically significant.

4.3.11 H11: PSP moderates the relationship between workplace violence and psychological outcomes, such that higher PSP weakens the positive association between WPV and burnout-related emotional exhaustion, and weakens the negative association between WPV and job satisfaction.

H11 proposed that PSP moderates the relationship between WPV and its psychological outcomes by tempering the positive association between WPV and burnout-related emotional exhaustion, and weakening the negative relationship between WPV and job satisfaction.

The moderation analysis showed that WPV was significantly associated with higher burnout-related emotional exhaustion levels ($\beta = 0.670, p < 0.001$) and lower job satisfaction levels ($\beta = -0.490, p < 0.001$). Moreover, PSP also displayed significant direct relationships with both psychological outcomes, exhibiting a positive association with job satisfaction ($\beta = 0.227, p < 0.001$) and a negative association with burnout-related emotional exhaustion ($\beta = -0.293, p < 0.001$).

However, the $WPV \times PSP$ interaction effects were not statistically significant for burnout ($\beta = 0.059, p = 0.472$) or job satisfaction ($\beta = -0.118, p = 0.189$). Further, the simple slope analysis directed that the relationship between WPV and psychological outcomes remained statistically significant across low, average, and high levels of PSP.

Therefore, H11 was not supported. Although PSP established direct associations with psychological outcomes, it did not meaningfully moderate the relationship between WPV and burnout-related emotional exhaustion or job satisfaction within the present study.

4.3.12 H12: PSP moderates the indirect relationship between WPV and turnover intentions by buffering its effect on psychological outcomes.

H12 proposed that the indirect relationship between WPV and turnover intentions, is moderated by PSP by buffering the effect of WPV on psychological outcomes, thereby influencing downstream behavioural and relational pathways. Moderated mediation analysis was conducted individually for the burnout-related emotional exhaustion and job satisfaction pathways using bootstrapped conditional indirect effects.

The findings showed that the indirect relationship between WPV and turnover intentions through burnout-related emotional exhaustion and job satisfaction remained statistically significant across low, average, and high levels of PSP. However, the interaction effects underlying the moderated mediation models were not statistically significant.

Moreover, the interaction terms involving WPV and PSP, as well as those involving PSP and the mediators, did not yield statistically significant effects in either model.

Although the indirect effects showed slight variation across different levels of PSP, the observed differences were relatively small and did not indicate meaningful conditional variation in the indirect relationships. As the moderation effects were non-significant at the initial psychological stage, the further robustness check was done which implied no statistical significance for any substantial downstream conditional influence on the behavioural and relational pathways included in the proposed framework.

Therefore, H12 was not supported. Also, the findings suggest that while the relationship between WPV and turnover intentions was significantly mediated by burnout-related emotional exhaustion and job satisfaction, PSP did not significantly moderate these indirect relationships within the present study.

4.3.13 Hypothesis Testing Summary

Table 4.25 presents an overall summary of hypothesis testing based on results obtained from SEM, bootstrapped indirect effects analysis, and regression-based moderation and moderated mediation analyses. The findings show that most of the proposed direct and indirect relationships were statistically supported. However, certain hypothesized relationships, particularly those involving CPMB and the moderating role of PSP, were not empirically supported within the present study.

Table 4.25: Hypothesis Testing Summary

Hypothesis	Hypothesis Statement	Result
H1	WPV is positively associated with burnout-related emotional exhaustion among doctors.	Supported

H2	WPV is negatively associated with job satisfaction among doctors.	Supported
H3	Burnout-related emotional exhaustion is positively associated with RAB.	Supported
H4	Burnout-related emotional exhaustion is positively associated with CPMB.	Supported
H5	Job satisfaction is negatively associated with RAB.	Supported
H6	Job satisfaction is negatively associated with CPMB.	Not Supported
H7	RAB is positively associated with deterioration in the DPR.	Supported
H8	CPMB is positively associated with deterioration in the DPR.	Not Supported
H9	Deterioration in the DPR is positively associated with doctors' turnover intentions.	Supported
H10	The relationship between WPV and turnover intentions is mediated through a sequential multi-stage process, wherein parallel psychological outcomes (burnout-related emotional exhaustion and job satisfaction) influence parallel behavioural responses (RAB and CPMB), which in turn affect the DPR, ultimately leading to turnover intentions.	Partially Supported
H10a	The relationship between WPV and turnover intentions is sequentially mediated through burnout-	Supported

	related emotional exhaustion, RAB, and deterioration in the DPR.	
H10b	The relationship between WPV and turnover intentions is sequentially mediated through burnout-related emotional exhaustion, CPMB, and deterioration in the DPR.	Not Supported
H10c	The relationship between WPV and turnover intentions is sequentially mediated through job satisfaction, RAB, and deterioration in the DPR.	Supported
H10d	The relationship between WPV and turnover intentions is sequentially mediated through job satisfaction, CPMB, and deterioration in the DPR.	Not Supported
H11	PSP moderates the relationship between WPV and psychological outcomes, such that higher PSP weakens the positive association between WPV and burnout-related emotional exhaustion, and weakens the negative association between WPV and job satisfaction.	Not Supported
H12	PSP moderates the indirect relationship between WPV and turnover intentions by buffering its effect on psychological outcomes.	Not Supported

Source: Author's compilation based on primary survey data findings

4.4 Summary

This chapter detailed the analysis and findings of the study based on the responses collected from doctors practising in healthcare settings across Punjab and Chandigarh. The chapter started with data screening, common method bias, descriptive analysis, followed by assessment of reliability, validity, and the measurement model using CFA. The structural relationships among the key constructs were subsequently examined using SEM, bootstrapped indirect effects analysis, and regression-based moderation and moderated mediation analyses.

The findings revealed that WPV established significant relationships with burnout-related emotional exhaustion, job satisfaction, behavioural responses, deterioration in the DPR, and turnover intention. The results further specified that burnout-related emotional exhaustion and job satisfaction played important mediating roles within the proposed conceptual sequential framework. RAB showed a significant association with deterioration in the DPR, whereas the relationship between CPMB and deterioration in the DPR did not achieve statistical significance.

The moderation and moderated mediation analyses exposed that PSP exhibited significant direct relationships with certain psychological outcomes. However, its moderating role for the relationship between WPV and psychological outcomes, or the indirect effect on turnover intentions, was not statistically significant.

Overall, the findings yield clear empirical evidence reinforcing the proposed model linking WPV with psychological, behavioural, relational, and attitudinal outcomes among doctors. The next chapter discusses these findings in connection with existing literature, theoretical viewpoints, practical implications, and directions for future research.

CHAPTER 5

DISCUSSION, CONCLUSIONS, AND IMPLICATIONS

5.1 Introduction

This chapter outlines the detailed discussion, conclusions, and implications developed from the findings of the present study. The main objective of the study was to examine the multidimensional impact of WPV on doctors by studying its psychological, behavioural, relational, and attitudinal consequences within the healthcare context of Punjab and Chandigarh. The present study used an integrated conceptual model founded on theories, namely the Job Demands-Resources (JD-R) model, Conservation of Resources (COR) theory, Affective Events Theory (AET), and Social Exchange Theory (SET), and investigated how WPV influences burnout, job satisfaction, behavioural responses, deterioration in the DPR, and turnover intentions among doctors.

The previous chapter presented empirical results from SEM, bootstrapped mediation analysis, and regression-based moderation and moderated mediation analyses. The findings confirmed that WPV significantly influenced several psychological and behavioural outcomes, while also disturbing relational dynamics and increasing turnover intentions among doctors. The findings further revealed that certain behavioural pathways emerged more significantly than others within the proposed framework, signifying the presence of layered and parallel mediating processes rather than a strictly sequential model. Moreover, the proposed moderator, PSP demonstrated direct associations with some psychological outcomes and its hypothesized moderating role was not empirically supported within the present study.

Moreover, the interpretations of the results in relation to prior literature and theoretical perspectives, will be discussed in this chapter, so that a broader system could be developed which explains how WPV affects healthcare professionals. The discussion also undertakes the practical certainties of the healthcare system, including professional stress, defensive clinical behaviour, stressed doctor-patient interactions, and the perceived notion of systemic support within healthcare settings.

The chapter is broadly divided into five major segments. Initially, the findings related to the constructs are discussed with respect to the proposed hypotheses, prior literature, and theoretical frameworks. This is followed by a summary of the findings, overall conclusions of the study, and the implications and applications resulting from the findings for theory, healthcare practice, institutional administration, and policy development. The chapter finally provides limitations of the empirical study, directions for further research prior to concluding with a brief chapter summary.

5.2 Discussion of Findings

This segment of the chapter reviews the findings related to the proposed hypotheses in relation to the prevailing literature and related theoretical frameworks. The discussion aims to interpret the observed relationships of WPV and its wide-ranging impact on doctors.

5.2.1 WPV and Psychological Outcomes

The survey responses that exhibit the doctors' profiles provide important facts for interpreting the findings. The sample largely comprised doctors registered with the Punjab Medical Council (83.7%), which highlights the importance of the findings for the Punjab healthcare context. The respondents represented a rationally balanced gender distribution, with 56.9% males and 42.5% females, and included doctors from different qualification levels, with MS/MD doctors forming the major group (53.1%), followed by MBBS doctors (26.2%) and super-specialists (9.3%). A large chunk of respondents was practicing in private

hospitals (51.2%), followed by government hospitals (23.3%) and medical colleges (15.2%). Most participants were from city-based practice settings (75.5%), and a considerable proportion worked in tertiary-level hospitals (43.1%). This demographic outline suggests that the findings should be understood as the experiences of the sampled doctors, who mainly work in urban, specialist, and institution-based healthcare settings in Punjab and Chandigarh. Therefore, the results may not be generalized to rural doctors, general practitioners, or non-institutional practitioners. This generalizability limitation is also noted in Section 1.7.2. The fact that 70% of respondents had taken professional indemnity or legal protection cover also indicates a relatively high level of awareness of medico-legal risk and professional self-protection among doctors in the sample.

The item-level WPV responses further suggest that violence was experienced more commonly through repeated non-physical forms than through severe physical assault. Being shouted at or spoken to aggressively was the most frequently reported experience, with 33.4% reporting it sometimes and 16.9% reporting it often. Insult or humiliation was also reported, with 27.9% experiencing it sometimes and 8.2% often. Threats of complaints, legal action, or media exposure were particularly notable, as 27.5% reported such experiences sometimes, often or very often. In contrast, direct physical assault was less frequent, with 89.2% reporting that they had never experienced it. However, attempted physical assault, vandalism, being blocked or surrounded, and repeated aggressive calls or messages were still reported by some respondents. This pattern indicates that WPV in the present sample was rarely in the form of extreme physical incidents, but was more commonly presented as routine verbal aggression, intimidation, complaint-related coercion, and medico-legal threat. Such a pattern explains why WPV showed strong psychological associations with burnout-related emotional exhaustion and job satisfaction. Even though violence does not always

become physical, repeated intimidating and threatening interactions can still create a continued stressful atmosphere for doctors.

Further, the violence-related findings of the present study imply that from a rare or isolated workplace happening, WPV has transformed into a frequently occurring occupational reality within the healthcare settings. A substantial share of respondents (83.7%) reported experiencing WPV, indicating that exposure to violence has become highly prevalent among doctors in Punjab and Chandigarh. Notably, verbal abuse was reported by 90.9% of respondents, in line with the findings of Adhikari et al. (2022), Debnath et al. (2023) and Rehman et al. (2024); exceeding the overall prevalence of WPV itself. This inconsistency is particularly important because it directs a possible standardization of verbal aggression within healthcare settings, where behaviours such as shouting, aggression, humiliation, or threats, may no longer be considered as violence despite their significant psychological effect. Rather than representing rare or infrequent incidents, these findings collectively highlight a stressed healthcare environment in which such hostile interactions among doctors have increasingly become routine clinical practice.

The findings further show that WPV in healthcare settings is mostly relational and emotionally driven rather than stimulated externally. Patient attendants and relatives constituted the primary aggressors in most incidents (61.3%), whereas comparatively fewer incidents involved outsiders, media persons, or politically connected individuals. This pattern is consistent with the observations of Paliwal et al. (2025), who similarly specified that attendants and patient relatives are the major perpetrators of WPV against doctors. The reasons reported by respondents in the present study further reflected the complex and emotional nature of WPV in healthcare settings. Doctors frequently identified poor understanding of disease progression, unrealistic expectations regarding immediate recovery, dissatisfaction despite treatment efforts, communication gaps, financial disputes,

overcrowding, infrastructural limitations, and referral-related dissatisfaction as major contributors to WPV. Similar contributory factors have also been emphasized in existing studies investigating violence against healthcare professionals in India and other developing healthcare settings, where communication breakdowns, treatment dissatisfaction, unrealistic expectations, long waiting times, and mistrust toward healthcare systems were found leading to dispute within clinical environments (Debnath et al., 2023; Kumar et al., 2019; Kumari et al., 2023; Sharma et al., 2019; Singh et al., 2019). Several respondents furthermore underlined situations involving critical illness, poor prognosis, explained seriousness, patient's referral, internet-aided self-diagnosis, social media misrepresentation, allegations of negligence, political pressure, and influence of intoxication among attendants as various factors that intensified tensions within healthcare settings. Collectively, these findings suggest that WPV often occurs within settings resulted in emotional distress, ambiguity, mistrust, and stressed doctor-patient interactions rather than solely instigated by aggression.

Most WPV incidents were perceived as minor (62.6%) or moderate (22.2%), while severe or life-threatening events were less frequently reported. However, this does not decrease the significance of WPV because recurrent minor hostility events can still create psychological stress. This becomes especially relevant when 48% of doctors stated that the WPV incident was not formally reported, while 28.1% reported it to hospital administration, and 13.1% reported it to both hospital administration and police. This suggests that under-reporting remains an important issue, mainly because many doctors may standardize verbal aggression, question the usefulness of formal action, or prefer to avoid such escalations. Kaur et al. (2020) and Shahjalal et al. (2023) similarly noted prevalent under-reporting due to a lack of organizational support and disbelief in action. Jointly, these findings show that WPV in the present study was not only a matter of severe violence, but also a matter of concern due

to its pattern of repeated low to moderate aggression, weak reporting, and strained trust between doctors, patients, and attendants.

The SEM results demonstrated that WPV significantly increased burnout-related emotional exhaustion among doctors while simultaneously reducing job satisfaction, thereby supporting H1 and H2. While the WPV-job satisfaction link was robust, the downstream pathway from job satisfaction to CPMB (H6) was not statistically supported in the present sample, suggesting that reduced job satisfaction translates more readily into avoidance-based responses than into adaptive-defensive practice modifications. These findings suggest that WPV not only occurs as a dangerous episode but also as a constant psychological stressor hampering doctors' emotional well-being and altering professional attitudes of doctors toward healthcare practice. A similar relationship was identified by Çabuk and Menteş (2023), Debnath et al. (2023), and Sachdeva et al. (2025). The structural relationships recognized in the model further show that the psychological consequences of WPV act as an important foundational stage within the comprehensive pathway linking WPV with consequent behavioural, relational, and attitudinal outcomes among doctors.

