BMJ Public Health

Experiences of healthcare workers who faced physical workplace violence from patients or their relatives in Nepal: a qualitative study

Mukesh Adhikari ,[1,2,3] Dinesh Timalsena,[4,5] Kalpana Chaudhary[3,6]

To cite: Adhikari M, Timalsena D, Chaudhary K. Experiences of healthcare workers who faced physical workplace violence from patients or their relatives in Nepal: a qualitative study. *BMJ Public Health* 2024;**2**:e001032. doi:10.1136/bmjph-2024-001032

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/bmjph-2024-001032).

MA, DT and KC contributed equally.

Received 10 February 2024
Accepted 24 April 2024

For numbered affiliations see end of article.

Correspondence to
Mr Mukesh Adhikari;
adhmukesh@gmail.com

ABSTRACT:

Introduction Workplace violence (WPV) against healthcare workers (HCWs) has become a global concern. Our aim was to investigate the firsthand experience of HCWs who faced physical WPV from patients or their relatives in Nepal and to identify the factors that contribute to WPV, its consequences, as well as recommendations from HCWs on preventing and managing WPV in healthcare settings.

Methods We conducted semistructured in-depth interviews of 12 HCWs who faced physical WPV from patients or their relatives in the last 2 years in Nepal. We recruited participants by announcing volunteer participation on social media and reaching out to HCWs who had experienced WPV through a review of national news archives. All interviews were conducted between September and November 2022. We analysed the data using a hybrid thematic analysis.

Results Most participants were male (9/12). The average age of participants was 31.6 years with an average experience of 8.3 years. We generated three domains: (1) factors contributing to WPV, (2) response to WPV and (3) recommendations. Within these three domains, we identified a total of nine themes: two themes (proximal and distal factors) under domain 1, four themes (personal response, hospital administration response, police response and other responses) under domain 2 and three themes (recommendations at personal, organisational and policy level) under domain 3. We found that physical WPV against HCWs is multifactorial. Most HCWs did not receive expected support from hospital and police administration. They had a wide range of recommendations at personal, organisational and policy level. The most important recommendation was to ensure safety and security of HCWs.

Conclusions This qualitative study showed that experiences of HCWs who faced physical WPV in Nepal were traumatic. The concerned stakeholders should carefully consider the recommendations from HCWs to establish a safe, secure and supportive working environment.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Workplace violence (WPV) against healthcare workers (HCWs) has become a global concern since its prevalence is more than 60% around the world.
⇒ The WHO estimates that 8%–38% of HCWs experience physical WPV at certain points in their professional careers and the perpetrators are mostly patients or their relatives.
⇒ Recent studies in Nepal showed that prevalence of WPV ranges from 51% to 65% among doctors and nurses, with physical WPV ranging from 13% to 15%.

WHAT THIS STUDY ADDS

⇒ Most HCWs reported that patient or near relatives who were affiliated to political parties or had a linkage with authorities were more likely to commit WPV compared with those who were not.
⇒ HCWs who faced physical WPV from patients or their relatives in Nepal had a traumatic experience, leaving longer run emotional and psychological impact on HCWs at personal level, and affecting healthcare quality and availability of health workforce at system level.
⇒ HCWs received adequate support from family and friends but less support from hospital and police administration.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Further research is needed to investigate the linkages between patient's lower socioeconomic condition and WPV, as well as the connections between political affiliation and WPV.
⇒ For hospital administration, this research highlights the need of regular risk assessments, continuous communication between management team and HCWs, proper alarm and security system in working environment, crowd control mechanisms and strong supportive system.
⇒ The study findings serve as a wakeup call for policymakers to establish effective mechanisms that ensure implementation of existing legal provisions against perpetrators of WPV; this is essential to uphold the government's commitment to preventing WPV against HCWs.

INTRODUCTION

Workplace violence (WPV) against healthcare workers (HCWs) has become a global concern, with recent evidence indicating that nearly six in 10 HCWs worldwide have encountered some form of WPV,[1 2] ranging from verbal abuse to physical attacks. Most WPV can lead to reduced job satisfaction, mental stress, burnout and poor quality of life at personal level[3–6], and it can reduce quality of care at health system level. These consequences could be more severe in physical WPV compared with verbal abuse or threats. The WHO estimates that 8%–38% of HCWs experience physical WPV at certain points in their professional careers and the perpetrators are mostly patients or their relatives.[7] While the prevalence of physical WPV is stable in Europe and decreasing in North America, it has increased significantly in Asian countries, reaching 25% in 2010–18 compared with 19.6% in 2000–09.[1]

Nepal, a low-income country in South East Asia, has a weak health system characterised by poor infrastructure, inequitable distribution of healthcare services and inadequacies of human resources for health.[8] Amid such constraints, HCWs have to provide adequate and quality care on the one hand and face the challenges of WPV on the other. Although the nationwide prevalence of WPV in healthcare settings has not been documented, recent studies showed that prevalence of WPV ranges from 51% to 65% among doctors and nurses, with physical WPV ranging from 13% to 15%.[9–11]

Previous studies have widely explored the phenomenon of WPV against HCWs; however, most studies are from high-income and middle-income countries,[1 12 13] highlighting the need of evidence generation from low-income countries. In Nepal's context, some studies have been conducted in workplace violence, but they are mostly quantitative, estimating the prevalence of WPV and the associated factors.[9 11 14] Such studies are important to understand the burden of the problem; however, qualitative studies are needed to adequately understand the immediate and underlying causes, detailed experience of HCWs and how HCWs cope with such traumatic events. Recently, a qualitative study was conducted in Nepal to explore nurses' experience of WPV,[15] but it was limited to COVID-19 experience. From a legal perspective, Nepal revised 'Health Worker's and Health Institution Safety Related Act' in 2021.[16] The revision includes increases in financial penalties and jail sentences for perpetrators. However, there is limited scientific evidence regarding the effective implementation of the act.

