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Trends of violence against health care workers and facilities: understanding the unheard

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Abstract

This article evaluated trends of violence against healthcare workers and healthcare facilities. It further assessed risk factors, perpetuating, precipitating, and predicting factors. This article presented a framework on how to address, minimize and control the violence against healthcare workers and facilities in an effective way. It further presented a framework for policy developers and decision makers to ensure the safety and protection of the healthcare profession.

Keywords: Healthcare workers, healthcare facilities, COVID-19, violence, policy making

"I have been slapped, pushed, hair pulled, stalked, harassed, and verbally abused," says Dr. John Doe of the Sheikh Zaid Hospital of Pakistan

When health-care workers are subjected to more acts of violence than police officers and prison guards then imperativeness of this matter cannot be overlooked. Situations such as these indicate prevalence of violence towards healthcare personnel at healthcare facilities [1]. Healthcare personnel's violence appears to be the underreported but alarmingly ubiquitous and persistent problem [2].

Operational definitions

Healthcare refers to the facilities, services and activities that ensure, delivered and access for the wounded and sick in the context under consideration that grouped into four main categories, doctors, nurses, paramedical staff and administrative staff.

Health-care facilities includes health-care centers, first aid posts, blood transfusion centers, clinics, medical laboratories, medical and pharmaceutical stores, medical vehicles (ambulances, civilian or military medical ships or aircrafts carrying medical supplies or equipment) of *healthcare personnel* consists of doctors, nurses, physiotherapists, pharmacists, ambulance drivers, paramedics, support staff (ward orderlies, gate keepers), administrative staff, medical rescue workers, clinical professionals, social and community workers and volunteers, local health providers including polio teams, and midwives are subjected to violence. In health-care settings, possible sources of violence include patients, visitors, intruders and coworkers [3, 4].

Violence is defined as the intentional or accidental use of physical force perceived or real, threatened or actual, interpersonal or collective against oneself or another person, or against a group or community which results in or has likelihood to result in harm or death, physiological, verbal, sexual or psychological harm, deprivation or under- development. The National Institute for Occupational Safety and Health (NIOSH) defines *workplace violence* as violence acts such as physical assaults and threats towards people at work or on duty [5, 6]. *Violence against health-care* consists of acts or threats of violence that hinder, obstruct or adversely affect the deliverance or access to healthcare. *Violence against health-care personnel* includes physical, verbal psychological harm or death while performing their

duties [7]. *Violence against patients* includes physical, verbal, or psychological harm in getting medical care in the form of killing, injuring, deliberate failure or denial of medical assistance [8].

Violence against healthcare providers

Violence against health-care has become an epidemic, with almost equal intensity of COVID-19 pandemic, threatening to dissuade the entire health system throughout the industrialized, developing and transitional countries. The prevalence of physical and non-physical violence against health-care constitutes from 8% to 38% observed during the COVID-19 pandemic [9]. Most violence incidents are perpetrated by patients and visitors, even become the subject of individualistic, collective or political violence [10]. Health-care personnel especially individuals from BIPOC, women, and minority workers are the most vulnerable professionals susceptible to workplace violence [11, 13]. Reports have indicated responses of health-care personnel from different countries ranging from physical or psychological violence: 76% in Bulgaria; 67% in Australia; 61% in South Africa; 60% in health centers in Portugal; 54% in Thailand; and 47% in Brazil [14]. *Violence against lady health-care workers* has increased drastically in Pakistan especially during Pakistan's polio eradication struggles. Besides 110,000 lady health-care workers in Pakistan negotiation access and security interests remains same [15-16]. Physical, non-physical assaults and aggression are common occurrences at many parts of Pakistan varying from aggression to harassment [17]. Such violence against health-care workers has negative influence on their occupational performance, well-being and consequently impact patient's health and satisfaction as shown by a study conducted during the peak of COVID-19 pandemic [18]. A study conducted by the ICRC in Karachi and Peshawar indicated that ambulance drivers are at higher risk, other drivers' unwillingness to let the ambulance past, afar location of hospitals with trauma wards, general lack of respect towards medical profession. [19,20]. In Karachi, Pakistan's largest city, 130 doctors were killed and 150 kidnapped between 2012 and 2014 [21-22].