The empirically examined significant positive relationship between WPV and burnout-related emotional exhaustion does not limit WPV to a simple occupational stressor. The findings suggest that frequent exposure to such uneventful, hostile and emotionally-confronted situations slowly exhausts doctors' emotional strength and mental coping capacity. The group difference analysis showed that doctors exposed to WPV reported markedly higher burnout-related emotional exhaustion levels ($M = 3.07$) than those not exposed ($M = 2.16$), with a large effect size ($d = 1.123$). Similarly, correlation analysis discovered a large positive association between WPV and burnout-related emotional exhaustion ($r = 0.574$, $p < 0.001$; Cohen, 1988). Together, these results depict that WPV puts

a substantial psychological burden on doctors and intensifies emotional exhaustion within healthcare practice.

The present findings greatly align with earlier literature reporting that repeated exposure to workplace hostility leads to emotional exhaustion and psychological fatigue among doctors and other healthcare professionals. Awooda (2020) similarly reported higher burnout among doctors exposed to WPV, while Çabuk and Menteş (2023) observed that such intimidating experiences deliberately increased emotional exhaustion among healthcare workers in stressful healthcare environments. Chen et al. (2024) and Wu et al. (2021) further suggested that repeated exposure to aggression gradually weakens emotional flexibility and professional motivation among healthcare professionals. Likewise, Hacer and Ali (2019) identified higher emotional exhaustion and depersonalization, while reduced personal achievement among healthcare workers exposed to verbal and physical violence. The findings of the present study reinforce the broader argument within existing literature that WPV is not just a physical safety fear but also a major psychological occupational peril for doctors.

Besides, the present study also offers a more refined understanding of how burnout-related emotional exhaustion related to WPV may vary across different specialities of doctors. Although exposure to WPV itself remained relatively uniform across specialities, burnout-related emotional exhaustion levels differed significantly across medical fields. High-intensity specialties such as emergency medicine, critical care, cardiology, and surgical branches demonstrated comparatively higher burnout-related emotional exhaustion levels than relatively lower-intensity specialties such as dermatology, pathology, and general practice. This distinction is particularly important because it suggests that while WPV exhibited as a generalized occupational risk across various disciplines and its psychological consequences are not experienced evenly. Comparable patterns were identified in studies

conducted by Kunnath et al. (2023), Mukta et al. (2025), and Paliwal et al. (2025), depicting doctors working in critical and emotionally challenging clinical environments may experience increasing psychological burden due to constant exposure to emergency decision-making, critically ill patients, emotionally distressed attendants, and poor prognosis and outcomes alongside WPV. However, a contradictory pattern was identified by Singh et al. (2023), stating the doctors working in department of medicine are more prone to workplace hostility.

The interaction analysis between WPV and experience further strengthens the depth of this interpretation. Although burnout-related emotional exhaustion levels generally increased across experience groups (Junior < Mid < Senior), the interaction effect confirmed that the psychological impact of WPV varied significantly according to doctors' experience levels ($F = 5.04$, $p = 0.007$). The estimated marginal means suggested that burnout-related emotional exhaustion remained consistently higher among doctors exposed to WPV across all experience groups, but the difference appeared particularly noticeable among junior doctors. These findings partially accord with the studies of Al-Shimari et al. (2024) and Ranjha et al. (2022), who reported greater sensitivity among younger doctors exposed to WPV. However, unlike Lafta et al. (2021) and Ranjha et al. (2022), who also found greater vulnerability among male doctors, the present study showed no such significant gender-based differences in burnout levels. Similarly, the findings contrast with Ghoshal et al. (2022), who reported relatively higher burnout among male doctors. Instead, the current findings recommend that WPV may be placed as a shared work-related psychological stress affecting doctors across genders, while professional experience may be meaningful in deciding the extent of burnout exposure.

The findings associated with job satisfaction also expose important inferences regarding the demanding professional environment within healthcare systems. Doctors

exposed to WPV reported substantially lower job satisfaction ($M = 3.04$) compared to those not exposed ($M = 3.91$), again with a large effect size ($d = -1.175$). Correlation analysis further exhibited a significant negative relationship between WPV and job satisfaction ($r = -0.390$, $p < 0.001$). This indicates that repeated exposure to verbal abuse, threats, and strained workplace interactions gradually deteriorates doctors' professional attachment within healthcare practice.

These observations firmly align with previous studies reporting diminished job satisfaction among healthcare professionals exposed to WPV. Duan et al. (2019) correspondingly observed that healthcare professionals exposed to violence reported lower professional satisfaction and reduced enthusiasm toward work. Yu et al. (2018) further suggested that repeated hostile interactions decline emotional involvement and trust among doctors. Likewise, Dursun and Aytac (2021) identified extensively lower job satisfaction among healthcare workers exposed to WPV compared to those who had not experienced violence. Likewise, within the Indian context, Ahamed et al. (2021) reported that doctors who perceived greater workplace safety and organizational safeguards demonstrated comparatively higher levels of job satisfaction. The present results alarm that WPV progressively erode doctors' emotional well-being and their long-term job satisfaction and engagement within healthcare practice.

The significant positive association between WPV and burnout, and the negative relationship between WPV and job satisfaction, may be understood through an integrated theoretical framework that considers the assumptions of the COR theory, JD-R model, and AET. Within the JD-R framework, WPV functions as an undesirable occupational demand that continuously exposes doctors to emotional strain, interpersonal disputes, psychological pressure, and uncertainty within healthcare systems (Demerouti et al., 2001). Persistent exposure to verbal abuse, coercions, aggressive exchanges, and emotionally challenging

situations may therefore exaggerate existing workplace demands and contribute to emotional fatigue among doctors. Simultaneously, COR theory suggests that repeated exposure to hostile workplace communications gradually depletes valuable emotional and professional resources such as emotional stability, psychological well-being, confidence, perceived safety, and professional respect (Hobfoll, 1989). When these imperative resources start getting exhausted, doctors may become more vulnerable to burnout-related emotional exhaustion and reduced professional accomplishment. Further, AET explains that repeated adverse workplace experiences influence doctors' emotional responses and workplace attitudes over time (Weiss & Cropanzano, 1996). As observed in the present study, regular exposure to hostility, stressed interactions, and violence-related trauma may have contributed to emotional exhaustion and reduced job satisfaction among doctors. Together, the empirical finding incorporated with theoretical justification, show that WPV affects both the psychological well-being and professional attitudes of doctors by creating an environment of persistent emotional strain, resource depletion, and adverse workplace experiences within healthcare settings.

5.2.2 Psychological Outcomes and Behavioural Responses

The raw data from the questionnaire provide an initial insight into how psychological strain resulting from WPV translates into behavioural change among doctors. The burnout responses showed that emotional exhaustion was not limited to a small group of respondents. Around 33% of doctors testified that they sometimes felt emotionally drained by work, while 38.5% reported feeling emotionally drained often or very often. Similarly, 34.5% reported feeling exhausted at the end of the workday sometimes, while another 37% experienced it often or very often. These responses advocate the fact that emotional fatigue among doctors is no longer an occasional event, but has become a part and parcel of their daily job routine. This pattern is similar to earlier observations by Cao et al. (2023), who argued that exposure

to workplace hostility contributes to emotional distress, reduced concentration, and decreased motivation among healthcare professionals. Similarly, Lafta et al. (2021) linked WPV with emotionally safeguarded clinical responses by doctors, suggesting that psychological tiredness may gradually covert into changed professional behaviour impacting patient care and healthcare efficiency.

The job satisfaction responses showed a more complex and quite inconsistent pattern. A substantial proportion of doctors continued to express positive professional attitudes, 42.9% agreed that they felt satisfied with their current job, 43.8% agreed that they felt positive about their job most days, and 52% either agreed or strongly agreed that they experienced a sense of accomplishment from their work. However, this professional commitment coincided with apparent signs of doubt about long-term working in the profession. For example, 43.1% either disagreed or strongly disagreed that they would choose the medical profession again if given the chance, whereas only 37.2% agreed or strongly agreed. This dissimilarity is important to be noticed because it suggests that many doctors may continue to find meaning in their work in their profession while simultaneously feeling emotionally worn-out or uncertain about choosing the same medical profession again. This finding is mainly consistent with the study done by Duan et al. (2019), who demonstrated that WPV is linked with increased burnout, reduced job satisfaction, and stronger turnover intentions among healthcare professionals. Likewise, Yu et al. (2018) also indicated that violence declines professional confidence and diminishes job satisfaction. Godinho and Cacodcar (2024) similarly indicated that WPV can affect doctors' mental well-being and personal life even when routine patient care continues. However, the present study adds a more subtle pattern stating that many doctors continued to report satisfaction and accomplishment from work despite showing emotional exhaustion and uncertainty about

choosing medicine again. This suggests that professional determination of doctors is under stress rather than complete detachment.

The RAB-linked responses exhibited some of the most prominent patterns in the study. Nearly 70.2% of doctors either agreed or strongly agreed that they avoid managing complicated or high-risk cases whenever possible. Also, more remarkably, 85% agreed or strongly agreed that they try to avoid cases likely to lead to disputes with patients or attendants. Further, 68.1% reported referring certain cases to other doctors or hospitals to avoid potential conflicts, and 79.6% preferred seeking consultation from other specialists rather than taking full responsibility for risky cases themselves. These preliminary findings show that risk avoidance is not an exceptional reaction, rather it can be considered as an extensive behavioural adjustment among doctors. This closely resembles the behavioural pattern described by Kaur et al. (2020), stating WPV experience reduced willingness to manage complicated or critically ill patients and increased referral tendencies. Hu et al. (2025) and Arafa et al. (2023) similarly described such avoidance as a protective measure, in the form of a clinical response among doctors facing repetitive aggression, complaints, or litigation-related risks.

One particularly important RAB finding was that 46.7% of doctors agreed and 10.6% strongly agreed that they avoid adopting new treatment methods that may involve a higher perceived risk, while 34.2% remained neutral. This is a subtle but important finding. The high neutral response may suggest that many doctors are cautious but may not willingly identify this caution as avoidance. At the same time, the mixed responses indicate that workplace-related risk may be leading to case selection and referral decisions and limiting clinical innovation and professional confidence. The present findings seem to support this distinction, as many doctors reported avoiding risky situations before full clinical engagement rather than simply practicing defensively after assuming responsibility for the case. Adhikari et al.

(2023) provide a suitable viewpoint to this interpretation by observing that increased referrals and reduced management of critical or complicated cases may raise healthcare expenditure, intensify patient expectations, and lead to negative public perceptions of doctors as being financially driven. Therefore, RAB may function as a self-protective strategy for doctors but it can also create relational consequences by increasing dissatisfaction, mistrust, and potential conflict among patients and attendants.

The CPMB responses further demonstrated that doctors were not only avoiding risk of disputes or conflicts but also altering how they manage patients. Around 67% of doctors agreed or strongly agreed that they order additional investigations or diagnostic tests to reduce the risk of complaints or disputes. Similarly, 58.6% agreed or strongly agreed that they sometimes prescribe additional or more aggressive treatment to minimize the risk of treatment failure or disputes. These findings suggest that defensive medicine is not confined to referral or avoidance alone but also encompasses the clinical decision-making process through over-investigation, precautionary treatment, and legally cautious care. Kaur et al. (2020) reported a similar change in clinical behaviour, where doctors exposed to violence increased dependence on diagnostic investigations and reduced engagement with critical or complicated cases. Karpinar et al. (2025) also noted that physicians exposed to verbal or physical violence may develop self-protective and guarded patient-management styles.

The other CPMB responses were related to legal caution, documentation, communication, and infrastructure sensitivity. Around 88.8% of doctors agreed or strongly agreed that they had become more cautious in clinical decision-making due to potential legal or conflict situations. Similarly, 81% agreed or strongly agreed that they consider possible legal consequences while planning treatment, and 84.3% reported maintaining more detailed documentation of patient care than before. Almost 89.6% reported providing more detailed explanations to patients or attendants about treatment risks and prognosis. These findings

show a shift from purely clinical decision-making toward medico-legally safeguarded decision-making. Hu et al. (2025) and Pai et al. (2024) also observed that fear of complaints, litigation, and inadequate systemic protection can lead doctors to engage in defensive documentation and cautious communication. Bayram et al. (2023) also described how repeated verbal aggression may cause healthcare professionals to become emotionally secured and formal in their interactions.

Another distinct CPMB finding was that 88.5% of doctors agreed or strongly agreed that they consider available hospital resources and infrastructure more carefully before deciding on treatment. This finding is particularly relevant in the Indian context, where patient load, infrastructure limitations, referral pressures, and medico-legal risks often co-exist. While such attentiveness may improve patient safety in some cases, it may also reflect a more defensive approach in which clinical decisions are no longer assessed solely by medical knowledge but also by the institution's ability to withstand disputes or legal action. This explanation aligns with Hu et al. (2025), who argued that WPV influences medical decision-making and may push doctors toward conservative or defensive clinical approaches. It also corresponds with Berlanda et al. (2019), who noted that violence can indirectly affect patient care quality as doctors restrict their clinical exposure or modify decisions to reduce probable risks.

The preliminary statistical results further support these descriptive outlines. Behavioural responses were reported at relatively high levels, with mean scores of 3.79 for RAB and 3.93 for CPMB, indicating that defensive and adaptive behavioural responses were prominent in the sample. Doctors exposed to WPV reported higher RAB scores than those not exposed to violence, and they also demonstrated higher CPMB scores. Correlation analysis also showed that burnout-related emotional exhaustion was positively associated with both RAB and CPMB, while job satisfaction was negatively associated with RAB and

CPMB. These preliminary patterns suggest that psychological strain and reduced job satisfaction were not isolated psychological outcomes but were linked with practical changes in doctors' clinical-decision making and patient-management behaviour. This strengthens the relevance of earlier researches by Arafa et al. (2023), Kaur et al. (2020), and Hu et al. (2025), which suggested that exposure to violent incidents changes doctors' readiness to manage risky patients and encourages defensive clinical practices.

Although behaviours of doctors like RAB and CPMB have appeared in earlier literature under broader themes such as defensive medicine, avoidance of high-risk cases, increased referrals, over-investigation, guarded communication, and medico-legal attentiveness, they have rarely been positioned as separate measurable constructs within a unified SEM framework. The present study distinguishes RAB from CPMB. RAB is an avoidance-based withdrawal, in which doctors tend to reduce exposure to risky or conflict-related cases, whereas, CPMB is an adaptive-defensive modification, in which doctors continue patient care but modify management through greater alertness, documentation, investigation, communication, and medico-legal safety. This distinction helps explain whether doctors respond to psychological outcomes by withdrawing themselves from risk altogether or by remaining clinically involved in a more guarded and defensive manner.