Understanding HCWs detailed experience with WPV by patients or their relatives is important for comprehending the circumstances, underlying factors and psychological/emotional impacts. These insights can be used for policy interventions to create a safe, supportive and resilient healthcare environment. Therefore, this study aimed to identify the factors that contribute to WPV, its consequences, as well as recommendations from HCWs on preventing and managing WPV in healthcare settings.

METHODS

Study design

We conducted a qualitative study using online semistructured in-depth interviews and hybrid thematic analysis approach.[17]

Patient and public involvement

Patient or public were not involved in the design, conduct, reporting or dissemination phases of our study.

Participants

The study participants were the HCWs who faced physical WPV by patients or their relatives in Nepal in the last 2 years (2020–22).

Data collection

We conducted semistructured interviews with HCWs who experienced physical WPV by patients or their relatives. To enrol participants, first, we used social media such as Facebook, LinkedIn and Twitter, where we shared an online survey link to screen HCWs facing WPV by patients or their relatives. We used a purposive sampling method where we particularly shared the survey link to the social media group of doctors, nurses and paramedics in Nepal. Since this study is a qualitative study, and the purpose of the online survey is to identify the HCWs who faced physical WPV for in-depth interviews, we did not calculate the sample size beforehand. The survey gathered sociodemographic information and type of WPV incidents. A total of 99 health workers completed the screening, with 59 (59.6%) reporting violence. Of these, 11 (18.6%) experienced physical WPV by patients or their relatives. As the initial survey lacked sufficient inclusivity, and all surveyed individuals who had physical WPV were not willing to participate for in-depth interview, we turned to explore Nepali news media to identify the HCWs who experienced physical WPV. First, we used the Google search engine to identify the news article using keywords such as 'health workers', 'doctors', 'nurses', 'paramedics', 'violence', 'assault', 'physical attack', 'hospital vandalism' and 'Nepal'. Additionally, we employed these key words with their Nepali language translations. Second, we visited the websites of top online news portals in Nepal to identify the violent incidents against HCWs. Through these two exercises, we identified six additional HCWs who had experienced physical WPV. Finally, we reached out to the local health coordinators, district health officers and hospital managers to establish connections with potential study participants. While recruiting the participants, we adhered to the following inclusion and exclusion criteria. Inclusion criteria: (1) HCWs who faced physical WPV in the last 2 years; (2) HCWs aged between 18 and 60 years. Exclusion criteria: (1) HCWs not actively providing clinical services; (2) non-HCWs who were working in healthcare facilities.

For sample size determination, we applied the information power concept by Malterud *et al*.[18] Initially, we planned to interview 12–16 participants. During analysis phase, we continuously evaluated the adequacy of the sample size, and with code saturation, we ended up taking 12 interviews. Given that our study aimed to specifically explore the experience of a highly specific study population (HCWs experiencing physical WPV by patients or their relatives), our interviews were robust, providing rich information. Furthermore, with an analysis based on a predetermined framework, a sample of 12 participants was considered sufficient to achieve information power.

We developed the semistructured interview guide, primarily based on an integrated model of WPV in healthcare by Bhattacharjee,[19] with some additional components from a previous qualitative study in India.[20] We divided our interview guide into three domains: (1) factors contributing to WPV; (2) response after WPV and (3) recommendations. We pretested the interview guide in two participants and revised it in subsequent interviews (see online supplemental file 1). Two trained qualitative researchers (DT and KC) conducted virtual interviews with participants in Nepali language through Zoom (https://zoom.us/). Notes were created immediately after interview, which lasted for 45 to 75 min. The recorded interviews were transcribed and analysed in Nepali language by DT and KC. Finally, MA, DT and KC translated relevant quotes in English. We adhered to the Standards for Reporting Qualitative Research for reporting.[21] We received ethical approval from the Nepal Health Research Council (Registration No. 233/2022 P).

Table 1 Characteristics of the participants

Characteristics	Frequency
Age in years (median, range)	29 (21–48)
Gender	
Male	9
Female	3
Experience in years (median, range)	7 (1–25)
Educational status	
Clinicians (MBBS or consultant physician)	6
Paramedics (health assistants or auxiliary health workers)	3
Nurses (staff nurse or higher level of nursing)	3
Type of health facilities	
Tertiary hospital	5
Secondary hospital	4
Primary healthcare facility	3
Health facility ownership	
Public healthcare facility	9
Non-public healthcare facility	3
Highest education	
Graduate level	3
Undergraduate	5
Diploma level or less	4

MBBS, Bachelor of Medicine and Surgery.

Consent

We obtained written consent from each participant where we provided detailed information about the study and potential consequences. Before interview, we reiterated the interview protocol and assured participants of the confidentiality of their responses. To maintain privacy, we ensured that the participants positioned themselves in a private space. Participants were not asked to review transcripts.

