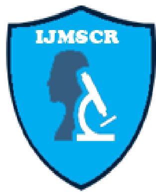

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Workplace Violence against Health Care Personnel in a Tertiary Health Care Institute of Purba Bardhaman District of West Bengal, India

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Abstract

Background: Violence in health sector although being a global issue as well as an alarming burden in India, has received limited attention till now. The present study aimed at estimation of magnitude, nature and perceived causes of workplace violence (WPV) in health sector and exploration of the possible measures to prevent it.

Methods: A mixed method study was undertaken in Burdwan Medical College and Hospital a tertiary health care facility of West Bengal, during September – December 2018 among different types of health care personnel. Assuming WPV in doctors, nurses and staffs 13.8%, 43% and 42%, taking 95% confidence interval, 5% allowable error and non-response of 10%; sample size for them became 201, 415 and 411 respectively among which 192 Doctors, 384 Nurses and 384 other support staffs gave consent. They were serving there for at least 12 months and were interviewed using Survey questionnaire. Data collection was done applying probability proportional to size sampling in each work station till the desired number of sample size was achieved.

Results: Among doctors, nurses and other support staffs 75%, 90.1% and 87.5% were exposed to workplace violence respectively among which verbal abuse was the most prevalent. Doctor patient miscommunication, lack of manpower, political influence was few of the salient reasons of violence in health sector.

Conclusion: The study highlights several issues like behavioural aspects, communication gaps between service provider and beneficiaries, resource crisis and political as well as social factors to be causative for violence in health sector

Keywords: Violence, Workplace violence, Survey questionnaire, Doctor patient miscommunication

Introduction

Violence in workplace has become a burning issue now a days and health sector are the mentionable sufferer in this aspect. Violence may be defined as behaviour involving physical force intended to hurt, damage or kill someone or something, and when that violence happens in the place of health seeking that ruins the care, care providers as well as the health benefits supposed to come out of it. Doctors, nurses and other support staffs are the care-providers in the health sector. World Health Organisation (WHO),

International Council of Nurses (ICN), International Labour Office (ILO) and Public Service International (PSI) have launched a joint programme to reduce workplace violence and to minimize the negative impact on the victims and services. They have defined Workplace violence (WPV) as "Incidents where staff are abused, threatened or assaulted in circumstances related to their work including commuting to and from work involving an explicit or implicit challenge to their safety, well-being or health". [1] The survey is to be done using a survey questionnaire. The violence in health sector is now a global issue, [2][3][5][6][7]and also being alarming in India. [8] To prevent this WPV [4] or before taking any minimisation efforts one must have the idea of the magnitude of this burden. But till now this workplace violence has received limited attention. [9] WPV may be verbal, physical, psychological as well as sexual. In a study of south Delhi verbal abuse was proved to be more prevalent than physical violence. [10] Tertiary health care institutes being the uppermost tier of health care delivery system and comprising of so many health facilities are more prone to WPV as the loads of expectations from the beneficiaries also poses a challenge which very often results in untoward happenings due to un-fulfilment.

Purba Bardhaman is one of the 23 districts in West Bengal. There are 94 Primary Health Centres, 31 Block Primary Health Centres, 6 Rural Hospitals, 4 Sub-divisional Hospitals and a District Hospital. No study is available in West Bengal regarding workplace violence at best and there is lack of information about this burden at worst. In this context the present study was planned with the objective of estimating the magnitude and nature of workplace violence in Burdwan Medical College and Hospital which is the tertiary health care institute of Purba Bardhaman district.

Objectives:

1. To estimate the magnitude and nature of workplace violence against health care personnel in Burdwan Medical College and Hospital (BMCH).
2. To explore the perceived causes of workplace violence and the possible measures to prevent it.

Methods

Study Type And Design: This was a mixed method study.

Study Area: Burdwan Medical College; the study was conducted in all the work stations which provide health care services.

Study Duration: The study was done during September– December 2018.

Study subjects: The study was done among different types of health care personnel i.e. Doctors (House-staffs, Junior and Senior Residents as well as Visiting Doctors) Nurses (Staff Nurses as well as on duty Nursing Students) and other support staffs (Laboratory Technicians, Word Boys etc.) who were engaged in providing health care.

Inclusion Criteria: All the health personnel who were working in BMCH, giving consent and were serving in this hospital for at least 12 months were included as study subjects.