The SEM findings provided stronger model-supported confirmation of these relationships. Burnout-related emotional exhaustion was positively related to RAB ($\beta = 0.3125$, $p < 0.001$) and CPMB ($\beta = 0.4250$, $p < 0.001$), thereby supporting both H3 and H4. These findings indicate that emotionally exhausted doctors exhibited more probabilities to adopt both avoidance-oriented and defensive patient-management behaviours. Job satisfaction was negatively associated with RAB ($\beta = -0.7222$, $p < 0.001$), hence validating H5. This suggests that the doctors who were more satisfied with their work are less likely to withdraw from risky or complicated clinical situations. The finding is important because it

shows that job satisfaction may retain clinical engagement and professional confidence among doctors, whereas burnout-related emotional exhaustion tends to push them toward self-protective behavioural responses.

However, H6 was not supported because the association between job satisfaction and CPMB showed statistically non-significance ($\beta = 0.1203$, $p = 0.112$). This shows that CPMB may not be mainly caused by doctors' satisfaction or dissatisfaction with their work. Unlike RAB, which was significantly affected by burnout-related emotional exhaustion and job satisfaction, CPMB appeared to be more associated with burnout-related emotional exhaustion and thorough clinical practice. The retained CPMB items mainly reflected cautious decision-making, medico-legal awareness, detailed documentation, resource availability, and detailed explanation of risks. Therefore, CPMB may represent a form of cautious or patient-modified clinical adaptation rather than a dissatisfaction-led behavioural outcome. This differs from Lorenc et al. (2024), who suggested that defensive practice can reduce professional independence and job satisfaction by forcing doctors to make clinically compromised decisions.

This distinction between RAB and CPMB is one of the important contributions of the present study. RAB appears to represent withdrawal from perceived risk, whereas CPMB represents a change of in-treatment methods while remaining engaged in patient management. The strong RAB responses suggest that many doctors may now prefer to avoid risky clinical exposure altogether, especially in cases likely to involve disputes, violence, or medico-legal complications. CPMB, on the other hand, reflects a more guarded style of continued clinical engagement, where doctors still manage patients but with caution, detailed documentation, legal attention, and careful communication. This distinction should be considered as a conceptual extension of earlier literature rather than a direct usage of already established constructs. Previous studies have discussed several components that resemble

RAB and CPMB, including avoidance of complex cases, increased referrals, defensive medicine, over-investigation, guarded communication, medico-legal caution, and altered clinical decision-making. However, these behaviours have generally been examined separately or under broader themes rather than as distinct behavioural constructs within an integrated SEM framework. The present study consolidates these components into two differentiated behavioural responses, namely, RAB as avoidance-based defensive withdrawal from perceived risk, and CPMB as adaptive-defensive modification of patient-management practices.

The present findings extend earlier literature by showing that behavioural outcomes of WPV are not uniform. Kaur et al. (2020) had already shown that violence exposure could increase referrals and reduce doctors' willingness to handle serious or complicated patients. The present study supports that pattern but adds a layered and sequential explanation by showing that burnout-related emotional exhaustion and job satisfaction act as psychological routes through which such behaviours develop. Similarly, while Karpinar et al. (2021) and Bayram et al. (2023) discussed emotional disengagement, guarded communication, and defensive therapeutic care after violence. The current findings show that such behavioural changes can be empirically positioned within a broader SEM framework linking psychological strain to behavioural adaptation. This is important because it takes the discussion beyond isolated observations of defensive practice and places RAB and CPMB within a structured pathway from psychological strain to altered clinical behaviour.

The theoretical interpretation of H3 to H6 is best interpreted through an integrated understanding of the COR theory, JD-R model, and SET. For H3 and H4, burnout-related emotional exhaustion appears to function as the psychological point at which excessive job demands begin to alter professional conduct. Within the JD-R model, WPV increases the emotional demands placed on doctors, and due to these accumulated demands, behavioural

withdrawal or defensive practice becomes more usual (Demerouti et al., 2001). COR theory explains this further, as emotionally exhausted doctors may try to conserve their valuable resources by avoiding risky cases, referring conflict-related patients, increasing documentation, or over-prescription (Hobfoll, 1989). Therefore, the positive relationships of burnout-related emotional exhaustion with both RAB and CPMB show behaviour reflection and preservation of resources under threat.

For H5, the negative relationship between job satisfaction and RAB suggests that professional satisfaction may act as a calming psychological resource. Doctors who remain satisfied with their work may feel more confident, engaged, and willing to manage difficult clinical situations, thereby reducing avoidance behaviour. SET also helps explain this pathway, as when doctors perceive their work as meaningful and rewarding, they may be more willing to invest effort in patient care despite occupational challenges (Blau, 1964). However, H6 shows that job satisfaction does not necessarily reduce CPMB. This is theoretically practical because CPMB may not always indicate withdrawal, it may also reflect cautious working in an unsafe or complex environment. Thus, the theoretical integration also suggests that RAB is more clearly a withdrawal-oriented outcome, whereas CPMB contains both defensive and adaptive elements. Overall, the results indicate that WPV reshapes doctors' behaviour through psychological strain, but the nature of this behavioural response differs depending on whether doctors withdraw themselves from risk or continue patient care through more protected and legally safe patient-management practices.

5.2.3 Behavioural Responses and Deterioration in the DPR

The questionnaire responses indicate that deterioration in the DPR was not limited to worsening in concrete relationships but also appeared in everyday clinical interactions. A large proportion of respondents reported that emotional reactions from patients or attendants made clinical interactions challenging, with 62.2% agreeing and 19.2% strongly agreeing

with this statement. Similarly, 63% agreed and 11.6% strongly agreed that patients sometimes make demands that are difficult to accommodate in clinical practice. These responses suggest that the relational stress experienced by doctors is closely linked with emotionally stimulating expectations, difficult communication, and increasing pressure from patients or attendants. This pattern is in line with Qiao et al. (2019), who highlighted that expectations of treatment, waiting time, hospital environment, disputes, and communication-related issues shape doctors' perception of the DPR. Similarly, Liu et al. (2020) also observed that high workload, medical disputes, communication time, and institutional conditions influence how doctors perceive their relationships with patients.

The survey results also show a clear strain between respect, trust, and interactional issues. While some doctors continued to report positive interactions, a substantial proportion did not perceive the relationship as fully comfortable or cooperative. For instance, only 26.4% agreed that patients generally show respect toward doctors, whereas 33.2% disagreed and 14.8% strongly disagreed. Similarly, 64.9% agreed, and 15% strongly agreed, that maintaining a cooperative relationship with patients or attendants had become more difficult than before. Communication difficulty was also prominent, with 59.4% agreeing and 12.9% strongly agreeing that maintaining good communication quality with patients or attendants is often difficult. These findings suggest that the DPR in the present study reflects a mixed but strained pattern. Doctors may continue to interact with patients and attendants, but the interaction has seen reduced ease of communication and apparently weakened respect.

This relational impact of WPV becomes more meaningful when interpreted with the behavioural findings discussed in the previous section. High levels of RAB indicated that many doctors were avoiding complicated, conflict-prone, or risky cases, while CPMB responses showed greater dependence on extensive documentation, legal caution, additional explanations, and infrastructure-based treatment planning. These behaviours may protect

doctors from immediate conflict, but they may also make clinical interactions more formal and less relational. These observations support earlier findings reported by Eftekhari et al. (2024).

The preliminary descriptive statistical analysis further supports this relational interpretation. The mean score for deterioration in DPR was moderate to high ($M = 3.55$), indicating a visible level of relational strain in the sample. Correlation analysis showed that both RAB and CPMB were positively related to deterioration in DPR, with RAB showing a stronger correlation ($r = 0.453$, $p < 0.001$) than CPMB ($r = 0.353$, $p < 0.001$). Moreover, burnout-led emotional exhaustion was also positively associated with deterioration in DPR, while job satisfaction was negatively associated with it, indicating that psychological strain and reduced professional satisfaction were closely connected with relational deterioration. These findings support the broader argument that relational deterioration is not produced by one individual factor but emerges through a blend of psychological exhaustion, defensive behavioural responses, and strained clinical communication.

The group difference and interaction analyses further strengthened this relational interpretation. Doctors who experienced WPV reported greater deterioration in DPR compared with those who did not experience WPV, suggesting that hostile experiences may continue to shape doctors' relational viewpoint even after the immediate incident has passed. Experience-based analysis also showed significant differences in DPR deterioration across experience groups ($F = 4.00$, $p = 0.020$), with senior and mid-level doctors reporting greater deterioration than junior doctors. This may be due to the accumulation of relational stress over years of exposure to disputes, workload pressure, and violence-related experiences. Furthermore, seriousness-based analysis depicted that higher levels of WPV seriousness were significantly linked to greater deterioration in DPR, with life-threatening, severe, and moderate incidents showing higher relational strain compared with minor incidents.

However, regression-based interaction testing showed that neither $WPV \times RAB$ nor $WPV \times CPMB$ significantly moderated deterioration in DPR. The $WPV \times RAB$ interaction was not significant ($\beta = 0.107$, $p = 0.146$), and the $WPV \times CPMB$ interaction was also not significant ($\beta = 0.149$, $p = 0.143$). This suggests that although WPV, RAB, and CPMB were individually connected with relational strain, the combined interaction between WPV and these behavioural responses did not significantly increase deterioration in DPR within the sampled doctors of Punjab and Chandigarh.

The SEM findings exhibited stronger evidence regarding the role of behavioural responses in explaining deterioration in the DPR. The structural model analysis showed that RAB had a strong and statistically significant positive association with deterioration in the DPR ($\beta = 0.9333$, $p < 0.001$), thereby validating H7. This indicates that doctors who increasingly avoided risky or conflict-related cases were more likely to report deterioration in their relationship with patients. However, CPMB was not significantly associated with deterioration in the DPR ($\beta = 0.0546$, $p = 0.276$), and therefore H8 was not supported. This contrast is meaningful as it suggests that avoidance-based withdrawal (RAB) may be more detrimental to relational quality than defensive modification (CPMB), considering the patient-care.

The non-significant $CPMB \rightarrow DPR$ pathway suggests that CPMB did not deteriorate the DPR way as RAB among sampled doctors. It may be due to the fact that the retained CPMB indicators showed cautious patient-management modifications, such as careful decision-making, resource consideration, medico-legal awareness, safe documentation, and detailed explanation of risks. It may not simply reflect avoidant or disengaging behaviour with patients. Such practices may not necessarily damage the DPR, as patients or their attendants may perceive this as thoroughness or responsible care. Therefore, CPMB may represent continued engagement with patients under risk-aware conditions, whereas RAB

may reflect behavioural withdrawal or avoidance, which is more likely to affect DPR. The observed difference between RAB and CPMB is consistent with the mentioned distinction in Section 2.6.2. This finding differs from a simple assumption that all defensive patient-management behaviour necessarily is linked with damaged DPR, as stated by Qiao et al. (2019). Instead, it suggests that CPMB may contain both risk-protective and relationship-preserving elements. The non-significant CPMB → DPR pathway indicates that the behavioural stage of the model operated only partially in parallel. While RAB clearly worked in a relationship-deterioration pathway, CPMB did not significantly convert into deterioration in the DPR, suggesting that defensive modification of patient management may not affect relational outcomes of doctors, as done by avoidance-based withdrawal.

The stronger role of RAB can be explained by the nature of its existence and the behaviour itself. Whenever doctors avoid complicated or critically ill cases, refer patients to prevent conflict, or decline adopting new but risky treatment methods, patients and attendants may perceive difficult approachability and reduced availability, lower confidence, or diminished personal involvement from the doctor. Therefore, RAB may directly weaken continuity, trust, and perceived responsiveness within the DPR. This interpretation is consistent with Daniels and Marneffe (2023) and Kakeman et al. (2022), who reported that exposure to violence increased referrals and reduced willingness to manage complicated or serious patients. Similarly, Lorenc et al. (2024) and Pai et al. (2024) discussed how distress arising from aggression, adverse legal consequences, or clinical liability may lead doctors to avoid high-risk situations. In the present study, this avoidance-based response appears to be the behavioural pathway most clearly connected with deterioration in DPR. The findings also line up with prior literature highlighting that relational strain in healthcare is shaped by broader external systemic and social factors. Panday and Choudhary (2020) argued that media influence, poor healthcare policy, weak infrastructure, rising consumerism, and legal

pressures contribute to conflicts and deterioration in the DPR. Liu et al. (2020) similarly noted that clinical conflicts, high patient load, restricted interaction time, and weak organizational support are associated with more negative DPR perceptions, whereas safety protocols, organizational support, security personnel, and indemnity insurance improve doctors' practices in patient relationships. In the present study, the examples of stressed emotional reactions, difficult demands, communication problems, and reduced comfort during patient interaction replicate these widespread burdens among sampled doctors in the Punjab and Chandigarh.

Theoretically, the findings for H7 and H8 may be understood through AET and SET (Blau, 1964; Weiss & Cropanzano, 1996). Considering H7, repeated WPV and emotionally difficult patient interactions function as negative affective events that slowly shape doctors' emotional responses toward future clinical interactions. When these negative experiences accumulate, doctors may adopt RAB as a self-protective and defensive response, but this withdrawal can weaken communication, trust, and cooperation, thereby deteriorating the DPR. SET further explains that when doctors perceive the relationship as unbalanced, where continued and dedicated professional effort is answered with hostility, disrespect, mistrust, or threat. Thus, giving rise to interpersonal restrictions and relational withdrawal. This helps explain why avoidance-based withdrawal exhibited a strong association with deterioration in DPR.

In view of H8, however, CPMB did not significantly deteriorate DPR, suggesting that defensive modification does not function in the same way as avoidance-based withdrawal. From an AET perspective, CPMB may still arise from negative emotional experiences, but it allows doctors to remain attached to the system. From a SET perspective, detailed explanation, documentation, and careful treatment planning may be sought as professional responsibility, even though it started as a proactive measure for self-protection. Therefore, the

findings suggest that behavioural responses to WPV have biased relational consequences. RAB appears to weaken DPR more clearly because it lessens engagement, whereas CPMB may be characterized as protected engagement that does not necessarily damage the DPR directly.