Analyses

We employed a hybrid thematic analysis approach[17] using both a priori deductive codes and generating new codes from the data using inductive approach. This approach was adopted to capitalise the benefit of both theory-driven and data-driven strategies. We had predetermined domains and potential themes based on the integrated model of WPV in healthcare (a theory-driven strategy)[19] while also aiming to comprehensively understand the Nepali context through a data-driven strategy. Furthermore, qualitative methodologists have recommended thematic analysis as an appropriate method for analysing experience, opinions and perspectives.[22 23]

Interviews were coded independently by DT and KC using Dedoose 9.0.62 (https://dedoose.com/). Prior to coding, three researchers (MA, DT and KC) established a common understanding of coding procedures and coding scheme. The coding process comprises two cycles[24]; the first cycle involved summarising the segments of data, while the second cycle generated pattern codes or categories. The coders (DT and KC) recorded the coding procedures and their rationales. Thereafter, MA evaluated the coding outputs and documented agreements and disagreements in coding; disagreements were addressed by MA. To reach final consensus, all authors (MA, DT and KC) engaged in discussions to identify the potential sources of disagreements and ultimately finalised the subthemes and themes across the three domains.

RESULTS

Sample characteristics

Most participants were male (9/12). The average age of participants was 31.6 years with an average experience of 8.3 years. Table 1 shows the detailed characteristics of our participants. We generated nine themes under three domains (figure 1). The detailed coding scheme is presented in online supplemental table 1. Hereafter, we discuss subthemes under each theme across three domains.

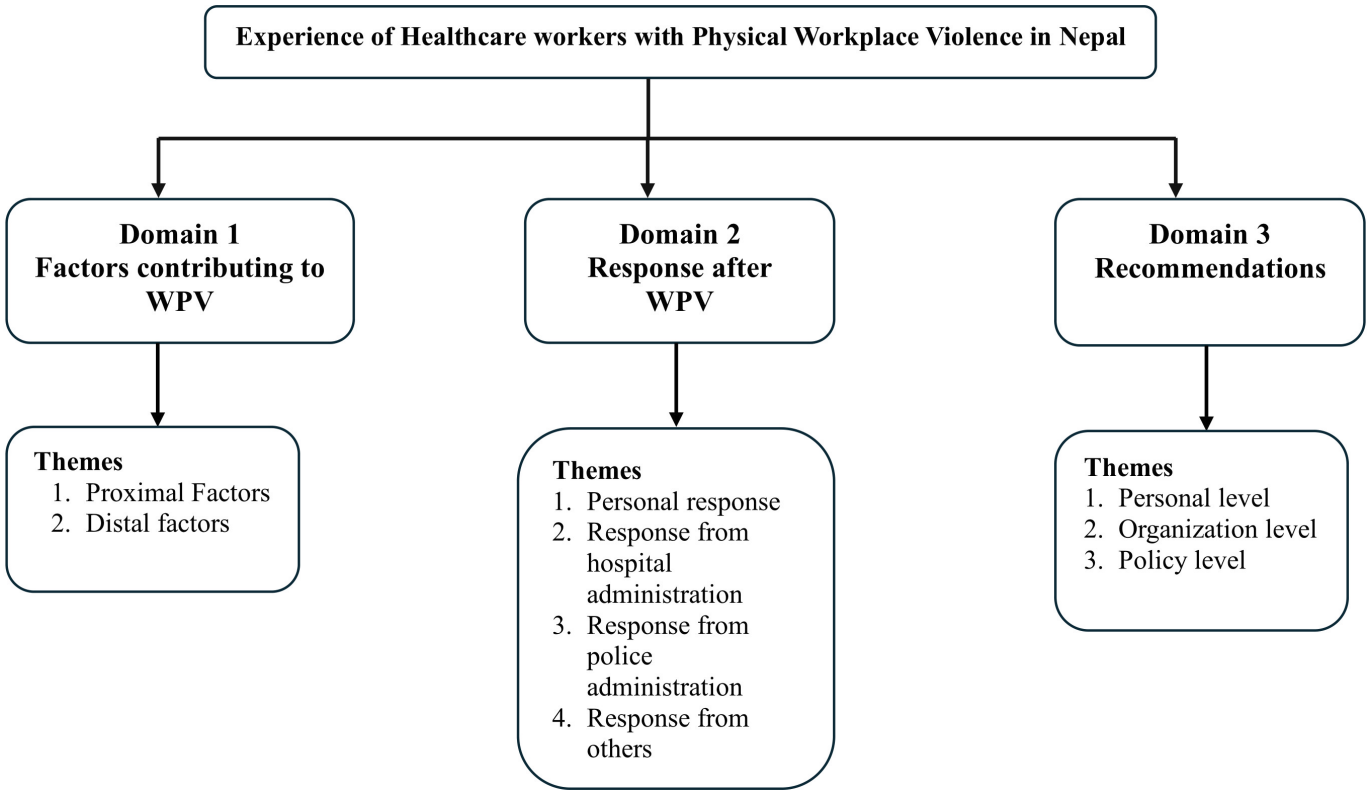

Figure 1 Graphical representation of themes.

Domain 1: factors leading to WPV

The themes within this domain were proximal and distal factors.

Theme 1: proximal factors

This theme consists of two subthemes: patient or near-related perspective and healthcare-related perspective.

Subtheme 1: Patient or near-relative related perspective

Participants reported that patient severity and influence of alcohol played a primary role in WPV. Most participants mentioned that relatives or acquaintances of critically ill patients were more aggressive; the main intention was to pressurise HCWs for better care for the out-of-pocket payments they had done. Surprisingly, some participants mentioned that such aggressive behaviour was intended to receive compensation or discounts in the cost of received services from the hospital.

> If I shout at a health worker, gather a crowd of people, cause physical damage to the infrastructure of the hospital then the hospital will call for negotiation, and I can negotiate for compensation of the expenses incurred during treatment. – Participant 2

Further, patients or patient relatives under the influence of alcohol were more likely to misbehave towards HCWs to express their dissatisfaction with the available services.