Exclusion Criteria: Health personnel who were seriously ill or absent on the day of visit were excluded.

Sample Size: According to a study done in UK, "Aggression towards health care staff in a UK general hospital: variation among professions and departments",[2] 13.8% of doctors, 43% of nurses and 42% of staffs have faced violence. Assuming these to be the magnitude of violence in workplace, taking 95% confidence interval and 5% allowable error; using the formula $Z^2 \times p \times (1-p) \div L^2$ [Z= 1.96, p = prevalence, L = allowable error] the sample size for doctors, nurses and other support staffs became 183, 377, and 374 respectively. Considering non-response of 10% the sample size became 201, 415 and 411. As 9 doctors, 31 nurses and 27 support staffs did not respond the interview was undertaken using the questionnaire among 192 doctors, 384 nurses and 384 support staffs.

Sampling Technique: The study had a quantitative as well as a qualitative component, i.e. a mixed method study was being planned. The lists of health personnel were collected from all the work stations. The required number of doctors, nurses and other support staffs from each work station were selected after that applying Probability Proportional to Size sampling. Data collection was done in each work

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station till the desired number of sample size was achieved.

14 doctors, 18 nurses and 11 support staffs were identified to be the victims of workplace violence in the last 2 weeks of data collection. Out of these 43 health care personnel six from each stratum i.e. 18 health personnel were included as the study subjects in Focussed Group Discussions (FGD) to explore the perceived causes of workplace violence. In-depth interview were (IDI) done with the rest 25 individual.

Tools and Technique: The questionnaire developed by the joint programme of International Labour Office (ILO), World Health Organisation (WHO), International Council of Nurses (ICN) and Public Service International (PSI) regarding workplace violence was used. The tool contained series of questions regarding socio-demographic features of the health personnel, nature of violence, professional position of the worker, reporting of violence, measures taken against the violence, organisational support etc. We interviewed the study subjects and recorded their response using the questionnaire.

43 health care personnel were identified to be the victims of workplace violence in last two weeks of data collection. 3 Focussed Group Discussions (FGD) were conducted using an FGD guide; each interview comprising 6 health personnel.

In-depth interviews (IDI) were done with rest 25 individual. Three Key Informant Interviews (KII) were done among senior faculties associated with hospital administration.

Study variables:

Basic socio-demographic variables: Age, Sex, Marital status, Migration from other country

Exposure variables: Professional position, work experience, interaction with patients, maximum time spent in main job etc.

Operational definition:

Exposure to workplace violence: Exposure to workplace violence was meant to the experience of the individual to at least any one type of violence (physical, psychological, verbal abuse, sexual violence as well as racial harassment) in last 12 months.

Outcome variables:

1. Proportion of Doctors, Nurses and Other support staff facing Workplace Violence.
2. Proportion of physical violence and psychological violence (verbal abuse, bullying/mobbing, sexual violence and racial harassment)
3. Major causes/ factors contributing to WPV.
4. Major suggestions for prevention of WPV.

Ethical considerations:

Ethical clearance was sought from Institutional Ethics Committee of Burdwan Medical College, Purba Bardhaman. Informed consent was obtained from each and every respondent and they were also assured regarding confidentiality of the information.

Data collection:

The investigator prepared the list of all the workers who were then working in the BMCH and full-filing the eligibility criteria. After taking consent of the participants, respondents were interviewed. The health personnel were asked to state the experiences of preceding 12 months regarding physical and psychological violence including verbal abuse, bullying/mobbing, sexual violence as well as racial harassment.

A total of 25IDI were conducted to elicit the perceptions of the victimised health personnel. One participant and one interviewer were engaged in each interview lasting not more than 20 minutes. Participants were posed with neutral questions but no leading questions. Their responses were heard with attention and follow up questions were only asked if it was necessary. They were not shown any approval or disapproval of what they said.

3Focussed Group Discussions (FGD) were undertaken with the 18 health care personnel comprising 6 participants in each session with the help of a predetermined FGD guide composed of some guiding questions. There was a moderator for conducting the discussion and a recorder to note down the proceedings. The discussions were conducted at a place and time according to the convenience of the participants. They were asked to sit in a semi-circular manner so that each one of them is in the view of the other. The moderator started the discussion after addressing the participants and briefly described the topic of interest. Then the predetermined logically sequenced open-ended

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questions were asked to understand the perception of the participants regarding the reasons of workplace violence. Complete proceedings of the discussion including sociogram were noted and electronic recording of the session was done. Each session lasted for not more than 30 minutes. Participants were assured regarding anonymity of their responses. The recordings were kept in a locked facility safely and after transcribing word for word on the same day they were destroyed.

