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DOCTORS AND PARAMEDIC STAFF IN PAKISTAN FACING VIOLENCE AND AGRESSION IN HOSPITALS

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Abstract:

Objectives:

To identify the frequency and consequences of workplace violence and possible factors related to physician and nurses in a public medical facility in Lahore, thus providing a basis for appropriate interventions.

Study Design:

Cross sectional study

Duration of Study:

The study was conducted aty outdoor and indoor in Mayo Hospital from april 2016 to June 2017.

Materials and Methods:

The research is based on samples of 150 respondents. The respondents include doctors and nurses. Data was analysed using (SPSS) version 17.

Results:

There were more than 2/3 of the respondents (n = 101 / 150) about 67 %, who were victims of violent abuse (n = a little more than 12 months and (87 / 101) 86% of them were the main types of aggression encountered. About 61/101 (60%) of violent victims reported and most (25/61, 41%) have reported them to colleagues only. The most common reason of not reporting was "No previous action" 75%. The most common attacker, the patient's family (n = 68 / 101, 68%) followed by the patient himself (n = 31 / 101, 31%). Overcrowding and lack of security have been cited as the main causes of such incidents.

Conclusion:

Health care workers in public hospitals in Punjab are often subject to aggression and violence, and it are associated with many adverse consequences, that includes high levels of stress at workplace. A safer environment for hospitals and appropriate precautionary measures including occupational support are needed for the worker to work in a safe and peaceful environment leading to better performance.

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INTRODUCTION:

Workplace violence and aggression has been considered an important occupational hazard in health care establishments worldwide [1] and is a subject of in reading interest lately, both in the developed and developing countries [2]. Although steadily increasing there is no standard agreed definition of violence in it rapture. The World Health Organization (WHO) defines the violence as' an intentional use of force that causes an individual or group of people to cause injury, death or psychological harm [3]. Workplace Violence Another definition used by the International Labour Organization (ILO) in the study of extermination of former vessels is that 'events in the context of abuse, threat or attack are related to the definition of their work [4]. The use of violence and demographic research differences and in what constitutes human perceptions of change across border to develop a knowledge gap on precautionary measures. Another area that needs to be clarified is the reporting of these events, as well as institutional policies and training to deal with such incidents. Different cultural and social types of violence make it difficult to compare previous research findings.

The exact incidence of violence and aggression to health care workers (HCW) is unknown as reported under common [5]. In addition, many health-care workers have observed an acceptance of violence and aggression as part of their clinical work.6 Still, some studies have shown that 90% of health care workers report exposure to violence at work, which is fairly alarming [7]. Evidence suggests that violence and the health care aggression results not only in negative affect on the physical and emotional well-being of affected one, but also has serious consequences for the patient's effective health care delivery [8].

In addition to the dissatisfaction caused by the material addressed and low productivity.[9,10] Many studies have focused on the prevalence of violence and aggression and the huge factor in psychiatric hospitals [11,12] of the A & E working environment in public hospitals [13], welfare sectors[14] and nursing homes but most of these the study had have taken in the developed world . The results of these studies can only be applied to the developing world to a limited extent to the countries, including Pakistan, mainly because of the different organizational structures of medical settings. Violence and wasteland are a major concern in Pakistan's technological composition.

MATERIALS AND METHODS:

Cross sectional study conducted in govt. hospitals of Lahore. The sample of 150 respondents including doctors and nurses were interviewed. The ethics committee approved the study and was given the institutional review board. Data were collected through the various major departments of the hospital during the data collection period, at different times, to ensure that the various shift staff were on duty. We used the non-probabilistic sampling method and all staff (doctors and nurses) in their wards during the day were discussed and invited to participate in the study.

The oral and written interpretation of the purpose of this study was provided to participants, and informed consent was sought by former participants who completed the questionnaire. The questionnaire was anonymous to encourage participation. It is administered and collected immediately after completion of the data collection team. The questionnaire is composed of four parts. The first section seeks information about the general population of respondents (age, Kent, years of experience in the health care sector, occupation, educational level, the department). Section II gives respondents a binary file (yes / no) to answer questions about whether they have been subjected to any violence in the past year.

The answer is that certain people are asked to identify types of violence (physical aggression, verbal attacks, threats, harassment and verbal and physical; definitions of terminology and previous studies on this topic, source of violence etc. Respondents were asked to identify possible causes of violence as they encountered and their possible sequences were used as a basis for their well-being using a closed checklist of references the subject of the review.

In the last section, respondents were asked to rate three levels of violence against and support training colleges at all levels, low, intermediate and good, and to seek to prevent such incidents in the future in their workplace. Data was analysed using (SPSS) version.

Descriptive statistics are used to report the results. Chi-square tests were used to compare the frequency of violence among different professional groups between men and women. P values <.05 are considered to be equally important.

RESULTS:

Approximately 150 health care workers out of 210 agreed to participate in the study (response rate 71%). No further data were collected from those who refused to participate and were not available for analysis. Respondents were mainly young, with an average age of 30 ± 5.02 years. Male (n = 93, 62%) accounted for the majority of respondents. Doctors accounted for 80% (n = 120) and nurses 18% (n = 25) of the study samples. Respondents were recruited from three divisions; Medical and Allied (n = 85, 56%), Surgery and Allied (n = 59, 39%) and Emergency Department (n =07, 5%)

Table No. 1: Type, Place, Time, Source & Perceived Causes of Violent Incidents Encountered By Respondents In Tertiary Care Public Sector Hospitals In Lahore.