Additionally, HCWs mentioned that personality trait was also a factor that led to WPV. For example, a medical officer from a tertiary hospital argued that personality traits of a patient's close relatives, particularly those with aggressive nature, were more likely to abuse HCWs.

Subtheme 2. Healthcare-related perspective

Under proximal factors, most HCWs blamed working environments that led to WPV at work. They reported that the primary drivers of working environments that leading to WPV were shortage of employees, heavy workloads and crowded workplace because these factors hinder HCWs to provide proper and timely care, mismatching patient expectations and actual service delivery.

A night-shift nurse who expressed her working condition as following:

> Patients do have expectations that nurses provide services promptly when needed, but with two or three nursing staffs in inpatient ward, we can't provide timely care, and sometime, due to heavy patient load, we commit mistakes. Providing adequate care in such pressurised time is challenging with a limited staff. – Participant 11

Furthermore, some clinicians reported that they could not allocate adequate time to counsel patients and their relatives, and they were not able to inform patient's status, treatments and investigation procedures, which led to frustration, aggression, and WPV.

Theme 2: distal factors

This theme consists of two subthemes: patient or near-related perspective and healthcare-related perspective.

Subtheme 1: Patient or near-relative related perspective

Participants reported that political party affiliation and patients' low socioeconomic status were the major factors that significantly contributed to WPV. Most participants claimed that those in positions of greater authority or influence were more likely to mistreat HCWs. A medical officer reported his bitter experience as such:

> I was busy with my work and a patient came near me and said: You refuse to provide treatment to me? Are you aware of my identity? I am the president of the X political party in this community. I think he took pride in his political status. – Participant 8

Diving deeper into the reasons, most participants reported that the perpetrators had a strong belief that they would not face any legal repercussions even if they abused HCWs due to their political affiliation. The affiliation provided immunity from any legal actions due to a high-level connection with authorities.

Further, most participants reported that patient's lower socioeconomic status could be a distal factor. Individuals from low-income backgrounds may not afford the high cost of care. Therefore, they resorted to using WPV as a bargaining strategy to reduce the cost of care or in case of unforeseen patient complications or deaths, they would protest for exorbitant monetary compensation from healthcare facility.

Apart from these factors, a few HCWs mentioned that personal animosity towards them incited WPV.

Subtheme 2: Healthcare related perspective

Participants reported that residence of HCWs, duration of work experience and time of work shift were the key distal factors for WPV. HCWs from outside the local community were more vulnerable to WPV compared with local resident staff because the community tended to favour local people compared with non-locals. With frustration, a paramedic explained this idea as such:

> One day a local resident told me: You are outsiders. You cannot live in this health facility. A person from our community should be employed here. I think he was dissatisfied with outsiders providing service in his community. – Participant 9

Further, some participants explained that HCWs with less working experience were trusted less, and they were more likely to suffer from WPV. Additionally, most participants reported that the probability of WPV was higher during night shifts.

Domain 2: response after WPV

This domain consists of four themes: personal response, hospital administration response, police response and other responses.

Theme 3: personal response

After a violent incident, HCWs decided to avoid contact with the perpetrator to prevent further escalation. In most cases, they swiftly relocated to a location where they could ensure their safety and plan for next steps. For example, a local health manager described his safety strategy as such:

> There was a massive crowd, therefore, I ran away from the place where the violent incident occurred. My first plan was to save myself from physical attack. – Participant 7.

After ensuring safety, some HCWs explained the situation to patients and their relatives, managed their anger and tried their best to resolve the WPV. The next step all HCWs followed was to inform their higher authorities about the incident. For example, a consultant physician described his situation and steps followed as such:

> Upon seeing the massive crowd, I became concerned that the situation could potentially go out of control, resulting in media reporting and damaging our reputation. As a precautionary measure, we promptly informed the director, nursing director, and security. – Participant 1

Most participants expressed that the incident resulted in frustration and depression for a few days or weeks depending on the severity of WPV and threats. For example, a consultant physician expressed his fear as such:

> For two days and nights, I was mentally distressed due to that violent incident. I was also scared for my family because they threatened to harm them. This was immensely tough, particularly without any support during this time. – Participant 1

A week after the violent incident, some respondents reported that they returned to work but with a reduced level of confidence in their abilities and decision-making skills. They also mentioned that they experienced memory lapses and confusion regarding patient treatment. Sadly, almost all doctors expressed their desire to leave Nepal after experiencing such WPV. They believed they could earn more income abroad and have more time to spend with their families.

All HCWs reported that with the passage of time, and support from their family, they successfully coped with the situation, but they also mentioned that the incident had left indelible bad memory with them.

Theme 4: hospital administration response

HCWs facing WPV received varied responses from the hospital administration. Only a few participants reported that hospital administration supported legal actions that helped them come back to normalcy. For example, a consultant physician shared the experience of support from the hospital administration as following:

> Getting support from the hospital administration was crucial for me, and thankfully, I did receive it. As a result, I was able to return to normal within a couple of days without much difficulty. – Participant 1.

However, most participants mentioned that the hospital administrations provided minimal support to them. In some cases, they even tried to suppress the voices of victims to prevent further escalation and damage of their reputation. For example, a resident doctor explained

how the hospital administration tried to convince him not to file a case against a perpetrator.