4Ps (precipitating, predisposing, perpetuating, predictive factors)

Studies conducted by International Committee of the Red Cross (ICRC) has indicated the following findings: health-care personnel were subjected to threats, physical assaults by patients and relatives, deprivation of their liberty, and coerced to act against health-care ethics; health-care facilities were effected against, inside, or within the perimeter through attack, disruptive armed entry, takeover, or looting such as bombing, burning or harming during the conduct of hostilities; break-ins and forced entry including pillage, robberies for perpetrating violence against health-care facilities often resulting the deaths of patients, bystanders, relatives and health-care personnel; obstruction of passage of ambulance and drivers of medical transports carrying patient; health-care personnel resulting in health-care personnel and patients were effected by threats and deprivation liberty, and health-care facility involved in the loss of resources to the suspension of health-care services.

The growing epidemic rate of violence, after the pandemic of COVID-19, against healthcare workers and healthcare facilities has been prevalent; however recent attention to this problem's magnitude is due to various factors [23, 24]. First, risk of verbal and physical violence has expanded across diverse types of healthcare settings, globally. Second, recent media attention to global school, workplace and religious citing's shootings raised the level of conscious awareness of dimensions of violence converting sensationalism into habituation or desensitization towards violence. Third, various psychological studies have observed the insurgence of decreased job satisfaction, increased occupational strain and poor wellbeing as a consequence of physical or nonphysical violence.

Furthermore, the escalating risk in the healthcare facilities is due to increased drug and alcohol use by patients, or presence of any form of weapon, or unhealthy coping skills, or long waiting times, and increased number of patients with violence history, mental health issues like dementia or psychosis. Healthcare workers' uniform of identification that instigated security and reverence has transformed into a threat for them [25].

It appears as the mainstream media stagger in comprehending violence against healthcare personnel and advertently or inadvertently conveys the message of 'do no harm' at the expense of personal risk. In an episode of House M.D (Season 1, Episode 15), a brother of the patient slapped Dr. Chase across the face but Dr. Chase 'decided' to silently endure without reporting [26]. Social media has expanded, exposed and expedited health-care data or information into a highly research issue on the internet. This accessibility and liberty have paved the way to give voice of the unheard health-care workers' issues to the masses – allowing individuals to share their experiences about service provisions, procedures, and treatment management for definitive diagnosis.

The role of culture in confluence of nature of service healthcare workers provide may render some particularly at risk of experiencing violence and even death. In global context, having more representation of women in healthcare system including majority of nurses and auxiliary nurses, and community outreach workers who are targeted by violence led to higher number of incidents involving women healthcare workers. In Pakistan, male gynecologists are specifically threatened or killed under the pretense of perceived violation of women's privacy. This intersection between job specialization, gender, culture and violent incidents may point towards a possible gendered exposure towards violence [27-30].

Impact of violence towards healthcare providers

The effect of threats and attacks against healthcare severely impacted entire healthcare system and has become the key humanitarian challenge of this time. So much a talk of efforts to reduce child mortality, to improve maternal health, to tackle stigmas against mental health, and to fight against diseases such as polio which majorly exist in Pakistan – it will take decades to rebuild the system if magnitude, patterns, intensity and dynamics of this issue left unacknowledged [31].

Many studies in the developed countries have focused on violence and associated factors at psychiatric and psychological facilities at hospitals, emergency departments, public sector hospitals, welfare sectors, and nursing homes [32-35]. Many developing countries including Pakistan remained in the want of more scientific researches to explore further factors of violence, aggression and gendered hatred towards women (misogyny, sexism, sexual assault, rape, harassment and bullying) in health-care setting to help in addressing policies and training to deal with such incidents [36-39].