Data Analysis:

For The Quantitative Data:

After collection data were checked to assure completeness and consistency and were entered into Microsoft Excel sheet. It was checked twice to detect any erroneous entry. Descriptive statistics was applied to summarise the demographic characteristics and frequency of health worker's response related to different outcome measures. SPSS-20 was used to analyse the data.

For The Qualitative Data:

Data collection and analysis were done simultaneously. After each interview and each FGD, data including all field notes and recorded audio were transcribed and translated from local language to English; close to verbatim on the day of data collection. Then all the interview transcripts were coded separately and any discrepancies in the coding were sorted out. Coded notes were thematically analysed and emerging themes were identified using illustrative quotations. Finally, a free-listing was done using Smith's Salience Value and pile sorting were conducted by key informants. In the pile sorting exercise, the key informants were asked to group those selected reasons which they opine to be gathered with a justification and also to suggest possible solutions for prevention. Data were analysed using Anthropac4.983 software. Two-Dimensional Scaling and Hierarchical Cluster Analysis of pile sorted data were undertaken. Debriefing of findings of free-listing, pile sorting and focussed group discussions to the participants were done to increase the credibility of results.

Results:

Magnitude and nature of workplace violence:

Majority of the doctors and support staffs belonged to age group of 30-34 years while majority of the nurses belonged to that of 25-29 years. 52.1% of doctors and 91.1 % support staffs were male. Majority of the health care personnel were married. (Table:1) 75% doctors, 90.1% nurses and 87.5% support staffs in BMCH were exposed to workplace violence. (Table: 2)

Table 3 showed that majority of the workplace violence was psychological in nature. All the health care personnel who faced violence in their workplace were verbally abused while magnitude of physical violence was the highest among support staffs (29.8%) and the least among nurses (15%). Among doctors 25% were the victims of physical violence. Bullying or mobbing was experienced by 33.3% doctors, 17.3% nurses and 25% support staffs. No episode of sexual violence or racial harassment was noted.

Table 4 revealed that majority of the workplace violence occurred among health personnel having lesser work experience. In every profession of health sector (doctors, nurses and other support staffs) violence was highest among those having work experience of 1-5 years and least among those having work experience greater than 20 years.

Exploration of perceived causes of workplace violence and possible measures to prevent it:

IDI of 25 health care personnel as well as 3 FGDs identified several causative factors of workplace violence. Themes that emerged out of these discussions and interviews were listed in Table 5. Few important causes perceived by them were:

Doctor Patient Miscommunication

Doctor – patient miscommunication was heard too many times during the interviews and discussions. In most of the case doctors do their duties knowing the things better than anyone but at the same time the lack of communication with the patients become the major issue creating lots of questions in the minds of the patient's relatives. One nurse told about this communication gap:

"maybe physical, may be verbal, may be even non-verbal waving you know…but you should let him know that yes I have heard that you searched me…don't worry …you are fine…this is

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communication…this is missing…the patient tells his relatives in visiting hours and a mob is now ready to ask you "why didn't you listen?" this is miscommunication… no one cares that you were serving another patient…so I think we should increase effort on this…doctor patient miscommunication"[Nurse 6, 35 years]

Lack Of Manpower

Another thing which was voiced so many times almost in every interview was the lack of manpower enhancing huge workload for the providers which is responsible for lesser time and care per patient. One doctor told that:

"lack of manpower…see…perhaps at night suppose a group D staff and a support staff are there who is at O.T. somehow at a particular point of time one of them is not present there and when we tell the staff who is present there to do the job of his partner he is not ready to do that…this is not my duty…let him come…now we come to verbal abuse…we abuse the staffs…like useless unprofessional needs to be replaced…they get irritated… but can't tell us as we are doctors…same with the sisters…suppose they bear with us since 4a.m. in the morning…had not enough time for even dinner… assisting us…assisting us…perhaps she has no one to rotate with her…suddenly she left the place and we start abusing them… how can she go leaving everything amidst an operation…in simple word lack of manpower…" [Doctor 2, 29 years, female]