5.2.4 Deterioration in the DPR and Turnover Intentions

The remaining DPR responses further indicated that the interactive worsening of doctors with patients was reflected in reduced comfort and uncertainty about trust. While 36.6% of doctors agreed that they generally trusted the information provided by patients or attendants, 29.8% disagreed, and 27.9% remained neutral, suggesting a split form of trust. Similarly, only 30.4% agreed that they generally felt comfortable and at ease while interacting with patients or attendants, whereas 32.8% disagreed and 26.9% remained neutral. These findings imply that many doctors may continue to engage with patients professionally, but the interaction is associated with hesitation and limited relational comfort. This supports the interpretation that deterioration in the DPR starts with the gradual weakening of trust and increasing relational discomfort. This fragmented response pattern proposes that many doctors are not completely detached from patients, but the basic foundation of a relation in the form of ease, trust, and comfort has become strained.

The turnover intentions responses show a similar pattern of partial but considerable attitudinal detachment. Around 38.1% of respondents agreed or strongly agreed that they often think about leaving their current place of work or medical practice. Around 34% agreed or strongly agreed that they had seriously considered leaving their current practice setting. The strongest firm response was seen in the opportunity-based item, where 48.2% agreed or strongly agreed that they would move to another place of work or practice if a suitable opportunity arose. This distinction is important. It suggests that many doctors may not be actively involved in planning a sudden exit, but a substantial proportion remain opportunistic

by being open to leaving if safer or better alternatives become available. This pattern resembles the results of Ahamad et al. (2021) and Cao et al. (2023), who linked reduced job satisfaction and stressful healthcare situations with stronger turnover intentions.

The preliminary statistical findings further support this interpretation. The descriptive results showed moderate deterioration in the DPR ($M = 3.55$) and moderate turnover intentions ($M = 2.95$), indicating that relational outcomes and attitudinal withdrawal were both present but not uniform across all doctors. Correlation analysis demonstrated a strong positive relationship between deterioration in the DPR and turnover intentions ($r = 0.593$, $p < 0.001$), signifying that doctors reporting weak relational experiences with patients showed higher tendencies to leave or change their place of work. Burnout-related emotional exhaustion was also positively correlated with turnover intentions ($r = 0.562$, $p < 0.001$), whereas job satisfaction showed a strong and negative correlation with turnover intentions ($r = -0.686$, $p < 0.001$). This indicates that turnover intentions in the present study were not the result of one isolated factor, but it appeared to be a combined result of burnout-related emotional exhaustion, reduced satisfaction, and deteriorating DPR.

The group difference analyses added another inference to this pattern. Doctors exposed to WPV reported substantially higher turnover intentions ($M = 3.10$, $SD = 1.02$) than those not exposed to WPV ($M = 2.17$, $SD = 0.71$), with a large effect size (Cohen's $d = 1.053$). This shows that exposure to WPV is not only associated with emotional, behavioural, or relational outcomes but also with a stronger attitudinal tendency to leave the current workplace or practice setting. Experience-based analysis also revealed significant differences in turnover intentions ($F = 3.86$, $p = 0.022$), with mid-level doctors reporting higher turnover intentions than senior doctors. This may suggest that doctors in the middle phase of their careers face a difficult balance as they are burdened with workload and personal and professional obligations, and are open to considering alternative career or workplace options.

Hospital type also played a significant role, as turnover intentions differed significantly across hospital types ($F = 9.00, p < 0.001$), with government hospital doctors reporting higher turnover intentions than those working in corporate or private hospitals. This may be caused by higher patient load, administrative pressures, low remuneration, resource limitations, or greater workplace conflicts in government healthcare settings.

The preliminary regression-based mediation analyses also indicated that burnout-related emotional exhaustion and job satisfaction partially mediated the pathway linking WPV and turnover intentions. This is important because it suggests that WPV does not translate into turnover intentions directly due to fear or disappointment with safety, but it passes through psychological strain and professional dissatisfaction before resulting in an attitudinal withdrawal tendency. Rahim and Cosby (2016) similarly supported that burnout mediates the association between workplace hostility and turnover intentions, while Kwon and Kim (2024) and Sinval et al. (2024) also reported that burnout arising from workplace stressors contributes to stronger intentions to leave. Likewise, Duan et al. (2019) found that turnover intentions are connected with increased burnout and decreased job satisfaction among doctors. In the present study, this complete model has been extended further by adding DPR as a relational bridge between psychological and attitudinal outcomes.

The SEM results provided convincing evidence for H9. The structural model showed that deterioration in the DPR has significantly positive association with doctors' turnover intentions ($\beta = 0.8167, p < 0.001$), thereby supporting H9. This finding signifies that when doctors perceive the DPR as strained, uncomfortable, less respectful, or less cooperative, they are more inclined to leave their current work place or medical practice. The strength of this path suggests that DPR is not only a relational variable but also a downstream mediator linking constant stress and behavioural outcomes to doctors' attitudinal withdrawal.

This finding is particularly substantial because turnover intentions in the present study should be considered as an attitudinal outcome rather than a simple decision to resign. Many doctors may continue to work in spite of experiencing dissatisfaction, burnout, or relational strain because of their professional commitment, financial responsibilities, family obligations, limited options, or affection to their field. However, stronger turnover intentions indicate an emotional gap between the choice to work and the compulsion to do so. Wang and Surienty (2025) similarly suggested that WPV may contribute to turnover intentions by reducing job satisfaction, exacerbating poor relational experiences, and increasing burnout. Chen et al. (2022) and Rahim and Cosby (2016) also support this explanation that burnout acts as a central factor through which workplace stressors translate into withdrawal intentions.

The findings also support the broader idea of a vicious cycle in healthcare relationships. WPV weakens trust and satisfaction, doctors become more guarded or avoidant, the DPR deteriorates further, and this deterioration increases turnover intentions. Li et al. (2023) similarly framed WPV as part of a sequence involving reduced job satisfaction, poorer doctor-patient interaction, lower care quality, and stronger withdrawal tendencies. In the present study, this cycle appears particularly appropriate because doctors reported both relational distress and a willingness to shift workplaces if a suitable chance arose. Thus, the problem is not about sampled doctors' leaving their current practice or workplace, but whether they continue practicing with discomfort, reduced trust, and increased willingness to exit.

Theoretically, H9 is best interpreted through SET, supported by AET (Blau, 1964; Weiss & Cropanzano, 1996). From the SET perspective, the DPR is based on perceived reciprocity, respect, trust, and fairness. When doctors repeatedly encounter incivility, turmoil, emotional reactions, poor respect, communication stress, or hostility from patients and attendants, the supposed balance of the relationship may weaken. Doctors may begin to feel

that their professional commitment, personal efforts, and emotional values are not adequately reciprocated by trust, cooperation, or respect by patients and attendants. This perceived imbalance can increasingly create psychological withdrawal and stronger turnover intentions.

AET further helps explain why relational deterioration becomes an attitudinal outcome. Repeated negative exchanges with patients or attendants function as adverse emotional events. Gradually, these events shape doctors' feelings toward their workplace and profession, making them exit or relocate. Therefore, the significant DPR to turnover intentions path suggests that turnover intentions among doctors are not driven only by workload or reward, but also by the emotional quality of day-to-day clinical relationships. Overall, the findings indicate that deterioration in the DPR is a major relational path through which WPV, psychological outcomes, and behavioural changes translate into doctors' attitudinal turnover intentions.

5.2.5 Sequential Mediation Pathways (SEM)

The sequential mediation findings deliver the most integrated understanding of how WPV influences doctors' psychological, behavioural, relational, and attitudinal outcomes. Unlike the previous subsections, which discussed individual relationships separately, this section exhibits the complete SEM-based pathway in which WPV influences burnout-related emotional exhaustion and job satisfaction, which then alter behavioural responses through RAB and CPMB, subsequently affecting the DPR and finally contributing to turnover intentions. The total indirect effect of WPV on turnover intentions was statistically significant ($\beta = 0.529$, $p < 0.001$), supporting H10 partially, as all the involved indirect paths were not statistically significant. This may show that WPV does not impact doctors' turnover intentions only through a direct psychological reaction, but through a sequential layered process involving psychological strain, behavioural adjustment, relational deterioration, and ultimately turnover intentions.

The strongest and well-defined indirect pathways were those involving RAB. The path from WPV to burnout-related emotional exhaustion, then RAB, DPR, and turnover intentions was statistically significant ($\beta = 0.188$, $p < 0.001$), supporting H10a. Similarly, the pathway from WPV to job satisfaction, then RAB, DPR, and turnover intentions was also significant ($\beta = 0.329$, $p < 0.001$), supporting H10c. These findings suggest that RAB represents a principal and central behavioural construct through which psychological consequences of WPV are translated into relational and attitudinal outcomes. If seen practically, doctors exposed to WPV may initially experience burnout-related emotional exhaustion or reduced job satisfaction, and these psychological changes may then lead them to avoid complicated, risky, or conflict-causing cases. Gradually, such avoidance can weaken relational aspects with patients and attendants, contributing to deterioration in the DPR and eventually higher turnover intentions. This pattern accords with Kaur et al. (2020), who found that doctors exposed to violence reduced their willingness to manage complicated or critical patients and increased referrals. Hu et al. (2025) also discussed how violence-related insecurity may encourage physicians to reduce exposure to risky clinical situations, while Fan et al. (2024) similarly treated risk avoidance as a form of professional withdrawal.

The indirect pathways involving CPMB were unreliable. The pathway from WPV to burnout-related emotional exhaustion, CPMB, DPR, and turnover intentions was statistically non-significant ($\beta = 0.015$, $p = 0.288$), which shows H10b is not supported. Similarly, the pathway involving WPV, job satisfaction, CPMB, DPR, and turnover intentions was not statistically significant ($\beta = -0.003$, $p = 0.4114$), therefore, H10d is not supported. This pattern suggests that CPMB is not as reliable as RAB within the sequential model. One possible explanation is that CPMB represents defensive modification rather than complete withdrawal. Doctors may continue to provide care but modify their management through additional documentation, more detailed communication, legal caution, and careful

assessment of hospital resources. Such actions may be defensive, but they may also form a part of proactive, transparent, and better professional engagement and communication with patients. Therefore, CPMB may not automatically deteriorate the DPR in the same way as avoidance-based withdrawal. This interpretation is partially consistent with earlier work stating defensive medicine, additional investigations, cautious communication, and medico-legal vigilance as consequences of workplace hostility and perceived risk (Lafta et al., 2021; Pai et al., 2024; Karpinar et al., 2021).

These findings support the fact that proposed conceptualized model is better understood as a layered framework with parallel psychological and behavioural pathways rather than as a completely sequential chain. Burnout-related emotional exhaustion and job satisfaction functioned as parallel psychological outcomes of WPV, while RAB and CPMB represented two different behavioural responses. However, the strength of these pathways was not equal. The RAB pathways were more stable and theoretically clearer, while the CPMB pathways were inconsistent. This distinction is important because previous literature has discussed components of this process separately, such as WPV leading to burnout, reduced job satisfaction, defensive medicine, poorer DPR, or turnover intentions, but these variables have rarely been integrated within one SEM framework. The present study, therefore, widens the prior research by empirically connecting these fragmented findings into a structured model among doctors practicing in Punjab and Chandigarh.

The findings are also consistent with prior studies that have examined different but partial segments of the same pathway. Li et al. (2023) discussed how WPV can lead to emotional disengagement, deteriorated interactions, job dissatisfaction, and intentions to leave. This corresponds with the present model, where burnout translated into behavioural responses that subsequently affected relational outcomes. Earlier literature has also linked WPV with burnout and turnover intentions (Rahim & Cosby, 2016), while other studies have

shown that reduced job satisfaction increases withdrawal tendencies among healthcare professionals (Ahamad et al., 2021; Cao et al., 2023). Similarly, a study on DPR suggests that deteriorating trust, communication, and cooperation can reduce doctors' professional attachment and increase attitudinal withdrawal (Wang & Surienty, 2025). However, this study contributes to the existing literature by demonstrating that these are not separate consequences but associated stages within a comprehensive process beginning from WPV and ending in turnover intentions.

The Punjab and Chandigarh situation gives further meaning to these pathways. In this setting, sampled doctors often work in environments where increasing patient expectations, medico-legal concerns, infrastructure limitations, the influence of media, social pressure, and fear of violence co-exist. Under such circumstances, WPV may not simply produce instant fear or stress. It can gradually change how doctors are emotionally and professionally engaged in their work, how they select or manage cases, how they communicate with patients and attendants, and how they view their long-term work in the same environment. The significant total indirect effect of SEM captures a wider professional journey. WPV first hampers psychological well-being, then reshapes behavioural adaptations, weakens relational aspects, and finally contributes to attitudinal withdrawal.

From a theoretical perspective, H10 is backed by the combined logic of JD-R, COR, AET, and SET (Blau, 1964; Demerouti et al., 2001; Hobfoll, 1989; Weiss & Cropanzano, 1996). The JD-R model explains the first stage of the structural path, where WPV acts as a severe job demand that increases burnout and reduces job satisfaction. COR theory explains how emotionally exhausted doctors may conserve remaining psychological and professional resources by adopting RAB or CPMB. AET explains how repeated negative workplace events alter emotional reactions and subsequent behavioural responses. SET explains the final relational and attitudinal stage, in which deteriorating DPR leads to weakened exchange,

trust, and professional accomplishment, thereby increasing turnover intentions. The overall sequential mediation model was significant, and the RAB linked pathways were strongly supported but CPMB did not function consistently across all projected pathways. This suggests that avoidance-based withdrawal (RAB) acts a more controlling behavioural connection between WPV and turnover intentions than defensive modification of patient-management (CPMB).

5.2.6 Moderation and Moderated Mediation Analysis: The Role of PSP

PSP, a newly integrated construct, is characterized as one of the most unique and context-specific contributions of the present study. Most of the previous studies have examined WPV in terms of demographics, prevalence, burnout, job satisfaction, defensive behaviour, or turnover intentions. Comparatively limited studies have examined whether doctors feel protected in the existing system encompassing them. In the present study, PSP was not limited to hospital-level safety alone. It was framed as doctors' perception of legal, organisational, administrative, policy-level, media-related, and societal protection against WPV. This is important because WPV against doctors in Punjab and Chandigarh is not confined to internal factors related to hospitals. It is also influenced by lawful implementation, police response, media descriptions, public attitudes, administrative assistance, and the chances of punishment for perpetrators. Existing constructs such as POS and workplace safety climate offer useful but limited insight because they mainly quantify organisational support or workplace safety culture (Chadhar et al., 2024; Eisenberger et al., 1986; Sorensen et al., 2018), whereas PSP extends the idea of protection into a comprehensive medico-legal and broader social support system. This difference is in line with the conceptualisation of this novel construct. Therefore, PSP is positioned as a broader concept combining legal, organisational, and societal extents of protection.