More research required in low resource settings of developing and underdeveloped countries to evaluate negative outcomes and impact on the occupational motivation, and physical and psychological wellbeing of the health-care workers. It will establish the course of action of different setting for interventions

to prevent violence against health-care for emergency and non-emergency settings through ensuring physical security of health-care facilities and treatment /management of high-risk patients or visitors, respectively. Poor political or economic stability, unemployment, poverty, deprivation of basic human rights political agitation give birth to anger, frustration, and importance resulting in more outbursts of violence against anyone

In Pakistan, 77% medical employees have experienced both physical and nonphysical assault. But only a fraction of actual cases gets reported like a trend seen in violence faced by young doctors in Pakistan [40]. Low rate of reporting may be due to lack of support from management, vague reporting procedures, and policies or laws in this regard and a perceived moral obligation of acceptance of violence at workplace including unpreparedness to cope with violence at workplace [41]. A problem that can only be dealt with thorough training in healthy working practices, de-escalation techniques with the assistance of institutional policies and occupational safety policies for the violence-free workplace.

Lack of understanding of the duties of medical personnel and unmet unreasonable expectations in terms of treatment, management, prescriptions of medicine can lead to violent encounters [42]. If patients who have non-emergency states denied hospitalization at emergency department or given simple treatment then the chance of violent episode from patient or visitors could occur. Studies conducted at psychological hospitals indicated that, on average, two aggressive assaults per week takes place [43]. Such aggressive incidents, active aggression, and relational aggression lead to chronic fatigue, intolerance, impatience, absence of frustration tolerance, and lack of sympathy towards patients. Therefore, violence in general is more prevalent in the society [44-47].

Health-care facilities in emergency department are subjected to over-crowding, insufficient number of medical and nursing staff, delay of laboratory tests or diagnostic imaging, and other health condition as one of the cardinal issues of health-care workers encountered. Violence occurs if the service is unsteady or health access is limited or delayed. Conflict with health-care workers at health-care facilities occur during times of high activity and interaction with multiple patients at a time or during meal times, visiting hours or patient transportation as a result of disciplinary action such as restraints of eatables for patients [48].

In humanitarian implication such as natural disasters (earthquakes, floods, dust storm, tsunami) or anthropogenic disaster (mass destruction, bombing, terrorism acts) tend to cause extended suffering to the people resulting in loss of health resources, water supply, nutrition, shelter, and obstruction of access to health-care facilities. This conditional conflict or violence again health-care or health-care facilities leads to collapse of social, economic, and political infrastructure – reformed through developing policies and protocols, health-care protection laws, reinforcing networks, emergency conditions and evaluating services during peace and conflict.

The frequency and intensity of violent events has direct proportionality with the probability of mental health issues [49]. The other consequences consist of negative emotions, and negative behavioral manifestations including burnout, negative self- concept towards oneself and the others, psychosocial complaints, and emotional- behavioral issues [50]. Many studies comprising of responses to violence against health- care across different countries, cultures, settings and emotional reactions including fear, anger, anxiety, and uncertainty and intention to quit profession [51-53].

Biopsychosocial model

An individual's defense mechanisms, coping strategies, risk assessment and management, assertive communication, resilience, empathy, and innate personality act as influential factors in any context, situation and environment in establishing a response continuum [54]. This triggers physical responses such as metabolic functions, immune system, tense up muscles and increasing heart rate to prepare for urgent action – F4 (Fight – Flight – Freeze – Fawn) response. This establishes an individual's reaction to the situational triggers who choose to respond to violence from multiple options: avoidance, denial, discussion, reporting, counseling and prosecution [55]. Emotional reactions to violence include shock, disbelief, anger, frustration, apprehension, high stress level, burnout, loss of self-esteem and professional competence, feeling of powerlessness, self-blame, avoidance of situations, lack of job motivation and job satisfaction, anxiety, depression, suicidal ideations, and other mental health concerns [3, 4]. Other responses could be high turnover, truancy, unsatisfactory job performance, relationship issues, sexual dysfunction, compromised ability to provide quality care to oneself and patient which was seen more prevalent and exacerbated during and post-COVID-19 pandemic [56].