> After I experienced a violent incident, the hospital administration did not directly pressurise me not to file a case against the perpetrator, but they indirectly pressurised me. They explained that if we filed a case against the perpetrator, there would be high chance of hospital vandalisation…. Participant 4

Theme 5: police administration response

Participants responded that police administration, in general, was not supportive to follow the existing legal provisions against the perpetrators, majorly due to political influence. For example, a medical officer in a remote hospital reported his experience as such:

> The police and lawyer did not support me, and instead of filing the case against the person who committed WPV, a lawyer filed a case against me. Additionally, local people blamed me, and labeled me as a haughty and stubborn person. – Participant 6

Theme 6: others response

Participants mentioned that they received a wide range of support from their colleagues, saving them from physical injury during the violent event, mental support after few days and advocating for legal actions to concerned authorities. Additionally, they also reported that the professional organisations such as Nepal Medical Association were supportive to pressurise police and local administration to conduct legal action against perpetrators, by releasing press notice and calling for a strike to stop outpatient services. However, most participants said that support was not long-lasting and often fruitless. Further, we found that doctors received more support from their professional organisations compared with paramedics and nurses.

Domain 3: recommendations

The themes under this domain are personal, organisational and policy level.

Theme 7: personal level

At the personal level, HCWs had a range of recommendations. Most HCWs emphasised that the most critical aspect of preventing and managing WPV was clear and effective communication. A paramedical worker who experienced physical WPV argued that HCWs should acknowledge that there is a problem with patient counselling.

> On one hand, people's expectations are too high, they expect their patients to be normal immediately after coming to the hospital. On the other hand, we, health workers, do not counsel the patients adequately. We should admit that we do not clearly communicate steps and procedures to patients and their relatives. – Participant 10

Additionally, some reported that communication within the health workers' team and peer support are important. In a tertiary hospital, a nurse who faced physical WPV shared her experience about the importance of communication within the team as follows.

> If my colleague, who handed over duty to me during the evening time, had properly communicated about the nature of patients and visitors, that incident could have been prevented. – Participant 11

Apart from proper communication, some HCWs highlighted the need to equip HCWs with situation handling skills when dealing with crowded environments. They also recommended to train HCWs on self-defence skills and de-escalation techniques to ensure personal safety in case of physical attacks.

Theme 8: organisational level

From the organisational perspective, almost all emphasised that the organisation should consider safety and security of the working environment as the number one priority. A doctor from a tertiary hospital who faced physical WPV with life-threatening warnings expressed the importance of safety as:

> There are a lot of things…. I think the first is that the management team should think about our job security…, security of our life…, and security of our family members. Participant 1

To make the workplace environment safe, HCWs had suggestions ranging from regular monitoring of the working environment and discussion with health workers, proper crowd control mechanisms and rapid alert mechanisms. Most emphasised that the hospital management team should assess the working environment regularly and evaluate the challenges faced by healthcare workers which could not only prevent WPV but also identify and address issues that may affect quality of care.

Citing the entry of an unnecessary number of patient visitors as one of the contributors for WPV, many HCWs recommended proper crowd control mechanisms. They pinpointed that the management team should provide security guards who could monitor and manage excessive entry by patient visitors. They also emphasised the importance of a rapid alert system that could alert the response team so that the situation could be handled better, preventing further damage.

Theme 9: policy-level

Regarding recommendations at policy levels, most HCWs prioritised their safety and security as a primary concern. They emphasised that the effective implementation of the existing rules and regulations is the first step to ensure safety and security.

For example, a nurse who faced physical WPV vocally responded as such:

> There should be strict implementation of current legal provision for WPV against health workers. There is a rule called 'Jail without bail' for the perpetrator who committed WPV against health workers. But, in my case, the

perpetrator came out of the jail in 15 days, and now he is doing his normal job. – Participant 11

A few HCWs recommended that the penalty in the current legal provision is not enough to discourage WPV against HCWs. They recommended to increase the penalty to discourage WPV against HCWs. Within the legal provision aspect, some HCWs also recommended that the government or institution should file the case against the perpetrator rather than the victim. Further, most participants mentioned that the policymakers should integrate approaches to improve communication skills of HCWs at various stages of their career, starting from academic training and extending to continuous medical education. Besides these recommendations, HCWs had a wide range of policy recommendations such as flexibility of working hours for residents, transfer of HCWs who faced WPV, provision of insurance for WPV and adequate supply of resources for remote health facilities to prevent the incidents associated with unavailability of services.

DISCUSSION

In our study, we found that physical WPV by patients or their relatives against HCWs is multifactorial. This finding is almost universal.[2 3 25] Our study revealed multiple patient-related proximal and distal factors, leading to WPV. Similar to our study, previous studies showed that alcohol influence in a patient or their relative is a common risk factor leading to physical WPV against HCWs.[26–28] Our finding that people with certain personality traits are more likely to commit WPV is supported by the general aggression model.[29] Further, we found that the relatives of severely ill patients were more likely to incite WPV; this finding is corroborated by the fact of higher prevalence of physical WPV in emergency and psychiatry settings.[1] This could be due to anticipatory loss in near relatives,[19] leading to negative or stressful mental state,[26] ultimately resulting in WPV.