Political Influence

Among some external issues the political influence plays a big role in creating workplace violence. Few external people with some recommendation from political leaders demands special facility in the hospital which if not dealt with proper care is an inevitable reason behind violence. One staff told:

"this is much more in Burdwan… I don't know how it is anywhere else…but people out here are very driven by power…you know…like from where with whose recommendations one is coming…so, they are concerned about their influences…It is difficult to say you know…but yes, it is… the political influence…if you are not handling with care… chaos is for sure…" [Staff 3,40 years, male]

Social Media

FGD and IDI both reported social media to be a major negative influence creator in people's mind. One doctor told that:

"look, this has become a trend now a days that you go to hospital…if anything goes wrong call media first…oh you know…some goes Facebook live…basic misunderstandings were in the past also…but today…anything goes wrong…anything you say…repeated attempts of channel…social media however does it in arteries…(laugh) they will make a news…they need bytes…they have a responsibility in creating the public awareness…what they are telling the people?

Sticks instead of stethoscope in doctor's hand…you do polio campaigning…so don't you think even one percentage of effort if given by social media to make people aware that doctor is not your enemy the problem may be solved? Think before you do…" [Doctor 3, 42 years, Male]

Decreased Security

According to many health personnel decreased security is a major problem as perceived by them. One doctor told:

"…yes, you can prevent a lot of mis happening by your every effort; be it communication, be it behaviour, be it patience but lastly we need more security as you go for the curative aspects of this violence…that's it." [Doctor 5, 35 years, Male]

Free listed items with Smith's Salience value responsible for workplace violence were presented in Table 6. Two-dimensional scaling and hierarchical clustering of pile sort data gave five subgroups. Then these subgroups were again clubbed due to the reasons of relation between them. Ultimately three subgroups were obtained according to key informants.

Subgroup 1 – Item no. 6,8,11,13,9,1,10 – Behaviour and communication issues

Subgroup 2 – Item no. 2,4,7,12 – Resource crisis

Subgroup 3 – Item no. 3,5 – Social factors

Discussions:

In the present study 75% doctors had been exposed to workplace violence. This finding was in contrast to

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that of a study done by Anand T et al.[8] among the resident doctors of a tertiary care in Delhi where 40.8% doctors had experienced violence in workplace. However, the present study finding was in line with the findings of a study done by Ori et al.[11] in Manipur in 2014 where 78.3% doctors had experienced workplace violence. In the present study 87.5% support staffs and 90.1% nurses experienced workplace violence which was similar to the finding of a study done by Imran N et al.[6] in which 74% health care workers experienced violence in a public health care facility in Lahore.

In the present study it was seen that verbal abuse was the most common type of violence among health care personnel which was similar to the finding of Anand T et al.[8]Arimatsu M et al.[12] and Kowalenko T et al.[13]

In the present study the perceived causes of workplace violence were doctor patient miscommunication, lack of manpower, political influences, workload of providers, social media, decreased security, punishing attitude of authority, decreased security, delay in test procedures, patient party's intolerance etc. Suggested solutions to prevent the workplace violence were enhancing security, development of policies by authority, creating counselling cites for patients at every work station, increasing manpower, improving facilities, strengthening legislation, regular training of providers on communication skill, increasing public awareness about the role of health personnel etc. This finding had a similarity with that of a study done by Imran N et al.[6] in a public health care facility in Lahore, Pakistan where the suggested measures to prevent the workplace violence were adequate security, policy making by hospital management and educating the patients and their families etc.

Conclusions

The present study reveals workplace violence in public health facility is a topic of high concern which is to be dealt with an immediate effect. The study highlights several issues like behavioural aspects, communication gaps between service provider and beneficiaries, resource crisis and political as well as social factors to be causative for violence in health sector. Measures are to be taken in various platforms i.e. increasing resources, policy development, strengthening legislation, patient's counselling, provider's communication training and even using the mass media enhancing public awareness are to be ensured. Further studies in this regard would be more helpful to dream an health sector free from nosocomial disharmony.

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Ethical Approval: Ethical clearance was sought from Institutional Ethics Committee of Burdwan Medical College, Purba Bardhaman. Informed consent was obtained from each and every respondent and they were also assured regarding confidentiality of the information.