Emotional behavioral reactions physical response (F4) to any situation varies individual to individual. If the health-care workers reluctantly tackle violent event as being a characteristic of the patient then the magnitude could be significant next time. This indicates the violence is not inevitable as health-care workers had assumed but situational. Short term exposure to violent incident become stressful event and long-term psychological reaction holds the beginning of Post-Traumatic Stress Disorder (PTSD).

The cluster of symptoms can be divided PTSD into acute or chronic PTSD which accounts duration and symptoms of persistent re-experiencing of the traumatic event; avoidance of similar situations and feeling anxiety, apathy, and hyper-sensitivity. Adjustment issues could become another factor for a victim in this situation. These mental health problems could be manifested in terms of inattentiveness, truancy, time off, psychosomatic complaints, emotional-behavioral reactions, psychosocial issues, relationship strains and occupational hazards. Sharing a traumatic event, no matter how trivial has cathartic outcome as a catalyst for optimism and change. And health-care facility could suffer from problems of recruitment and retention of staff after resignation.

An imminent need of a mental health practitioner for capacity building of healthcare workers to manage emotions after the encounter of violent incidents, and a research psychologist for consultation for development of training program for healthcare workers such as communication methods (aggressive, passive and assertive communication) to manage threatening situations (breaking bad news to patients and relatives, medical ethics, and ways to predict, prevent and pacify violence against healthcare workers. A research psychologist could publish manuals in esteemed journals, informative articles in impactful newspapers and magazines, coping strategies guidelines as part of curriculum modules.

Intervention and prevention

For intervention and prevention, a campaign could be initiated by taking an initiative and commencement of movement which aimed at addressing the issues of violence against healthcare workers, patients, and facilities by ensuring safety and quality deliverance of healthcare [57]. An initiative that should foster consolidation for identification, operationalization and

implementation of SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals to prevent violence and safeguard healthcare ought to be implemented.

The active mobilization of society is a key for support just as an adjoined community is a catalyst for change. It serves the purpose of prevention against violence through scientific research, debate, consultations, and workshops to create and strengthen awareness with practical steps to safeguard healthcare. This campaign could seek public communication to raise awareness on violence against healthcare by highlighting the concerns, humanitarian impact of violence and implementation strategies for the protection of healthcare. It consists of national and international organizations, indigenous research initiatives, academia, health professionals, government officials, non-government organizations, and more to advocate and implement measures for healthcare. Collective effort of humanitarian, development, and health communities with broader coalitions, formal or informal of different groups of society connected by interest in this issue are required to produce the monitored and measured results. Various indigenous and global initiatives and campaigns brought together under common action plan to address and prevent violence against healthcare. This common action plan seeks policy change, not only legislation but regulation and implementation (which requires time and commitment of authorities). A campaign could commission a brand-new framework for operational practices from existing data and literature.

A high-profile media campaign's impact can never be undervalued or undermined as media is the most powerful tool to modify behavioral patterns of people and alter cognitive schemas*, en masse*. Electronic, print and social media including television, radio, newspapers, blog, vlog, twitter, and others lay a foundation upon which journalists, healthcare providers, victims, rights advocates, public figures, public speakers, and medical and mental health professionals. Feasibility of changes, consolidation of practices, implementation of policies, commencement of laws and prompting behavioral change fosters a society free of violence against healthcare workers and facilities.