Apart from previous studies, we observed some new findings in our study. First, HCWs reported that there was a higher likelihood of WPV by the relatives of severe patients with low-income backgrounds because they need financial support to pay exorbitant charges for healthcare services, and therefore, they would try violence as a bargaining strategy to reduce the cost of care. We did not find similar mechanisms in existing research; however, several studies have shown that patient severity[1 30] and the lower educational status of patient and their relatives[31 32] are the significant predictors of WPV against HCWs. It is plausible that individuals from low-income households may have lower educational status, and consequently, decreased understanding of the perspectives of HCWs, which could potentially contribute to WPV. A recent study on patient response to medical dispute in China has also recommended to investigate violence tendency of different income groups.[33] For better understanding of this concept, future research should investigate it from patient and bystanders perspectives. Second, almost all HCWs vocally expressed that patients or their relatives having an affiliation or connection with political parties or higher authorities were more likely to commit WPV because they were quite confident that they would be immune from legal action arising from such violent action. HCWs mentioned that this was mainly due to poor and unfair implementation of existing legal provisions for WPV against HCWs. A study from Pakistan also showed that the patients or relatives with high social status such as politicians were more prone to perpetrate violence against HCWs,[32] but the authors did not comprehensively study the mechanism with which higher social status increases the likelihood of WPV against HCWs. Given the limited evidence regarding the connection between power, politics and WPV against HCWs, alongside the ongoing debate that WPV against HCWs has become a political problem,[34] such political dimension of WPV against HCWs should be explored thoroughly.

Previous global studies,[35 36] including some recent Nepali studies,[9 11] have shown that inexperienced HCWs, long waiting time, poor communication, staff shortages, night-shift work, poor communication and a crowded workplace were healthcare level factors, contributing to WPV; we observed similar patterns in our study. On one hand, due to these factors, the HCWs cannot provide timely and adequate care. On the other hand, patients and their relatives have growing expectations to receive quality care from healthcare systems.[19] When the gap between the expectation of patients or their relatives and reality of healthcare delivery grows, it may result in dissatisfaction and potentially lead to WPV against HCWs.

The study participants reported depression, frustration, low self-esteem, difficulty concentrating and absenteeism due to WPV they experienced. Similar experiences were observed in previous studies globally.[7 25 37] While physical injuries heal over time, such violent incidents leave longer run emotional and psychological impact on HCWs. From a healthcare perspective, in the short run, this could decrease the quality of care.[25] However, this could have long-run consequences. For example, all clinicians in our study said that they intended to leave the country for a better working environment. On the one hand, evidence shows that HCWs in Nepal are suffering from burnout and mental stress due to a pressurised working environment,[38] and on the other, there would be better opportunities and working environments abroad. Amidst such a scenario, violent physical attacks against them could increase brain drain,[39 40] which could ultimately weaken the health system in the long run. This implication is applicable for many low-income countries, and such pattern has already been seen in some countries like Ghana,[41] South Africa[42] and Turkey.[43]

Implications for practice, research, and policy

The participants recommended a lot of immediate actions at personal, organisational and policy level. Their most urgent recommendation was to prevent WPV by

ensuring safety and security of HCWs. Realising that the WPV against HCWs has become very common, at personal level, our participants recommended incorporating situation handling and proper communication skills into their curriculum, both during their medical education and on the job training. Similar concepts have been advocated by previous studies.[44 45] At organisation level, similar to previous studies,[26 46 47] our participants recommended regular risk assessments, continuous communication between the management team and HCWs, proper alarm and security systems in the working environment, crowd control mechanisms and a strong supportive system for those who experienced WPV.

At policy level, HCWs strongly emphasised that the government should strictly implement current legal provisions against perpetrators. Nepal government endorsed a historic ordinance on Safety and Security of Healthcare Workers and Health Institution (First amendment) in 2022,[48] where the perpetrator of physical WPV against HCWs receives a jail sentence of up to 3 years or penalty of 300 000 Nepali rupees (Approximately $2300 of 2024). However, its strict implementation has been rarely observed.[11 16] Therefore, to increase trust among HCWs that the government is serious against WPV, the current legal provision should be strictly implemented. Another policy recommendation by HCWs was the integration of communication skills into both academic training and continuous medical education. Poor communication by HCWs is often a precursor to the incidence of violence.[49 50] While some undergraduate and graduate level courses of medicine and nursing in Nepal cover communication-related subjects in their curriculum, integrating these skills into every course and clinical training programme could capacitate HCWs to tackle violent incidents.

Our study has some implications for future research. While we identified the influence of political power on WPV against HCWs, our investigation of this phenomenon was not exhaustive. Future research could delve deeper into the relationship between political actors, mediators and the patients' relatives to comprehensively understand the dynamics of influence. Additionally, the researchers could investigate the process of bargaining between patient relatives and hospital administration while resolving disputes through financial compensation.

Strengths and limitations

To the best of our knowledge, this is the first qualitative study in a Nepali context that provides in-depth experience of HCWs who faced physical WPV by patients or their relatives. Also in a global context, this is one of the limited qualitative studies in this area. Further, this study is comprehensive because we have not only investigated factors associated with physical WPV but also explored how HCWs coped with the incident and what their recommendations were to the concerned agencies. One limitation is that the study explored physical WPV from the perspective of HCWs; the perspective of patients, their near relatives and bystanders could have been different had we got opportunities to explore their perspectives of the same incident. This could be an area to investigate in future research. Second, it is important to note that our sample comprised of those who were willing to participate, whose incidents were covered by news media and those who experienced physical WPV in the last 2 years. Numerous HCWs may have experienced verbal abuse, emotional violence, minor or major physical injuries, and sexual violence, and their perspective about the incident could differ. Similarly, those who faced WPV over 2 years ago may experience long-lasting effects that could influence their perspectives. Despite these limitations, our study provides significant information for policymaking, practical applications and further research.