The PSP survey responses exposed a clear division between doctors' faith in visible hospital-level protection and their belief in broader systemic-level protection. Doctors showed fairly favourable views toward direct institutional safety measures, 44.2% agreed and 25.2% strongly agreed, that security and support mechanisms such as guards, CCTV, and administrative assistance help protect doctors from WPV. This suggests that doctors identify and value the instant, visible, and locally available protection. This aligns with Chen et al. (2024), Mukta et al. (2025), Kumari et al. (2020), Ranjha et al. (2022), and Sharma and Gupta (2023), who stressed important protective mechanisms at hospital-level such as anti-violence protocols, grievance mechanisms, empathetic supervision, trained guards, and institutional security arrangements. However, these organizational-level safeguards did not extend confidence of doctors to broader legal and policy frameworks. Around 82.7% of doctors either disagreed or strongly disagreed that government regulations and health ministry policies provide adequate protection to doctors, while 77.2% disagreed or strongly disagreed that existing laws and legal mechanisms effectively protect doctors from violence. This gap between evident organizational safeguards and uncertainty in the available legal-policy system and implementation is one of the most important informative findings of this section.

A similar pattern was observed in doctors' perceptions of law implementation and accountability. Around 67.2% of respondents disagreed or strongly disagreed that law enforcement authorities respond appropriately to incidents of violence against doctors, and 84.8% disagreed or strongly disagreed that individuals who commit violence against doctors are punished appropriately. These responses direct that doctors' pressing concern is not about the existence of protection laws for them, but whether such laws are actually enforced after a hostile incident. Pai et al. (2024) support the importance of policy-level protection by arguing that doctors' confidence is built on the associations' regulations, health ministry guidelines,

and accreditation responsibilities and its proper implementation. Similarly, the literature review records that the absence of strong legislative and institutional systems underpins doctors' perception of systemic negligence in India. Prior research done by Sharma et al. (2019) and Paliwal et al. (2025) have similarly emphasized doctors' concerns about deficient hospital security, weak legal frameworks, a lack of penal action, and the absence of formal reporting mechanisms. In the same way, the present findings indicate that PSP is related to physical security, appropriate justice, lawful enforcement, and confidence that the legal system will deliver after violence occurs.

The media and societal dimensions of PSP were equally concerning. Around 84.6% of respondents disagreed or strongly disagreed that media and society generally act responsibly when incidents of violence against doctors occur. This result is quite important because media and public opinion can influence how violent incidents are interpreted. It decides whether doctors are blamed, and whether public sympathy moves toward them or against them. Ranjha et al. (2022), Samant et al. (2024), and Sharma and Gupta (2023) emphasised that accountable reporting and supportive statements by the media contribute to doctors feeling protected against misrepresentation and defamation. They also highlighted that public literacy, unbiased reporting, and societal consideration of clinical uncertainty are important aspects of systemic protection, especially when patients or attendants are influenced by the fabrication of facts or impractical expectations from doctors. In the present study, low trust in media and societal responsibility indicate that doctors may perceive reputational harm as part of the WPV risk. This means that violence is experienced as physical or verbal aggression, along with threat of reputational defamation, one-sided media narratives, and lack of societal support.

The response regarding hospital or clinic administrative support after incidents was more mixed. Approximately 45.9% agreed or strongly agreed that hospital or clinic

administration provides adequate support after WPV incidents, while 30% remained neutral, and around one-fourth disagreed or strongly disagreed. This mixed response suggests that organisational support may vary considerably across hospital types and institutional settings. The group difference analysis supports this interpretation, as PSP differed significantly across hospital types ($F = 3.89, p = 0.007$). Doctors working in medical colleges reported significantly higher PSP than those in government and private hospitals, and trust-based hospitals also reported higher PSP compared with government hospitals. This finding suggests that PSP is shaped by the institutional type and its related environment, rather than by an individual's perception alone. Academic and trust-based settings may have more formal and disciplined administrative systems, documented protocols, security arrangements, and organisational support, whereas doctors in government and smaller private settings may feel more exposed to political influence, patient load, inefficient security measures, administrative delay, or uncertain reporting mechanisms.

The preliminary statistics also show why PSP is practically important even before considering moderation. PSP had a relatively low overall mean score ($M = 2.49$), reflecting limited faith of doctors in systemic protection. Doctors who experienced WPV reported significantly lower PSP ($M = 2.43, SD = 0.50$) compared with those who did not experience WPV ($M = 2.76, SD = 0.59$), having moderate effect size (Cohen's $d = -0.625$). This indicates that direct exposure to violence may weaken doctors' belief that the system can protect them. Considering correlations, PSP was also negatively associated with WPV, burnout-related emotional exhaustion, RAB, deterioration in the DPR, and turnover intentions, and positively linked with job satisfaction. These patterns are aligned with Duan et al. (2019), who studied PSP partially stating that inadequate social support leads to burnout, job dissatisfaction, and turnover intentions among doctors. Therefore, the present findings

suggest that PSP is directly connected with doctors' psychological and professional functioning, even if it does not change the strength of the WPV effect.

The preliminary interaction analysis also supported the pattern of direct impact but weak protection. The interaction between WPV and PSP did not show a significant association with turnover intentions ($\beta = 0.186$, $p = 0.357$), although WPV itself remained significantly associated with turnover intentions. This early result predicted the later moderation findings, indicating PSP appears related as a protective perception, but it did not meaningfully change the strength of the association between WPV and its consequences. Practically, doctors with higher PSP may generally feel safe or more supported, but once they experience WPV, the emotional and professional consequences may still come out profoundly. This feature is significant, and has to be considered because it prevents a simple conclusion that PSP is unimportant only because moderation was not supported.

Since the final PSP construct retained mainly legal and societal level items, the findings involving PSP should be understood as doctors' perceived protection from laws, government policies, law-enforcement, punishment of perpetrators, and responsible media or societal behaviour. Organizational-level indicators, such as hospital security mechanisms, post-incident support, and reporting-mechanism safety, were not retained in the final measurement model. Therefore, PSP in the present study should not be interpreted as a complete measure of organizational, legal, and societal protection, but rather as an exploratory measure of perceived legal and societal safety.

The actual moderation analysis for H11 showed a similar result. WPV was significantly associated with higher burnout-related emotional exhaustion ($\beta = 0.670$, $p < 0.001$) and lower job satisfaction ($\beta = -0.490$, $p < 0.001$). PSP also exhibited significant direct associations with both psychological outcomes; higher PSP was associated with lower burnout-related emotional exhaustion ($\beta = -0.293$, $p < 0.001$) and higher job satisfaction ($\beta =$

0.227, $p < 0.001$). However, the interaction effects between WPV and PSP were not statistically significant for burnout-related emotional exhaustion ($\beta = 0.059$, $p = 0.472$) or job satisfaction ($\beta = -0.118$, $p = 0.189$). Therefore, H11 was not supported. The simple slope plots further showed that the WPV $\rightarrow$ BO relationship remained positive across low, average, and high levels of PSP, while the WPV $\rightarrow$ job satisfaction relationship remained negative across all PSP levels. These generally parallel slope lines indicated that PSP did not substantially vary the strength of these relationships.

This noticeable finding needs a thorough interpretation. The non-significant moderation does not mean that PSP has no value. Rather, it suggests that PSP may function more as a direct psychological source than as a systemic moderator against the impact of WPV. In the JD-R framework, PSP was expected to function as a job resource that weakens the adverse effect of WPV as a job demand. The direct effects support this logic to some extent because doctors with higher PSP reported lower burnout-related emotional exhaustion and higher job satisfaction. However, the non-significant interaction suggests that this resource (PSP) may not be readily available, reliable, or implementable to reduce the psychological impact once WPV is actually experienced. This finding accords with the prior literature showing that strong perceived protection can make doctors feel psychological safe, but absence of such support can increase fear, mistrust, and defensive behaviour among doctors (Jain et al., 2023; Kaur et al, 2021; Kuppuswamy & Warriar, 2021; Mahani & Zadu, 2024). The present study adds distinction by showing that PSP may improve basic psychological conditions but may not fully absorb the emotional burden or cumulative strain of violence.

The moderated mediation results for H12 further strengthened this interpretation. The indirect effect of WPV on turnover intentions mediated through burnout-related emotional exhaustion remained significant at low PSP ($\beta = 0.212$, $p < 0.001$), average PSP ($\beta = 0.222$, p

< 0.001), and high PSP ($\beta = 0.232$, $p < 0.001$). Similarly, the indirect effect through job satisfaction remained significant at low PSP ($\beta = 0.211$, $p < 0.001$), average PSP ($\beta = 0.233$, $p < 0.001$), and high PSP ($\beta = 0.251$, $p < 0.001$).

However, the interaction effects within the moderated mediation models were not statistically significant. In the burnout-related emotional exhaustion model, the interaction between WPV and PSP did not show a significant association with burnout-related emotional exhaustion ($\beta = 0.028$, $p = 0.434$), the interaction between WPV and PSP did not show a significant association with turnover intentions ($\beta = -0.018$, $p = 0.713$), and the interaction between PSP and burnout-related emotional exhaustion also did not show a significant association with turnover intentions ($\beta = -0.004$, $p = 0.978$). Similarly, in the job satisfaction model, the interaction between WPV and PSP did not show a significant association with job satisfaction ($\beta = -0.057$, $p = 0.152$), the interaction between WPV and PSP did not show a significant association with turnover intentions ($\beta = -0.022$, $p = 0.531$), and the interaction term PSP x job satisfaction did not show a significant association with turnover intentions ($\beta = 0.156$, $p = 0.287$).

Thus, although the indirect effects remained significant across low, average, and high levels of PSP, the non-significant interaction terms indicate that PSP did not significantly moderate the indirect relationship between WPV and turnover intentions through either burnout-related emotional exhaustion or job satisfaction. Since PSP did not significantly moderate the initial WPV $\rightarrow$ psychological outcome paths, there was limited empirical basis to suggest that PSP conditionally influenced the downstream behavioural and relational pathways through burnout-related emotional exhaustion or job satisfaction. Thus, the proposed moderated mediation mechanism did not carry forward to RAB, CPMB, DPR, and ultimately turnover intentions. Therefore, H12 was not supported. This means that burnout-related emotional exhaustion and job satisfaction continued to mediate the association

between WPV and turnover intentions across all levels of PSP, but PSP did not implicitly change the strength of these indirect pathways. This result is theoretically significant as it suggests that the psychological pathway from WPV to turnover intentions is strong, confirming the structural model results. Once doctors experience violence, the pathway through burnout-related emotional exhaustion and job satisfaction remains functional even when perceived protection is higher.

Duan et al. (2019) and Rahim & Cosby (2016) similarly examined turnover intentions as an outcome influenced by WPV through psychological mediators such as burnout, job satisfaction, and social support. The present findings align with this broader pathway because burnout-related emotional exhaustion and job satisfaction remained significant mediators across PSP levels. However, this study adds that PSP did not significantly weaken the pathway. In other words, perceived protection may help doctors feel safe, but it does not necessarily interrupt the psychological chain through which WPV leads to attitudinal withdrawal tendency. This is especially relevant among sampled doctors of Punjab and Chandigarh, where doctors may doubt legal system, lawful enactment, social responsibility, and handling of perpetrators.

PSP did not significantly moderate the relationship between WPV and psychological outcomes and the indirect pathway between WPV and turnover intentions. Therefore, H11 and H12 were not supported. PSP may still have significance as an extensive protective perception but this was not the originally hypothesized in the moderation mechanism. Therefore, any interpretation of PSP as a direct protective factor should be treated as unanticipated exploratory finding. Moreover, it should be verified in future studies before considering it as an established and conclusive finding. The present study holds PSP as a moderator for conservative hypothesis testing. Also, the organizational-level protection indicators were not retained in the final measurement model due to its low reliability in the

model. Therefore, the finding suggests that perceived legal and societal protection may operate more as a baseline protective perception than as a stress-buffering moderator. This interpretation remains exploratory and should be tested in future studies using a fully validated PSP scale that includes organizational, legal and societal dimensions.

The relationship between PSP and behavioural outcomes needs to be analysed, even though H11 and H12 focused on psychological and moderated mediation pathways. Earlier literature indicates that violent incidents, emotional strain, occupational stress, and inadequate systemic protection contribute to risk-avoidance and defensive patient-management behaviour (Hu et al., 2025; Jith et al., 2024; Kaur et al., 2020). In this study, the low overall PSP and its negative association with RAB and CPMB suggest that when doctors feel inadequately protected, they may compensate by protecting themselves through avoidance-based withdrawal or defensive modifications like more referrals, increased specialist consultations, additional documentation, guarded communication, and cautious clinical decisions. This helps explain why PSP remains practically meaningful despite showing non-significant moderation empirically. It may not statistically buffer the WPV → BO or WPV → job satisfaction relationship, but it still acts as a wider safety layer that shapes doctors' readiness to remain exposed, confident, and engaged even in tough clinical settings.

PSP is also relevant to DPR, even though it was not the main outcome in H11 and H12. Liu et al. (2020) observed that doctors' perceptions of the DPR are shaped by medical disputes, workload, infrastructure, security personnel, institutional support, and insurance-related protection. The present study shows that PSP was negatively related to deterioration in the DPR, suggesting that doctors who felt less protected reported poorer relational experiences with patients or attendants. This is conceptually important because adequate systemic protection may reduce individual fear and improve the relational aspect of doctor-patient interactions. A doctor who feels unsupported by law, administration, media, and

society may become more proactive, guarded, less trusting, and more defensive in clinical interactions. Therefore, PSP functions as a background condition influencing the relational aspect of healthcare system, even if its moderating effect was not statistically supported.

The non-significant moderation findings suggest that PSP did not operate as a stress-buffering moderator in the present study. This finding does not reject the JD-R framework, rather it refines its application in the context of WPV against doctors. While JD-R theory recognizes that job resources may reduce the negative impact of job demands, the present findings suggest that PSP did not operate as a buffering moderator. Instead, PSP may function more as a baseline or additive protective perception in the form of legal and societal protection, as resultant from the retained indicators of PSP. Practically, this shows that systemic safeguards may improve doctors' general sense of protection and reduce overall psychological strain, but they may not necessarily reduce the additional impact of WPV on doctors, once it occurs. Thus, PSP appears to operate as an additive independent protective factor rather than as a multiplicative stress-buffering moderator.

The finding also helps distinguish PSP from POS. POS primarily concerns perception of employees' that their organization values and supports them. PSP, as conceptualized in this study, was broader and originally included legal-regulatory, organizational, and societal dimensions. However, after CFA refinement, the retained PSP indicators mainly included legal and societal protection, while organization-level protection indicators were dropped in the final measurement model. Therefore, the present study shows that legal and societal level factors were considered as more reflective indicators of PSP, than the organizational-level safeguards.

The statistically non-significant moderation may also reflect the complex and diverse nature of systemic protection in healthcare settings. PSP represents a broad perception of whether doctors feel protected by the nearby organizational, legal, and societal environment.