Variables	Frequency	Percentage
Place of violent act (n=101)		
Emergency department	76	76%
Ward	28	29%
Outdoor	12	13%
Time of violent act (n=101)		
Day	45	46%
Evening	39	39%
Night	36	37%
Source of violence (n=101)		
Patients Relatives	67	68%
Patients	30	31%
o - workers	50	51%
Others	4	4%
Possible Reasons for violence (n=150) (all respondents)		
Overcrowding	55	37%
Lack of security	49	33%
Negative media impact	51	34%
Excessive	46	31%
Shortage of staff	37	25%
Unmet Patients demand	34	23%
Patients health	32	21%
Lack of space	28	19%
Poor work organization	20	13%
Staff workload	18	12%
Irritating Staff attitude	7	5%
Inexperienced Caregivers	5	3%

Frequency and types of violence and aggression

Over two-thirds of the respondents (n = 101 / 150, 67 %) were victims of violent of abuse (n = over the past 12 months and (87 / 101, 86%) were the main types of aggression encountered. Workers exposed to violent aggression, the same high level of psychological distress. The most common attackers were the patient's family (n = 68 / 101, 68%) followed by the patient himself (n = 31 / 101, 31%). Overcrowding and lack of security are cited as the main causes of such incidents. Table 1 shows the various spectroscopic violent events, as well as the perceived causes, according to respondents.

Table No.2: Reporting of violence and reasons for not reporting by the health care professionals

Aspects		Frequency	%age
Reporting violent event (n=101)	Yes	61	61%
	No	40	39%
To whom reported (n=61)	Colleagues	26	41%
	Direct Supervisor	15	26%
	Hospital Management	14	24%
	Police	4	5%
	Relatives	2	3%
Reasons For Not reporting (n=40)	No Previous action	30	73%
	Feel it as part of job	15	37%
	Fear of consequences	5	11%
	Preparatory apologized	4	10%
	Lack of evidence	2	7%

Table No.3: Consequences of violence & aggression in workplace as identified by the study respondents

Effect of Violence	Frequency (150)	%age
Fear	30	20%
Anger/Rage	62	41%
Distress	45	30%
Anxiety/self-doubt/insecurity	35	23%
Humiliation	31	21%
Guilt	7	5%
Disappointment	37	25%
Helplessness/sadness	16	11%
Depression	12	8%
Became careful	20	13%
Physical impairment	-	-
Intention to quit workplace	13	9%
Intention to change behaviour	9	6%
Direct for revenge	2	1%
No reaction	9	6%

Reporting of the incidents: Only 61/101 (60%) of violent victims reported incidents of violence and most of the incidence (25/61, 41%) reported to colleagues only. "No previous action" (75%) was the most common reason not to report.(Table 2).

Consequences of violence at work

Seventy interviewers (47%) felt extremely stressed due to violence and various consequences of violence identified in (Table 3).of their institutions trained to handle (65%) of workplace violence and. The level of support (61%) for workforce violence was 75% low.

DISCUSSION:

A significant proportion (72%) of respondents in the study experienced workplace violence during the past year. The literature review revealed a range from 0.5% to 90% [15-17]. Other studies that focused on oral and physical aggression separately as healthcare 72% experienced physical and 80% verbal aggression over the last 12 months in Germany.[18] One out of ten workers reported physical attacks and one out of three non-physical attacks prevalent in public health care facilities in Italy [19]. Frequency of verbal attacks and facing physical aggression direct contact of health care with highly stressed patients and families due to illness [8,9] unrestricted visits of attendants in hospital, violence HCW with a high degree of emphasis on patients in the hospital, over crowded [10,11] and lack of hospital staff training in dealing with aggression are the major factors of high violence in hospitals.

Differences between study setups, medical systems and population studied are difficult to compare with the results of various studies but still very high numerical reports in our study and previous studies underscore the importance of violence and aggressive problems faced by healthcare workers in the workplace. Violence and aggression, negative consequences for physical and mental health are also confirmed in previous studies. The study found that healthcare workers coping with aggression was similar in different national, cultural characteristics and settings, including immediate reactions, such as fear, anger, anxiety [20,21] and intends to quit as profession [22]. As Expectations of our study-respondents who report-like anger, pain and guilt, as well as high work-related stress, thus transforming staff dissatisfaction and poor patient care in the negative effects of exposure to violence have been vulnerable to the health care service system. Our findings corroborate the report of the pre-set report under the HCW, the violence and aggression incident facing institutional authorities. Most of the staff seemed to have received support from the informal discussions of their colleagues. Only a small part of the actual situation of cases report [5,23] the trend of emergence of also bullying research among the faces by junior doctors in Pakistan.[24] No support from seniors, complicated reporting protocols and policies from institutes in this regard and acceptance of aggression causes low case report.

Majority of the respondents felt unprepared to deal with aggression and violence at workplace. Institutions should offer better training for managing violence and effectiveness of the training should be assessed by regular feedback from the staff. Several limitations need to be taken into account in the interpretation of our findings. First, because our study is limited to one institution, the result is limited. However, our findings are consistent with the literature on the subject and we do not have any reason to believe that this situation is not the same in other public health institutions in Bahawalpur. Retrospective studies also lead to recall bias. We rely on staff reporting measures to focus on the HCW point of view, which may not be accurate in all cases, but the lack of relevant records and reports allows us to use any objective criteria. Also how the event is viewed rather than the actual event itself has been observed to have significant consequences for individual.

CONCLUSION:

In short, violence in Pakistan's medical institutions is a hidden phenomenon. Our findings suggest that it exists and should be avoided. There is also a need for good work practices, along with a downgrade of technical policies and organizational security policies that may also reduce the risk of workplace violence in the direction of staff training. Support for workplace and team spirit can be further useful and effective in this regard.

Conflict of Interest: The study has no conflict of interest to declare by any author.

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