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Tables and Diagrams:

Table 1: Socio-demographic characteristics of the study population:

Characteristics	Doctors (n_1=192) No (%)	Nurses (n_2=384) No (%)	Support staffs (n_3=384) No (%)
AGE			
≤19	-	-	4 (1.0)
20-24	25 (13.0)	70(18.2)	50(13.0)
25-29	35 (18.2)	100(26.0)	90(23.4)
30-34	60 (31.3)	90 (23.4)	130(33.9)
35-39	40 (20.8)	60 (15.6)	70 (18.2)
40-44	14 (7.3)	24 (6.3)	32 (8.3)
45-49	6 (3.1)	16 (4.2)	8 (2.1)
50-54	5 (2.6)	10(2.6)	-
55-59	5 (2.6)	9 (2.3)	-
≥60	2 (1.0)	5 (1.3)	-
SEX			
Male	100(52.1)	-	350 (91.1)
Female	92 (47.9)	384(100)	34 (8.9)

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Marital status			
Single	50 (26)	140 (36.5)	150(39.1)
Married	132(68.8)	220(57.3)	200(52.1)
Living with partner	-	-	9 (2.3)
Separated/ Divorced	-	10 (2.6)	15 (3.9)
Widow/er	10 (5.2)	14 (3.6)	10(2.6)

Table 2: Distribution of study population according to exposure to workplace violence:

Exposure to workplace violence	Doctors (n_1=192) No (%)	Nurses (n_2=384) No (%)	Support staffs (n_3=384) No (%)
Present	144 (75)	346 (90.1)	336 (87.5)
Absent	48 (25)	38 (9.9)	48 12.5)

Table 3: Distribution of study population exposed to workplace violence according to nature of violence*:

Nature of violence	Doctors (n_1=144) No (%)	Nurses (n_2=346) No (%)	Support staffs (n_3=336) No (%)
Physical	36 (25)	52 (15)	100 (29.8)
Psychological	144(100)	346 (100)	336 (100)
Verbal abuse	144 (100)	346 (100)	336 (100)
Bullying /mobbing	48 (33.3)	60 (17.3)	84(25)

*This is a multiple response table.

Table 4: Distribution of study population exposed to workplace violence according to their work experience:

Work experience (years)	Doctors (n_1=144) No (%)	Nurses (n_2=346) No (%)	Support staffs (n_3=336) No (%)
1-5	58 (40.3)	160 (46.2)	140 (41.7)
6-10	48 (33.3)	90 (26.1)	120 (35.7)
11-15	36 (25)	60 (17.3)	60 (17.9)
16-20	1 (0.7)	24 (6.9)	10 (2.9)
>20	1 (0.7)	12 (3.5)	6 (1.8)

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Table 5: Pile sorting of causes of workplace violence into themes with reasons and suggested measures for prevention by key informants (Senior administrators)

Pile number	Theme	Causes of workplace violence	Reasons for grouping	Suggested measures for prevention
1	Behaviour related factors	1.Egoistic problem 2.Own profession misconduct 3.Intolerance of patient party	Directly related to behaviour of the health personnel and patients	1.Behaviour change communication among service providers 2.Counselling site creation for patients at every work station
2	Resource related factors	1.Lack of manpower, 2.Workload of providers 3.Decreased security 4.Delay in tests and reports	Directly related to resources – man, money, material and time	1.Increasing manpower 2.Improving facilities 3.Enhancing securities at every work station 4.Developing policies
3	Communication related factors	1.Doctor-patient miscommunication, 2.Lack of communication skills	Directly related to the communication between people (health-personnel and patients)	1.Regular training of service providers on communication 2.Regular meeting of different departments discussing issues and identifying problems
4	Management related factors	1.Punishing attitude of authority 2.Reluctance of senior faculties	Directly related to managerial skill	1.Training of authorities regarding management

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				regularly
5	Social factors	1.Social media 2.Political influence	Directly related to society	1.Making people aware about health personnel 2.Strengthening legislation

Table 6: Relative ranking of causes of workplace violence:

CODES	SMITH'S S VALUE
Doctor patient miscommunication	0.48
Lack of manpower	0.46
Political influence	0.42
Workload of providers	0.38
Social media	0.28
Punishing attitude of authority	0.22
Decreased security	0.19
Reluctance of senior faculties	0.113
Own profession misconduct	0.111
Lack of communication skill	0.09
Egoistic problem	0.09
Delay in tests, long waiting in the line	0.084
Patient party's intolerance	0.076

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Figure 1: Cognitive map showing relationship between perceived causes of workplace violence

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