Such perceptions may enhance sense of security among doctors and improve their professional confidence, but this alone may not be good enough to reduce the psychological impact once WPV has actually occurred. Therefore, the findings show that PSP operated more as a general protective insight related to lower burnout-related emotional exhaustion, higher job satisfaction, and lower turnover intentions, rather than as a strong safeguard that could buffer or moderate the effect of WPV on psychological outcomes or its indirect pathway toward turnover intentions. In the Punjab and Chandigarh context, PSP may not solely act as a moderating variable but as an investigative construct showing where doctors feel protected, where they feel vulnerable, and why systemic-level reforms are crucial for reducing the long-term consequences of WPV.

The findings redefine the theoretical role of PSP rather than completely confirming its originally hypothesized buffering mechanism. Theoretically, PSP was expected to function as a shielding job resource, attenuating the negative effects of WPV on psychological outcomes and reducing the influence of the indirect pathway on turnover intentions. However, the present findings did not support this moderating role. Instead, PSP appeared to operate more as a general protective perception, as it was directly associated with lower burnout-related emotional exhaustion and higher job satisfaction, but did not significantly moderate the WPV → BO, WPV → job satisfaction, or moderated mediation pathways. From a JD-R perspective, PSP seems to operate as a job resource associated with lower burnout-related emotional exhaustion and higher satisfaction, but it did not buffer the relationship by significantly weakening the WPV → psychological outcome path. This is due to the strong impact of WPV acting as a job demand which could not be neutralized by PSP, functioning as a job resource (Demerouti et al., 2001). Therefore, the results from the present study refine JD-R theory. From a COR perspective, PSP can be viewed as an external resource that may preserve doctors' sense of safety and security. However, actual WPV still causes resource

loss that PSP may not completely prevent (Hobfoll, 1989). From an AET perspective, violent incidents function as strong negative affective events, and their immediate emotional impact triggers adverse emotional reactions, irrespective of perception of systemic safety (Weiss & Cropanzano, 1996). From a SET perspective, PSP is considered a fundamental support system and a pillar of fairness by doctors. But if they feel that the system, law, society, and administration do not reciprocate their professional risk with satisfactory protection, the exchange becomes imbalanced, contributing to mistrust, dissatisfaction and withdrawal-oriented attitudes (Blau, 1964).

5.2.7 Integrated Theoretical Interpretation of the Findings

Although theoretical explanations have been discussed within each hypothesis-based subsection, an integrated interpretation is beneficial as the present study examined WPV and the related outcomes as a layered and sequential process rather than as a set of isolated relationships. Overall, the findings support the combined significance of JD-R, COR, AET, and SET in explaining how WPV affects psychological, behavioural, relational, and attitudinal domains among doctors (Blau, 1964; Demerouti et al., 2001; Hobfoll, 1989; Weiss & Cropanzano, 1996). The JD-R and COR theories were strongly supported in the psychological and behavioural stages, where WPV operated as a demanding and resource-depleting workplace experience that increased burnout, reduced job satisfaction, and instigated defensive behavioural responses among doctors. AET helped explain how frequent negative workplace encounters moulded emotional and behavioural outcomes, while SET was helped in understanding deterioration in the DPR and the following turnover intentions. Moreover, the findings refined the theoretical framework by showing some inconsistencies suggesting that PSP functioned more as an overall protective means than as a statistically significant moderator. Thus, the study supports a layered and partially parallel theoretical model rather than through a strictly uniform sequential pathway, in which psychological

outcomes significantly communicate the effects of WPV, but behavioural adaptations operate with varied strength. RAB emerged as a strong and clear relational pathway, whereas CPMB did not significantly translate into deterioration in the DPR, suggesting that the mediation is not uniformly supported across all behavioural paths.

5.3 Summary of the Study and Findings

The present study observed WPV against doctors in Punjab and Chandigarh and its influence on psychological, behavioural, relational, and attitudinal outcomes. The study was established around the idea that violence against doctors is not limited to direct physical or verbal harm, but may gradually affect how doctors feel, behave, interact with patients, and think about continuing in their work or profession. Using data from 526 valid responses, the study tested an integrated structural model involving WPV, burnout-related emotional exhaustion, job satisfaction, RAB, CPMB, deterioration in the DPR, turnover intentions, and PSP.

The analysis began with data screening, common method bias assessment, descriptive statistics, reliability analysis, and confirmatory factor analysis. The measurement model showed acceptable reliability and validity, allowing the structural model to be established. The structural model exhibited an overall acceptable fit, taking into account the complexity of the present model and the presence of multiple key constructs along the psychological, behavioural, relational, and attitudinal pathways. The empirical findings provided a basis for exploring how WPV operates through layered routes rather than as a single direct pathway.

The findings showed that WPV was significantly associated with both psychological outcomes. Explicitly, WPV significantly increased burnout-related emotional exhaustion among doctors and significantly reduced job satisfaction. These findings support the view that violence against doctors in healthcare settings plays a role in tough occupational

demands that fade doctors' emotional well-being and professional satisfaction. The descriptive findings also showed that WPV was highly prevalent in the sample, with verbal violence and threats considered as the most common form of WPV. This suggests that the psychological consequences of WPV may be triggered from severe physical incidents, as well as, from constant exposure to verbal aggression, intimidation, argumentative communication, and emotionally stimulating interactions.

The psychological outcomes further directed behavioural responses. Burnout-related emotional exhaustion was significantly and positively associated with both RAB and CPMB, indicating that emotionally exhausted doctors were more likely to adopt avoidance-based or defensive patient-management behaviours. Job satisfaction showed a significant and negatively association with RAB, suggesting that doctors who remained more satisfied with their profession were less likely to avoid risky or complicated cases. However, the association between job satisfaction and CPMB was not significant. This finding suggests that CPMB may not be responsible outcome caused by professional dissatisfaction among doctors. Instead, it may also represent a guarded, structured, defensively-modified and adaptive form of patient-management, where doctors remain involved in patient care but become more vigilant, documentation-oriented, legally alert, and communication-focused.

The most important finding of the study was the observed distinction between RAB and CPMB. RAB emerged as an avoidance-based defensive response, where doctors limit exposure to complicated, high-risk, conflict-prone, or medico-legal-related cases. On the other hand, CPMB reflected adaptive-defensive modification of patient-management practices, in which doctors remain clinically engaged but modify their way of patient care through more caution, documentation, explanation of risks and prognosis, and consideration of available hospital infrastructure. This distinction is important because earlier literature has

discussed several correlated behaviours, but these behaviours have rarely been positioned as distinct constructs within an integrated SEM framework.

The relational findings exhibited that RAB had significant positive association with deterioration in the DPR. This indicates that avoidance-based withdrawal may weaken communication, trust, cooperation, respect, and relational comfort among doctors, patients, and attendants. However, CPMB was not significantly associated with deterioration in the DPR. This means that the behavioural stage of the model operated only partially in parallel. While RAB clearly operated as a pathway linking behavioural adaptation with relational deterioration, CPMB did not significantly explain poorer DPR. This suggests that defensive modification of patient-management may not hamper relational outcomes in the same way as done by avoidance-based withdrawal behaviour.

The findings further showed that deterioration in the DPR had significant and positive association with doctors' turnover intentions, depicting that the turnover intentions in the present study is not purely a reaction to violence, dissatisfaction, or burnout alone. It is also affected by the quality of day-to-day clinical interactions between doctors and patients. When doctors observe stressed communication, less cooperation, reduced trust, disregard, and discomfort with patients or attendants, their probability of considering leaving their current workplace or clinical practice increases. Therefore, DPR emerged as an important relational link connecting psychological and behavioural outcomes with attitudinal withdrawal consequences.

The mediation analysis provided the most unified finding of this study. The total indirect effect of WPV on turnover intentions was found out to be statistically significant, showing that WPV influences turnover intentions through a layered process involving psychological outcomes, behavioural responses, and relational deterioration. The strongest indirect pathways were those involving RAB. Both the $WPV \rightarrow BO \rightarrow RAB \rightarrow DPR \rightarrow$

turnover intentions pathway and the $WPV \rightarrow \text{job satisfaction} \rightarrow RAB \rightarrow DPR \rightarrow \text{turnover intentions}$ pathway were significant. This shows that RAB played a dominant role in communicating the effects of WPV through the model. On the other side, the pathways involving CPMB were not statistically significant and less reliable. Overall, H10 was partially supported, indicating that the proposed framework functions better as a layered, partially parallel model rather than as a strictly uniform, sequential chain.

The moderation and moderated mediation findings related to PSP presented one of the most distinguishing insights of this study. PSP was directly and significantly associated with psychological outcomes; higher PSP was associated with lower burnout-related emotional exhaustion and higher job satisfaction. However, PSP did not significantly moderate the association between WPV and burnout-related emotional exhaustion or between WPV and job satisfaction. Similarly, PSP, as a moderator, did not significantly buffer the indirect effect of WPV on turnover intentions through burnout-related emotional exhaustion or job satisfaction. Therefore, H11 and H12 were not supported. These findings propose that PSP may play its role as a simple protective perception by doctors rather than as a robust moderating concept capable of reducing the psychological impact of WPV.

The study was theoretically based on various frameworks like JD-R model, COR theory, AET, and SET. Together, these theoretical models facilitate explaining how WPV functions as a workplace demand and resource-exhausting event, how it shapes doctors' psychological and behavioural responses, how repeated undesirable exchanges affect the DPR, and how weakened mutuality contributes to turnover intentions.

Overall, the findings support the notion that WPV affects doctors through multiple interconnected layers. It first affects their psychological well-being through burnout-related emotional exhaustion and job satisfaction, then alters their behavioural responses, especially RAB, which subsequently weakens the DPR and finally, results in turnover intentions.

However, the model did not run uniformly across all pathways. RAB appeared as the stronger behavioural mechanism, while CPMB displayed a more complex and moderately adaptive role. Similarly, PSP emerged as consequential in its direct association with psychological stressors but not as a significant moderator. In general, the study provides a more imparted understanding of how WPV affects doctors in Punjab and Chandigarh by moving beyond its prevalence and examining the psychological, behavioural, relational, and attitudinal consequences of WPV within an integrated, theory-driven framework.

5.4 Conclusion

The present study concludes that WPV against doctors is not an occasional safety concern but a multifaceted issue with wide-ranging consequences extending across psychological, behavioural, relational, and attitudinal domains. The findings show that WPV does not remain limited to the violent event itself. Rather, it extends to the professional life of doctors by increasing burnout, reducing job satisfaction, influencing clinical behaviour, weakening the DPR, and contributing to turnover intentions.

One of the fundamental conclusions of the study is that WPV creates psychological strain that forms the basis of subsequent behavioural and relational outcomes. Doctors who are exposed to unreceptive, threatening, or hostile workplace experiences are more prone to experience emotional exhaustion and reduced satisfaction with their work or job. These psychological outcomes are crucial as they affect doctors' well-being and influence how doctors later engage with patients, clinical risk, and professional accountability.

The study also concludes that behavioural responses of WPV are not uniform. RAB and CPMB represent two related but separate patterns of professional adaptation. RAB reflects avoidance-based defensive withdrawal, where doctors reduce exposure to risky or conflict-prone clinical situations. CPMB reflects adaptive-defensive modification, where doctors continue to manage patients but with more carefulness, detailed documentation, legal

awareness, guarded communication, and resource sensitivity. The greater inclination of behavioural outcomes towards RAB in the model suggests that withdrawal from risk may have more detrimental relational consequences than guarded continuation of care. This is one of the most important conclusions of the study because it shows how the impact of doctors' behavioural response to WPV determines how strongly violence affects the DPR.

The findings further conclude that deterioration in the DPR is a vital relational pathway leading to turnover intentions. Therefore, turnover intentions should be understood as an attitudinal outcome influenced by emotional exhaustion or job dissatisfaction, as well as by the relational atmosphere in which doctors practice. When doctors experience declining trust, reduced cooperation, tough communication, and a lack of comfort in patient interactions, their intentions to remain in the same workplace or clinical setting may decrease. This indicates that protecting doctors from violence should be considered crucial as a matter of safety and also essential for preserving the relational establishment of healthcare delivery.

The study also concludes that the proposed SEM framework is partially supported as a layered and partially parallel model. The psychological pathways were strongly supported, and the RAB involving behavioural pathways were particularly significant. However, the CPMB-related pathways were weaker or non-significant at the relational phase. Therefore, WPV does not move equally through all behavioural pathways. This finding refines the originally proposed conceptual model and suggests that the psychological outcomes and behavioural adaptations function in different ways depending on whether doctors withdraw from risk or continue patient care in a more protected manner.

The findings regarding PSP yield another important conclusion. The relationship between WPV and psychological outcomes was not significantly moderated by PSP, nor did it significantly moderate the indirect pathway from WPV to turnover intentions. However, PSP was directly associated with lower burnout-related emotional exhaustion and higher job

satisfaction. This indicates that PSP remains important, but it may not be strong enough to buffer the psychological effect of actual WPV once it happens. In reality, doctors may feel somewhat relieved by protective systems, but if legal enforcement system, organizational aid, societal support, and post-incident assistance are perceived as weak and ineffective, the emotional impact of violence may still remain strong or it might augment.

The findings also provide theoretical support for viewing WPV through an integrated framework rather than through isolated outcomes. JD-R and COR were predominantly useful in explaining psychological outcomes and resource-preserving behavioural responses, while AET and SET helped explain how repetitive negative workplace experiences weaken relational trust, hamper reciprocity, and contribute to attitudinal withdrawal. However, the findings also refined the theoretical model by demonstrating that PSP functioned more as a direct protective perception than as a significant buffering moderator.

Overall, the study concludes that WPV against doctors in Punjab and Chandigarh is a broader, systemic and professional issue rather than only an individual-level safety concern. Its consequences are visible in doctors' emotional well-being, professional satisfaction, clinical behaviour, doctor-patient relationships, and attitudinal withdrawal. The study contributes by integrating these outcomes into a single empirical framework and by introducing PSP, as a newly developed and comprehensive systemic construct. Although not all hypotheses were fully supported, the findings provide a meaningful and pragmatic understanding of how violence reforms doctors' professional experience. Therefore, the study underscores the need for healthcare institutions, policymakers, professional bodies, and society to consider doctor safety as a broader and vital security issue, as well as, a necessary condition for improving doctors' well-being, patient trust, quality of care, healthy interactions and job stability.

5.5 Implications and Applications

The findings of the present study have important implications for theory, healthcare practice, and policy-level decision-making. WPV against doctors emerged as a layered problem with consequences extending from psychological strain to behavioural adaptation, deterioration in the DPR, and attitudinal withdrawal. The study suggests that violence in healthcare settings should not be viewed only as an issue to be managed and dealt with suitably. Instead, it should be understood as a wider occupational and universal concern that affects doctors' emotional well-being, clinical practice behaviour, patient relationships, and long-term workplace stability.