CONCLUSIONS

This qualitative study showed that physical WPV against HCWs by patients or their relatives in Nepal is complex and multifactorial. Experience of HCWs who faced physical WPV in Nepal was traumatic. Although such violent incidents primarily affect the victim in the short run, it can have longer run negative consequences on healthcare quality and the availability of HCWs. HCWs recommended several immediate and urgent actions at individual, organisational and policy level. The concerned stakeholders should carefully consider these recommendations to establish a safe, secure and supportive working environment.

Author affiliations
[1]Health Foundation Nepal, Dang, Nepal
[2]Department of Health Policy and Management, Gillings School of Public Health, University of North Carolina, Chapel Hill, North Carolina, USA
[3]Institute for Implementation Science and Health, Kathmandu, Nepal
[4]Dhulikhel Hospital, Dhulikhel, Nepal
[5]Prayatnashil Community Development Society (PRAYAS-Nepal), Dhading, Nepal
[6]Kathmandu University School of Medical Science, Dhulikhel, Nepal

Correction notice This article has been corrected since it was first published. The funding statement was missing and has now been added.

X Mukesh Adhikari @mukes_adhikari

Acknowledgements We acknowledge Dr. Bom BC, Dr. Bivek Singh and Dr. Raju Dangal for their help in recruiting participants. We also thank Dr. Sean Sylvia and Dr. Archana Shrestha for advising us during research design phase. Lastly, we are immensely thankful to all the participants of our study who brought strong courage to share their traumatic experience for the study purpose.

Contributors MA is the principal investigator of the study and led the planning, conduction, manuscript preparation, funding acquisition and decision to publish. Further, MA is also the guarantor of this manuscript. DT and KC are co-investigators and were involved in the study design, development of interview guide, data collection, analysis, interpretation, preparation and review of manuscript. All authors have read and approved the final manuscript. All authors accept the full responsibility of the work and have access to the data.

Funding This study was funded by Joseph Chip Huges Worker Education and Training Research Fund of the University of North Carolina, Gillings School of Global Public Health and this fund covers the costs of data collection and analysis (#CHA002).

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by Nepal Health Research Council, Kathmandu, Nepal. Registration No. 233/2022 P. Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. Data will be made available on reasonable request according to the code of conduct of the Nepal Health Research Council.