Legislative measures for the implementation of the international legal framework, dissemination and training should be implemented meanwhile, policy makers, NGOs, humanitarian agencies and stakeholders initiated national level course of action for domestic policies to undertake comprehensive analysis, including causes and effects of violence against health-care workers [58-63]. Pakistan Penal Code (PPC) accommodates a law, Section 153 – A which stated that "By words, either spoken or written, or by signs, or by visible representations or otherwise, that promote or incite, or attempt to promote or incite, on grounds of religion, race, place of birth, residence, language, caste or community or any other grounds whatsoever, disharmony or feelings of enmity, hatred or ill-will between different religious, racial, language or regional groups or castes or communities: or commits, or incites any other person to commit, any act which is prejudicial to the maintenance of harmony between different religious, racial, language or regional groups or castes or communities or any groups of persons identifiable as such on any ground whatsoever, and which disturbs or is likely to disturb public tranquility shall be punished with imprisonment for a term which may extend to five years.

Limitation towards achieving these goals is the paucity of consensuses standard definition of assault, misinformation, battery, threat or harassment among governmental domain so establishing standardized operational definition can be the logical way forward. Another obstruction is abstruse differentiation between intentional and inadvertent violence [64-66]. A vigilant distinction should be placed to determine whether the attack was prompted due to delirium, psychosis, or dementia, however, an action undertaken under the influence of alcohol and drugs is a crime even intoxication, drug seeking and withdrawal leading to violence cannot be overlooked as an excuse for abusing healthcare workers. Judiciary should intervene and matter should be immediately reported to the authority to prevent recidivism [67].

Healthcare ethics

Health-care ethics is the field of ethics to deal with the ethical issues in the practice of health-care. Ethical decision-making demands impartiality, confidentiality, regard for dignity of others in need, fair treatment, avoid inflicting harm and acting in the best interest of individuals and groups in times of peace, conflict and emergencies Healthcare personnel's task is to provide necessary care in the accordance of human physical and mental health. Healthcare personnel act in the best interest of patients with their consent. Healthcare workers' obligation required them to render immediate attention and requisite care without prejudice and discrimination against anyone. Healthcare workers ensure respect, privacy and confidentiality and disclose confidential information with the consent of patient or in case of threat of harm to patient or to others. Safe access to health-care personnel, facilities or equipment should not be impeded or compromised. By endorsing these ethical conditions will minimize the chance of a conflict or encounter of inflicted harm against health-care personnel [68]. Healthcare personnel in under no circumstance should accept and agree with inhuman or degrading treatment based on gender, race or any other factor and must never be present at and may take part in such acts [69]. Health-care personnel, health-care facilities must be respected by all [70-73].

Healthcare workers endure perceived personalization and social tolerance of violence and from the perception that the training of their profession implies the acceptance of violence and aggression (victimization of health-care personnel) [74]. Another challenge contributing to underreporting rooted in cultural, economic and political dynamic where healthcare personnel feel professional and ethical obligation to 'do no harm' to patients over their own wellbeing or their unwillingness to report to avoid stigmatization of perpetrator due to illness or impairment. The acceptance of violence with healthcare workers and at healthcare facilities should not be considered as a part of a job. A related factor that prevents healthcare workers from reporting include apprehension towards being perceived as unprofessional amongst peers, or indicator of poor performance or negligent towards the job, fear of personal and professional stigmatization, and lack of support from administration.

Healthcare facilities can reduce workplace violence by implementing an inclusive violence intervention and prevention program that constitutes commitment from upper management and participation from lower management, health and safety training, occupational setting's analysis and occupational hazard identification, recordkeeping, program evaluation, and hazard prevention and intervention.

Violence against health-care is a prevalent factor that affects human rights and public health worldwide with social, economic, and physical and mental health consequences against gender norms, individuals, families, communities and societies. More consequences could be of workplace under productivity, minimal job motivation, less inclination of job retention, mental

health complaints, physical injury and suicidal ideations. A need to foster partnership among and beyond the individuals, community and society of concern – collective effort by humanitarian, health communities, civil society organizations, and media and health professionals to raise awareness at domestic and global level: make health-care system safe, secure, and progressive under all circumstances.

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