5.5.1 Theoretical Implications

The present study contributes to theory by uniting the constructs, developing and testing an integrated model linking WPV with psychological, behavioural, relational, and attitudinal outcomes among doctors. Previous studies have mainly examined individual consequences such as burnout, job satisfaction, turnover intention, or defensive medicine separately. In contrast, this study combines these outcomes into a unified structured SEM framework and demonstrates that the impact of WPV travels through multiple layers and pathways rather than a single direct route.

The findings of this study support the applicability of the JD-R model and COR theory in explaining the emotional or psychological consequences of WPV. WPV exerted a strong occupational demand, increasing burnout and reducing job satisfaction. This suggests that violence exhausts emotional, psychological, and professional resources of doctors, making them more vulnerable to emotional depletion and reduced professional fulfilment. The study therefore strengthens the claim that violence should be treated as a major job demand within healthcare settings.

The study also contributes by distinguishing between two behavioural outcomes, namely RAB and CPMB. RAB appeared as avoidance-based defensive withdrawal, where

doctors decrease exposure to risky, complicated, or conflict-prone cases. CPMB emerged as an adaptive-defensive modification, in which doctors continue clinical care while proactively modifying their management through greater caution, extensive documentation, detailed communication, investigation, and medico-legal awareness. This distinction is theoretically important because earlier literature has discussed such behaviours in dispersed forms, but they have rarely been conceptualised and tested these behavioural consequences as separate constructs within an integrated, theory-driven model.

Another theoretical implication associates to the partially parallel nature of the model. The psychological pathways were parallel strongly supported, and RAB emerged as a significant behavioural bridge between psychological strain and deterioration in the DPR. However, CPMB did not significantly predict deterioration in DPR. This indicates that not all behavioural responses cause the same relational consequences. Avoidance-based withdrawal behaviour appears more damaging to the DPR than protected continuation of patient care. Therefore, the study enhances the original conceptual model by showing that the sequential pathway is layered and partially parallel, rather than uniformly operational through all proposed behavioural pathways.

The findings also refine the theoretical role of PSP. PSP was expected to moderate the adverse effects of WPV, but the moderation and moderated mediation effects were not statistically significant. However, PSP was directly associated with lower burnout-related emotional exhaustion and higher job satisfaction. This suggests that PSP may function more as a general protective perception rather than playing the role of a strong conditional moderator. Theoretically, this is important because it shows that PSP may improve doctors' overall psychological condition but it may not be influential enough to neutralize the psychological impact of real violence once it takes place.

Finally, the study reinforces the combined use of JD-R, COR, AET, and SET in healthcare violence research. JD-R and COR explain the psychological stress and resource-depletion process, AET explains how repeated adverse workplace events influence emotional and behavioural reactions, and SET explains how faded trust and weakened reciprocity affect the DPR and turnover intentions. Collectively, these theories provide a detailed and comprehensive explanation of how WPV gradually transforms doctors' professional outcomes and related experiences into workplace leaving tendencies.

5.5.2 Practical Implications

The findings of the study have several real-world implications for hospitals, clinics, medical colleges, and healthcare administrators. The first implication is that WPV should be treated as an unceasing occupational risk rather than as an occasional emergency. Many doctors reported verbal aggression, threats, intimidation, emotional pressure, and complaint-related fears. Even though the incidents are not physically severe, recurrent exposure to such incivility can cause burnout-related emotional exhaustion, reduce job satisfaction, and change clinical behaviour. Healthcare institutions should create frameworks for the reduction, prevention, reporting, and documentation of such events, and therefore, provide post-traumatic support to the victims.

Hospitals should recognise that doctors' behavioural changes may be early warning signals of impending deeper stress. Increased referrals, avoidance of complicated cases, excessive caution, defensive documentation, additional investigations, and reluctance to handle dispute-prone cases should not be categorized as individual preference. These behaviours may reflect self-protection as a proactive reaction to violence, fear, mistrust, and perceived risk. Administrators should handle such behavioural changes and treat them as signals that doctors require stronger safety, emotional support and administrative intervention.

The significant role of RAB has direct implications for patient care. If doctors start avoiding complicated, high-risk, or conflict-prone cases, patient care gets adversely affected, especially for critically-ill patients requiring urgent, life-threatening, or specialist attention. Therefore, hospitals should identify probable risk-prone departments and complex situations, such as emergency, ICUs, obstetrics, paediatrics, surgery, and other high-intensity areas. Directed support in these departments may reduce avoidance-based withdrawal and help doctors remain clinically involved with increased confidence.

The findings also suggest that CPMB should be interpreted carefully. Some changed patient-management behaviours, such as better documentation, clearer communication of risks, and careful consideration of hospital resources, may improve transparency and protection. However, excessive defensive practices, such as unnecessary investigations, over-prescription of medicines, or overly guarded communication, may increase costs, intensify patients' suffering, and weaken trust. Thus, the hospitals should guide doctors toward balanced defensive mitigation with proper documentation and communication, whereas fear and anxiety-driven over-treatment or unnecessary referral should be supervised.

Doctor-patient interaction also requires practical attention. The deterioration in DPR was strongly associated with turnover intentions, which means relational stress has job-related consequences. Hospitals can reduce this strain by improving communication etiquette, consent procedures, counselling systems, and patient-attendant education. Dedicated counsellors, patient relationship officers, or proficient communication staff may intervene and help meet patients' expectations, explain risk and prognosis, simplify delays, and reduce upfront emotional pressure on doctors during complex situations.

Post-incident assistance is another practical necessity. Doctors exposed to WPV may require immediate after-care in terms of psychological first aid, administrative help, peer support, official documentation assistance, and affirmation that the incident will be taken

seriously. A doctor who feels neglected after a violent incident may become more depressed, avoidant, defensive, and dissatisfied. Therefore, institutions should devise effective post-violence follow-up policies so that doctors should know whom to contact, how to report, what action will be taken, and what protection coverage will be provided.

The findings also imply that professional indemnity and legal awareness are becoming practical truths in medical practice. Since many respondents had already taken indemnity or legal protection cover, hospitals and insurance providers may consider regular orientation sessions on medico-legal documentation, consent taking, communication, and complaint handling. This should be done in a positive and supportive way so that doctors feel prepared rather than being scared. The aim should be affirmative and confident clinical practice, not fear-driven practice.

5.5.3 Policy and Administrative Implications

At the policy level, the findings highlight the need to treat WPV against doctors as a healthcare governance matter. Legal provisions may not be considered enough if doctors perceive that they are not being enforced in a timely and protective way. The PSP findings showed that doctors value evident institutional safeguards, but they remain unsure about broader legal, organizational, societal, and implementation-related protection. This further implies that the success of a policy should not be measured only by its existence, but by its execution when such violence occurs.

State authorities and health departments should strongly reinforce mechanisms for prevention and response to violence in healthcare settings. This may include a mandatory, effective grievance mechanism, reporting protocols, well-defined response timelines, proper coordination between hospital administration and police, protection of healthcare workers in sensitive situations, and strict penalties for violence within healthcare facilities. Such a

receptive model should be clearly visible to doctors and patients, as perceived protection depends on awareness, reliability, and consistent implementation.

Administrative systems within hospitals also need improvement. Every healthcare facility should have a clear and designated WPV prevention policy, displayed patient-attendant conduct rules, emergency escalation procedures, incident reporting arrangements, and related documentation. Smaller hospitals and private clinics may require special support because they often lack specified security departments, in-house legal teams, or extensive administrative layers. Since a large proportion of the sample in this study comes from private healthcare settings, the findings are especially relevant to developing practical, implementable safety models for smaller and mid-sized institutions.

Government and professional bodies should also focus on standardised reporting of WPV. Under-reporting remained a major concern, with many incidents rendered invisible because doctors generalize verbal abuse, avoid escalation, or believe that reporting will not lead to any appropriate action. A state-level online reporting platform for violence against doctors could help gather reliable data, generate real-time statistics, identify high-risk areas, and support state-level policy framing. Such a system should be simple and confidential, linked with follow-up and provision of exact action-taken information.

Administrative attention towards public education is needed of the hour. Many triggers of WPV were linked with unrealistic expectations, poor understanding of disease and prognosis, emotional distress after poor outcomes, financial concerns, mistrust, and communication gaps. Public awareness campaigns can make patients and attendants aware of clinical uncertainty, referral decisions, treatment limitations, waiting time, hospital resource constraints, and the legal consequences of violence against healthcare workers. This is mostly important because violence often results from anxiety, anguish, confusion, and mistrust during emotional clinical situations.

Media responsibility is another important policy-level concern. Doctors' insight into societal and media support impacts their sense of protection and safety. Concerned professional bodies and health departments should engage with media and their correspondents to encourage responsible reporting of adverse healthcare events, the avoidance of premature blame on doctors, and an unbiased role during such incidents. Sensational reporting can deteriorate mistrust and increase resentment toward doctors. Responsible reporting by media can help preserve public's faith in healthcare system and decrease severity of the conflict.

Indian Medical Association (IMA) also has an important administrative role to play. They can provide legal guidance, counselling support, incident reporting assistance, advocacy, and training for doctors. They can also collaborate with hospitals and government agencies to create district-level rapid response teams that can act quickly and support doctors in the event of serious incidents of violence. Such united support may improve doctors' perception that they are not confronting WPV alone.

Overall, the policy and administrative implications are precise and clear as doctors' safety requires a pragmatic, implementable, and comprehensive system. CCTV cameras, guards, and exhibits may benefit, but they cannot fully address the concern unless supported by enforceable laws, receptive administration, responsible police authorities, fair media behaviour, public awareness, and strong organizational assistance. The findings of this study suggest that improving doctors' sense of protection is crucial for reducing burnout, preserving job satisfaction, avoiding clinical behavioural changes, maintaining the DPR, and preventing attitudinal withdrawal from medical practice.

The policy-level and administrative changes can be implemented at various levels of PSP. Table 5.1 shows the broader domains of PSP mapped into organizational, legal, and societal level implications. Therefore, PSP is not merely a theoretical concept but a practical

framework which needs implementation at various levels to create a better working environment for doctors within the healthcare settings.

Table 5.1: Policy and Administrative Recommendations Mapped to PSP

PSP domain	Existing recommendation in the section	Main policy/practical focus
Organizational protection	WPV prevention policies, incident-reporting systems, emergency escalation procedures, CCTV/security arrangements, post-incident administrative support, documentation assistance, and support for smaller hospitals/private clinics	Strengthening hospital-level preparedness and ensuring that doctors feel supported before, during, and after WPV incidents
Legal protection	Enforcement of doctor-protection laws, strict penalties, police coordination, FIR/reporting support, state-level WPV reporting platform, medico-legal training, and professional indemnity awareness	Making legal protection visible, enforceable, and reliable rather than simply existing on paper

Societal protection	Patient-attendant education, public awareness campaigns, responsible media reporting, IMA or professional-body role, counselling support, and district-level rapid response mechanisms	Reducing social impact of violence, improving public trust, patient awareness and preventing media-led escalation of doctor-patient conflict
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Source: Author's compilation based on findings of the study

5.5.4 Applications of the Study

The results of the present study can be applied by healthcare institutions, hospital administrators, professional bodies, and national and state-level policymakers to develop more effective system in order to overcome adverse impact of WPV against doctors. The study provides a real-time evidence-based framework for identifying how WPV gradually affects doctors through psychological outcomes, behavioural changes, deterioration in the DPR, and turnover intentions. Therefore, hospitals can use this model as a practical and indicative tool to identify early warning signs among doctors, such as burnout, reduced job satisfaction, increasing referrals, avoidance of risky cases, defensive documentation, and stressed patient communication.

The most important application of the study is the establishment of WPV prevention and response model in hospitals and clinics. Healthcare institutions can use the findings to design standard operating procedures for incident reporting, fast administrative response, formal documentation, police intimation, counselling support, legal assistance, and follow-up action. Since many doctors may under-report WPV or normalize vocal aggression, hospitals should create simple, confidential and trusted reporting platforms that encourage doctors to report incidents without any fear of guilt, delay, bias or inaction.

The findings can also be applied in training and human resource programmes. Hospitals and medical associations may plan regular training sessions on conflict resolving, difficult patient communication, informed consent, medico-legal documentation, and handling complaint-related threats. Such training would be particularly useful in high-intensity departments such as intensive care units, emergency care, obstetrics, paediatrics, surgery, and casualty services, where such aggressive exchanges are more common.

Another practical application relates to patient and attendant management. Hospitals can use the findings to come up with patient counselling desks, attendant education areas, waiting-time communication protocols, and standardized explanation formats for prognosis, treatment limitations, referral decisions, and hospital resource constraints. These measures may reduce unrealistic expectations, communication gaps, and mistrust, which were identified as central contributors to WPV in the present study.

The novel construct, PSP developed in this study also has direct application. Healthcare institutions and professional bodies can use PSP as a preliminary assessment tool to understand how protected doctors feel with respect to hospital administration, legal systems, law enforcement, media, and society. Periodic PSP assessment may help identify whether doctors trust the protective atmosphere around them. Low PSP scores can help to implement targeted plans such as improving security measures, strengthening legal support, developing effective reporting mechanisms, and forming robust post-incident response systems.

Finally, the study can be applied in academic and professional development institutes. Medical colleges and training institutions can use the findings and integrate them in their academic curriculum in order to educate young students and doctors about WPV, coping strategies, communication skills, documentation practices, related laws and institutional reporting systems. Since WPV affects both emotional well-being and professional conduct,

preparing doctors at early stage may help reduce fear-driven behaviour and improve their confidence in handling complex clinical situations.

Overall, the study offers an applied framework that can be translated into hospital protocols, patient communication systems, reporting mechanisms, medico-legal preparedness, doctor training modules, and policy-level safety involvements. Its wide-ranging application can help healthcare systems change from reactive handling of violent incidents to protective, organized, and doctor-friendly safety management.

5.6 Limitation of the Study

Despite a careful research design, the present study is subject to certain limitations.

1. RAB, CPMB, and PSP showed limited convergent validity. However, these constructs were retained because of their theoretical significance but treated as exploratory. Therefore, findings involving these constructs should be interpreted cautiously and treated as preliminary rather than fully conclusive.
2. RAB played a central role in the final SEM model, particularly in predicting DPR and carrying the supported serial mediation pathways. However, RAB showed weak convergent validity and some low item loadings. Although RAB was theoretically meaningful, future studies should refine and validate the RAB scale more strongly.
3. The RAB → DPR pathway was statistically significant but the standardized coefficient was high, and DPR showed high explained variance. This suggests that RAB and DPR relationship may be interpreted as a strong model-dependent association rather than a practical conclusion.