ORCID iD

Mukesh Adhikari http://orcid.org/0000-0002-1091-328X

REFERENCES

1 Liu J, Gan Y, Jiang H, *et al*. Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. *Occup Environ Med* 2019;76:927–37.
2 Sahebi A, Golitaleb M, Moayedi S, *et al*. Prevalence of workplace violence against health care workers in hospital and pre-hospital settings: an umbrella review of meta-analyses. *Front Public Health* 2022;10:895818.
3 Liu J, Zheng J, Liu K, *et al*. Workplace violence against nurses, job satisfaction, burnout, and patient safety in Chinese hospitals. *Nurs Outlook* 2019;67:558–66.
4 Ariza-Montes A, Muniz NM, Montero-Simó MJ, *et al*. Workplace bullying among healthcare workers. *Int J Environ Res Public Health* 2013;10:3121–39.
5 Wu S, Lin S, Li H, *et al*. A study on workplace violence and its effect on quality of life among medical professionals in China. *Arch Environ Occup Health* 2014;69:81–8.
6 Copeland D, Henry M. The relationship between workplace violence, perceptions of safety, and professional quality of life among emergency department staff members in a level 1 trauma centre. *Int Emerg Nurs* 2018;39:26–32.
7 World Health Organization. Preventing violence against health workers. Available: https://www.who.int/activities/preventing-violence-against-health-workers [Accessed 14 Jan 2024].
8 Mishra SR, Khanal P, Karki DK, *et al*. National health insurance policy in Nepal: challenges for implementation. *Glob Health Action* 2015;8:28763.
9 Bhusal A, Adhikari A, Singh Pradhan PM. Workplace violence and its associated factors among health care workers of a tertiary hospital in Kathmandu, Nepal. *PLoS One* 2023;18:e0288680.
10 Pandey M, Bhandari TR, Dangal G. Workplace violence and its associated factors among nurses. *J Nepal Health Res Counc* 2018;15:235–41.
11 Adhikari B, Subedi R, Thakur RK, *et al*. Prevalence, associated factors, and impact of workplace violence among physicians. *J Nepal Health Res Counc* 2023;20:636–44.
12 Kumari A, Kaur T, Ranjan P, *et al*. Workplace violence against doctors: characteristics, risk factors, and mitigation strategies. *J Postgrad Med* 2020;66:149–54.
13 Somani R, Muntaner C, Hillan E, *et al*. A systematic review: effectiveness of interventions to de-escalate workplace violence against nurses in healthcare settings. *Saf Health Work* 2021;12:289–95.
14 Silwal K, Joshi S. Verbal abuse among nurses in tertiary care hospitals. *JNMA J Nepal Med Assoc* 2019;57:243–7.
15 Lohani S, Rai M, Prasad Neupane G, *et al*. Nepalese nurses experiences of workplace violence during COVID-19 pandemic. *Nepal Med Jor* 2021;4.
16 Kharel S. A historic ordinance against violence to health workers of Nepal. *Lancet Reg Health Southeast Asia* 2022;3:100037.
17 Swain J. *A Hybrid Approach to Thematic Analysis in Qualitative Research: Using A Practical Example*. SAGE Publications Ltd, 2018.
18 Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. *Qual Health Res* 2016;26:1753–60.
19 Bhattacharjee D. Workplace violence in healthcare: towards a psychosocial perspective. *Aggress Violent Behav* 2021;58:101573.
20 Davey K, Ravishankar V, Mehta N, *et al*. A qualitative study of workplace violence among healthcare providers in emergency departments in India. *Int J Emerg Med* 2020;13:33.
21 O'Brien BC, Harris IB, Beckman TJ, *et al*. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med* 2014;89:1245–51.
22 Clarke V, Braun V. Thematic analysis. *J Posit Psychol* 2017;12:297–8.
23 Kiger ME, Varpio L. Thematic analysis of qualitative data: AMEE guide No.131. *Med Teach* 2020;42:846–54.
24 Miles MB, Huberman AM, Saldana J. *Qualitative Data Analysis: A Methods Sourcebook*. 3rd edn. SAGE Publications, 2014.
25 Lim MC, Jeffree MS, Saupin SS, *et al*. Workplace violence in healthcare settings: the risk factors, implications and collaborative preventive measures. *Ann Med Surg (Lond)* 2022;78:103727.
26 Gillespie GL, Gates DM, Miller M, *et al*. Workplace violence in healthcare settings: risk factors and protective strategies. *Rehabil Nurs* 2010;35:177–84.
27 Crilly J, Chaboyer W, Creedy D. Violence towards emergency department nurses by patients. *Accid Emerg Nurs* 2004;12:67–73.
28 Ferns T, Cork A. Managing alcohol related aggression in the emergency department (part I). *Int Emerg Nurs* 2008;16:43–7.
29 Allen JJ, Anderson CA, Bushman BJ. The general aggression model. *Curr Opin Psychol* 2018;19:75–80.
30 Li YL, Li RQ, Qiu D, *et al*. Prevalence of workplace physical violence against health care professionals by patients and visitors: a systematic review and meta-analysis. *Int J Environ Res Public Health* 2020;17:299.
31 Alsaleem SA, Alsabaani A, Alamri RS, *et al*. Violence towards healthcare workers: a study conducted in Abha city, Saudi Arabia. *J Family Community Med* 2018;25:188–93.
32 Mirza NM, Amjad AI, Bhatti ABH, *et al*. Violence and abuse faced by Junior physicians in the emergency department from patients and their caretakers: a nationwide study from Pakistan. *J Emerg Med* 2012;42:727–33.
33 Du Y, Wang W, Washburn DJ, *et al*. Violence against healthcare workers and other serious responses to medical disputes in China: surveys of patients at 12 public hospitals. *BMC Health Serv Res* 2020;20:253.
34 Kuhlmann E, Brînzac MG, Czabanowska K, *et al*. Violence against healthcare workers is a political problem and a public health issue: a call to action. *Eur J Public Health* 2023;33:4–5.
35 Kumar M, Verma M, Das T, *et al*. A study of workplace violence experienced by doctors and associated risk factors in a tertiary care hospital of South Delhi. *J Clin Diagn Res* 2016;10:LC06–LC10.
36 Sun S, Gerberich SG, Ryan AD. The relationship between shiftwork and violence against nurses: a case control study. *Workplace Health Saf* 2017;65:603–11.
37 Zafar W, Siddiqui E, Ejaz K, *et al*. Health care personnel and workplace violence in the emergency departments of a volatile metropolis: results from Karachi, Pakistan. *J Emerg Med* 2013;45:761–72.
38 Singh B. The crisis of physician well-being in Nepal: a multifaceted dilemma demanding urgent intervention. *Int J Qual Health Care* 2023;35:mzad070.
39 Kadel M, Bhandari M. Factors intended to brain drain among nurses working at private hospitals of Biratnagar, Nepal. *BIB* 2019;16:213–20.
40 Phuyel BR. Doctor's brain drain in Nepal: exploring the patterns, causes, consequences and solutions. 2013.
41 Boafo IM. Ghanaian nurses' emigration intentions: the role of workplace violence. *Int J Afr Nurs Sci* 2016;5:29–35.
42 Bidwell P, Laxmikanth P, Blacklock C, *et al*. Security and skills: the two key issues in health worker migration. *Glob Health Action* 2014;7:24194.
43 Yılmaz S, Koyuncu Aydın S. Why is Turkey losing its doctors? A cross-sectional study on the primary complaints of Turkish doctors. *Heliyon* 2023;9:e19882.
44 Wong AH, Wing L, Weiss B, *et al*. Coordinating a team response to behavioral emergencies in the emergency department: a simulation-

enhanced interprofessional curriculum. *West J Emerg Med* 2015;16:859–65.
45 Wong AHW, Combellick J, Wispelwey BA, *et al*. The patient care paradox: an Interprofessional qualitative study of agitated patient care in the emergency department. *Acad Emerg Med* 2017;24:226–35.
46 D'Ettorre G, Pellicani V, Mazzotta M, *et al*. Preventing and managing workplace violence against healthcare workers in emergency departments. *Acta Biomed* 2018;89:28–36.
47 Runyan CW, Zakocs RC, Zwerling C. Administrative and behavioral interventions for workplace violence prevention. *Am J Prev Med* 2000;18:116–27.
48 Belbase P, Basnet A, Parajuli A, *et al*. Ordinance on the safety and security of health workers and health institutions in Nepal: a critical analysis. *J Nepal Health Res Counc* 2021;19:408–10.
49 Najafi F, Fallahi-Khoshknab M, Ahmadi F, *et al*. Antecedents and consequences of workplace violence against nurses: a qualitative study. *J Clin Nurs* 2018;27:e116–28.
50 Papadopoulos C, Ross J, Stewart D, *et al*. The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatr Scand* 2012;125:425–39.