4. Some of the indicators of WPV, RAB, CPMB and PSP showed poor factor loadings. So, these were dropped and not retained in the final structural model. Therefore, the interpretation of results was done accordingly.
5. The Fornell-Larcker criterion was not fully satisfied for selected construct pairs, especially among psychological outcomes, relational consequences, and turnover intentions. However, HTMT values remained below the suggested threshold. Thus, the discriminant validity was considered acceptable under HTMT, but findings involving closely related constructs were interpreted cautiously.
6. During bootstrap estimation, a small proportion of bootstrap runs produced non-admissible solutions. Although the percentage was low and acceptable for a complex SEM model, it indicates some estimation sensitivity. Therefore, bootstrap-based indirect effects were interpreted cautiously. The non-admissible solutions which were not shown in Jamovi, can be found using other software which can help to detect the pathways leading to such results.

5.7 Future Research

The limitations of this study unlock several directions which can be considered for future research on this topic.

1. Studies may test the proposed model in other Indian states and compare findings across regions, hospital systems, and cultural contexts. Since the present study focused on doctors in Punjab and Chandigarh, extensive multi-state research may help to explore how the psychological, behavioural, relational, and attitudinal pathways operate across different healthcare settings.
2. Future research can be conducted to examine the model separately across hospital types, specialities, and levels of clinical experience. The present findings suggested that experience, specialty, and hospital type may influence burnout-related

emotional exhaustion, DPR deterioration, turnover intentions, and PSP. Future studies can explore these subgroup differences more intensely, especially in high-risk areas such as emergency medicine, intensive care, obstetrics, paediatrics, surgery, and government hospitals.

3. Future studies should use marker variables, longitudinal designs, or multi-source data to assess and control common method bias more efficiently.
4. Longitudinal research would be beneficial to comprehend how the effects of WPV develop over time. The present study used cross-sectional data, which recorded doctors' perceptions at a single point of time. Future studies may survey doctors over months or years to examine whether repeated WPV gradually increases burnout, reduces job satisfaction, increases risk avoidance, deteriorates the DPR, and intensifies turnover intentions.
5. Future research should include patients, attendants, hospital administrators, nurses, paramedical staff, security personnel, and legal/administrative authorities. This would provide a more complete understanding of WPV causes, reporting issues, institutional support, and DPR deterioration.
6. Studies may further refine and validate RAB, CPMB, and PSP as constructs. These are important areas because earlier literature has discussed related behaviours and protection mechanisms separately, but their integrated measurement remains limited. Future researchers may test these constructs in larger samples, across different regions, and across different healthcare systems to strengthen their quantitative accuracy and practical usefulness.
7. Future research should examine whether PSP is better conceptualized as a moderator, direct predictor, mediator, formative construct, multidimensional construct, higher-order construct or baseline contextual resource. Since PSP did not

significantly moderate WPV based pathways in the present study, future studies should test additive or direct impact models and compare them with moderation models using refined PSP measures. Also, further studies should compare PSP with POS, as the comparison would show whether PSP adds an extra value to the available organization-based support scales.

5.8 Chapter Summary

This chapter summarizes the finding of the study in relation to the existing literature, theoretical models, and the healthcare context of Punjab and Chandigarh. The findings showed that WPV significantly affects doctors at multiple levels. It increases burnout-related emotional exhaustion, reduces job satisfaction, alters behavioural responses, weakens the DPR, and contributes to turnover intentions.

The discussion further emphasized that the impact of WPV does not follow a single path. Instead, it operates through a layered and partially parallel process. Psychological outcomes were strongly supported, and RAB emerged as a major behavioural pathway mediating psychological strain with deterioration in the DPR and turnover intentions. CPMB showed a more complicated role, reflecting adaptive-defensive modification of patient-management rather than a purely detrimental behavioural response.

The role of PSP was one of the most important and novel contributions of the study. Although PSP emerged out as a general protective perception and did not significantly moderate the hypothesised relationships, it remained directly associated with lower burnout-related emotional exhaustion and higher job satisfaction. This suggests that doctors' perception of systemic protection is considerable, even if it may not completely moderate the psychological impact of actual WPV.

Overall, the study concludes that violence against doctors should be understood as a major professional and serious systemic concern. It affects doctors' well-being, clinical

behaviour, patient relationships, and working stability. The findings indicate that an urgent intervention is required to frame robust institutional support system, better reporting mechanisms, responsible communication, legal enforcement, and healthcare policies that protect doctors while preserving sanctity of DPR.

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APPENDIX A

QUESTIONNAIRE

Introduction

Dear Doctor,

You are invited to participate in a research study titled “From Burnout to Broken Bonds: An Integrated Study of Workplace Violence and Its Consequences on Doctors’ Practice and Patient Care in India.”

The purpose of this research is to understand how workplace violence experienced by doctors affects their professional well-being, clinical practices, and relationships with patients. The study also explores how such experiences influence burnout, defensive medical practices, and doctors’ intentions regarding their professional future.

The findings from this research aim to contribute to a better understanding of the challenges faced by doctors and may help inform healthcare policies, workplace safety measures, and institutional support mechanisms in the healthcare system.

Your participation will provide valuable insights into this important issue.

Eligibility

This questionnaire is intended only for qualified medical doctors (MBBS or higher) who are currently practicing in Punjab, India.

If you are not currently practicing as a medical doctor in Punjab, kindly do not proceed with the survey.

Voluntary Participation

Participation in this study is completely voluntary.

You may choose to skip any question or withdraw at any time.

The questionnaire will take approximately 6-8 minutes to complete.

Confidentiality

All responses will be anonymous and strictly confidential.

- No personally identifiable information will be collected.
- The information will be used only for academic research purposes.
- Results will be reported only in aggregated form.

Consent

By proceeding with this questionnaire, you confirm that:

- You are a qualified medical doctor currently practicing in Punjab, India.
- You have read and understood the purpose of the study.
- You voluntarily agree to participate in this research.

Consent Question (Required)

Do you agree to participate in this research study?

- Yes, I voluntarily agree to participate
- No, I do not wish to participate

SECTION A: Demographic and Professional Information

Please provide the following information about yourself and your professional background.

All responses will remain confidential and will be used only for research purposes.

1. Are you a registered allopathic (MBBS/MD/MS/DNB) medical doctor currently practising clinical medicine? Yes/ No (If No - End survey)
2. Your highest medical qualification: MBBS / MD/MS / DNB/DrNB / DM/MCh / MBBS with Diploma (DA/DCH/DGO etc.) / Other (please specify)
3. Which council are you registered with? (No registration number required): Punjab Medical Council / Other State Medical Council (allopathy) / Indian Medical Council / Not sure
4. Are you currently practising medicine in Punjab or Chandigarh, India? Yes/ No (If No - End survey)
5. Age (in years)
6. Gender: Male/ Female/ Prefer not to say
7. Which district do you currently practice in?
8. Type of hospital (Govt / Private / Trust / Corporate / Medical College)
9. Level (Primary / Secondary / Tertiary)
10. Years of experience
11. Area of practice: Town/City / Village
12. Specialty
13. Marital Status: Married/ Unmarried/ Others
14. Have you ever experienced workplace violence? (Yes/No)

15. Have you taken professional indemnity insurance / legal protection cover? (Yes/No)

There are no right or wrong answers. Please respond based on your personal experiences and perceptions.

SECTION B: Experiences in your workplace (WPV)

1. During the past 12 months, how often have you personally experienced the following at your workplace (from patients or attendants/relatives)?

I. Being shouted at or spoken to aggressively.

a. Never b. Rarely c. Sometimes d. Often e. Very Often

II. Being insulted or humiliated (abusive language or personal comments).

a. Never b. Rarely c. Sometimes d. Often e. Very Often

III. Being threatened with harm (to you, staff, or hospital).

a. Never b. Rarely c. Sometimes d. Often e. Very Often

IV. Being pressured or intimidated to provide treatment against your clinical judgment.

a. Never b. Rarely c. Sometimes d. Often e. Very Often

V. Attempted physical assault (someone tried to hit/push/throw objects at you).

a. Never b. Rarely c. Sometimes d. Often e. Very Often

VI. Physical assault (hit, pushed, slapped, grabbed, etc.).

a. Never b. Rarely c. Sometimes d. Often e. Very Often

VII. Damaged hospital property during a conflict/incident (vandalism/breaking items).

a. Never b. Rarely c. Sometimes d. Often e. Very Often

VIII. Being blocked or surrounded to restrict your movement and force a demand.

a. Never b. Rarely c. Sometimes d. Often e. Very Often

IX. Received repeated aggressive calls/messages related to care, outcome, or payment.

- a. Never b. Rarely c. Sometimes d. Often e. Very Often

X. Facing threats of complaints, legal action, or media exposure intended to intimidate you.

- a. Never b. Rarely c. Sometimes d. Often e. Very Often

2. In the most recent/most serious incident, who was the main aggressor?

- a. Patient
- b. Patient attendant/relative
- c. Visitor/outsider (not directly involved)
- d. Staff member/colleague
- e. Security/police
- f. Politically exposed person
- g. Media person
- h. Not Applicable

3. What were the main reasons/triggers (as you perceived) for the incident?

a. Patient-related factors

- i. Unrealistic expectations from treatment
- ii. Lack of understanding about the disease or treatment
- iii. Emotional distress after worsening condition or death of patient
- iv. Financial stress due to medical expenses

b. System-related factors

- i. Delay in treatment or long waiting time
- ii. Shortage of beds or infrastructure
- iii. Inadequate hospital resources or medicine supply
- iv. Overcrowding or high workload in the hospital

c. Doctor-related factors

- i. Miscommunication or misunderstanding between doctor and patient
 - ii. Perceived lack of empathy or rude behaviour from staff
 - d. External factors
 - i. Influence of drugs or alcohol
 - ii. Political or media involvement
 - iii. Previous mistrust in the healthcare system
 - e. Other
 - i. Medical negligence
 - ii. Other (Please specify)
 - f. Not Applicable
4. Thinking about the most recent or most serious incident you experienced, how serious was the incident overall?
- a. Minor
 - b. Moderate
 - c. Severe
 - d. Life-threatening
 - e. Not Applicable
5. Was the incident formally reported?
- a. Yes, to hospital administration
 - b. Yes, to police
 - c. Yes, both
 - d. No
 - e. Not Applicable

SECTION C: Work-related feelings (Burnout)

The following statements describe feelings that people may experience as a result of their work. Thinking about your work during the past four weeks, please indicate how often you have experienced each of the following.

1. I feel emotionally drained by my work.
a. Never b. Rarely c. Sometimes d. Often e. Very Often
2. I feel exhausted at the end of the workday.
a. Never b. Rarely c. Sometimes d. Often e. Very Often
3. I feel burned out because of my work.
a. Never b. Rarely c. Sometimes d. Often e. Very Often
4. I feel frustrated by my work.
a. Never b. Rarely c. Sometimes d. Often e. Very Often
5. I feel I am working too hard in my job.
a. Never b. Rarely c. Sometimes d. Often e. Very Often

SECTION D: Satisfaction with your work (Job Satisfaction)

Please indicate the extent to which you agree with the following statements about your current job.

1. I feel satisfied with my current job.
a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
2. Most days I feel enthusiastic about my work.
a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
3. I find real enjoyment in my work.
a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
4. Most days I feel positive about my job.
a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

5. I feel a sense of accomplishment from my work.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

6. I would choose this profession again if given the chance.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

SECTION E: Future work plans (Turnover Intentions)

Please indicate the extent to which you agree with the following statements regarding your intention to leave or change your current place of work or medical practice.

1. I often think about leaving my current place of work or medical practice.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

2. I will probably look for a different work opportunity in the near future.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

3. I have seriously considered leaving my current practice setting.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

4. If a suitable opportunity arises, I would move to another place of work or practice.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

SECTION F: Clinical Decision-Making Behaviour (RAB)

To what extent do you agree with the following statements regarding your clinical practice?

1. I avoid managing complicated or high-risk cases whenever possible.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

2. I try to avoid cases that are likely to lead to disputes with patients or their attendants.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

3. I refer certain cases to other doctors or hospitals to avoid potential conflicts.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

4. I prefer to seek consultation from other specialists rather than taking full responsibility for risky cases myself.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

5. I avoid adopting new treatment methods that may involve higher perceived risk.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

SECTION G: Patient management practices (CPMB)

To what extent do you agree that concerns about disputes, complaints, or aggression from patients or attendants influence your patient management practices?

1. I order additional investigations or diagnostic tests to reduce the risk of complaints or disputes.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

2. I sometimes prescribe additional or more aggressive treatment to minimize the risk of treatment failure or disputes.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

3. I am more cautious in clinical decision-making because of potential legal or conflict situations.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

4. I consider the available hospital resources and infrastructure more carefully before deciding on treatment.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

5. I consider possible legal consequences while planning patient treatment.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

6. I maintain more detailed documentation of patient care than before.
- a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
7. I provide more detailed explanations about treatment risks and prognosis to patients or attendants.
- a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

SECTION H: Interaction with patients and attendants (DPR)

Please indicate the extent to which you agree with the following statements regarding your interactions with patients and their attendants.

1. Emotional reactions from patients or their attendants sometimes make clinical interactions challenging.
- a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
2. Patients sometimes make demands that are difficult to accommodate in clinical practice.
- a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
3. Patients generally show respect toward doctors. (reverse coded)
- a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
4. Maintaining a cooperative relationship with patients or their attendants has become more difficult than before.
- a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
5. I generally trust the information provided by patients or their attendants. (*reverse coded*)
- a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree
6. Maintaining good communication quality with patients or their attendants is often difficult.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

7. I generally feel comfortable and at ease when interacting with patients or their attendants. (reverse coded)

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

SECTION I: System support for doctors (PSP)

Please indicate the extent to which you agree with the following statements regarding the protection available to doctors against workplace violence.

1. Government regulations and health ministry policies provide adequate protection to doctors against workplace violence.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

2. Adequate security and support mechanisms (e.g., guards, CCTV, administrative assistance) in healthcare settings help protect doctors from workplace violence.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

3. Existing laws and legal mechanisms effectively protect doctors from violence by patients or attendants.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

4. Law enforcement authorities respond appropriately to incidents of violence against doctors.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

5. Individuals who commit violence against doctors are punished appropriately.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

6. Media and society generally act responsibly when incidents of violence against doctors occur.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

7. Hospital or clinic administration provides adequate support to doctors after incidents of workplace violence.

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

8. Doctors feel safe reporting incidents of workplace violence to their healthcare institution or to appropriate external authorities (e.g., police or regulatory bodies).

a. Strongly Disagree b. Disagree c. Neutral d. Agree e. Strongly Agree

Thank you for participating in this research.

Your responses will help contribute to a better understanding of the challenges faced by doctors and may support efforts to improve workplace safety and healthcare systems.