

High time to stop workplace violence against health professionals in the context of COVID-19

Yu Xiao^{1,2,*†}, Na Du^{2,†}, Ting-ting Chen³, Hao-fei Cheng²

¹Psychosomatic Medical Center, The Clinical Hospital of Chengdu Brain Science Institute, MOE Key Lab for Neuroinformation, University of Electronic Science and Technology of China, Chengdu, China

²Psychosomatic Medical Center, The Fourth People's Hospital of Chengdu, Chengdu, China

³Nursing School, Chengdu University of Traditional Chinese Medicine, Chengdu, China

†These authors contributed equally to this paper.

*Corresponding author: Psychosomatic Medical Center, The Clinical Hospital of Chengdu Brain Science Institute, MOE Key Lab for Neuroinformation, University of Electronic Science and Technology of China, The Fourth People's Hospital of Chengdu, No. 8, Huli West Lane 1, Yingmenkou Road, Chengdu 610036, China. E-mail: xiaoy3@outlook.com

As doctors working at the clinical front line, we found the article “The occurrence and consequences of violence against healthcare workers in Turkey: before and during the COVID-19 pandemic”¹ thought-provoking. By distributing a structured online questionnaire to health professionals (HPs) in different medical institutions, the authors determined the frequency, causes, and consequences of workplace violence (WPV) against HPs before and during the pandemic. The results of this study¹ show that during the pandemic, a quarter of HPs were subjected to violence. The most common kind of violence was verbal violence. On the other hand, more than half of the HPs did not report violent incidents. Finally, this article¹ delivers the key message that special efforts should be made to minimize violence against HPs. However, the authors did not propose any specific measures to solve the problem of violence in the medical workplace. According to a recent systematic review,² violence against HPs became more serious during the COVID-19 epidemic, thus predisposing HPs to high levels of mental stress as well as an increased tendency to develop mental health problems. These mishaps could make HPs frustrated with their job and may promote the intention of quitting their profession.^{3,4} To stop this imminent danger, based on the experience of global health practice, we will explore how to take effective measures to prevent WPV against HPs.

Global prevalence and the serious consequences of medical WPV

As revealed by this study,¹ WPV against HPs is very common. According to the data of the International Committee of the Red Cross,² 611 incidents of hospital violence were recorded between February 1 and July 31, 2020. The World Medical Association recently defined violence against HPs as “an international emergency that destroys the foundations of health systems and has a serious impact on the health of patients.”⁵ Many countries have reported cases of violence in the medical workplace, and some are especially affected by this problem. A national survey of Chinese medical staff showed that the in-

cidence of hospital violence was 65.8%.⁶ Verbal violence accounted for 64.9% of the total hospital violence cases, while sexual harassment and physical violence accounted for 3.9% and 11.8%, respectively.⁶ This study¹ shows that in Turkey, the incidence of violence against HPs ranges from 49% to 87%. In the United Kingdom, 181 National Health Service (NHS) Trusts reported 56,435 physical assaults on staff in 2016–2017.⁷ In the United States, 70%–74% of WPV occurs in medical facilities.² In Iran, the prevalence of verbal or physical WPV against emergency medical service personnel was 73% and 36%, respectively.⁸ A large number of studies have shown that the consequences of medical WPV can be very serious: depression, post-traumatic stress disorder,⁹ deaths or life-threatening injuries,⁴ reduced work interest, decreased retention, impaired work functioning, increased practice of defensive medicine,¹⁰ and decline of ethical values. In addition, medical WPV is directly related to lower patient safety and more adverse events.² These results are also confirmed in this study.

Suggestions for preventing WPV against HPs

Faced with the COVID-19 epidemic sweeping the world, different governments including those of the United Kingdom, United States, India, and Algeria have amended their emergency laws to enhance the protection of HPs.² To curb violence initiated by patients, the Chinese legislature issued the first legal document to protect HPs in 2020.¹¹ But the law alone is unlikely to solve the root cause of the problem. Experience has shown us that the prevention of violence in health care activities cannot rely solely on 1 type of measure, but only the coordinated implementation of structural, organizational, and personal interventions, preferably participatory interventions, can achieve effective results.¹²

First of all, we should take action against the general shortage of staff in medical institutions around the world, and increase investment to hire more HPs.¹³ Especially in overburdened public hospitals, young doctors should be provided with more opportunities for medical practice and encouraged to build

meaningful relationships with patients. In China, at the beginning of the COVID-19 epidemic, the collection of nucleic acid samples was basically done by doctors and nurses. Recently, the government has tried to recruit and train volunteers from the community to take on the task of nucleic acid sampling, so as to reduce the burden of HPs in medical institutions. Besides, at present, the focus of China's medical reform is to speed up the formation of a graded diagnosis and treatment system with community-first diagnosis, 2-way referral and up-down linkage according to national conditions.¹⁴ This initiative aims to optimize the allocation of medical resources and promote the healthy development of the medical system. Second, sanctions should be imposed on all perpetrators of WPV against HPs, as this will serve as a deterrent to others.⁴ Chinese policy-makers also try to distinguish punishment for hospital violence from that for other forms of general violence, and impose more severe penalties. This will help China to achieve the purpose of warning and supervision.¹⁵ At the same time, HPs who report any physical or verbal violence should be fully supported by their health care organizations, which will reduce the huge problem of under-reporting of WPV.¹⁶ As shown in this study,¹ most HPs who were exposed to violence at least once failed to report this. Third, medical institutions and universities should organize effective courses for HPs to help them improve their communication skills and teach them how to identify the early signs of hospital violence.¹¹ Fourth, the hospital management should formulate communication strategies through which information on delays in service provision during long waiting times are properly communicated to patients and their relatives.² We can recruit and train social workers to carry out these activities. Fifth, closed-circuit television surveillance and alarms should be installed in high-risk departments (such as emergency departments) and areas where HPs work in isolation.¹⁶ Staff numbers should be increased and security personnel should be available, especially at night and in the emergency rooms (violence often occurs in the evening, when more patients under the influence of alcohol and drugs appear). Finally, it may be helpful to raise public awareness of the negative influence of WPV on HPs through mass media campaigns.¹⁷ Besides, the media should stop contributing to the public's distrust of medical institutions and HPs. Many patients report their negative experiences of medical care to the news media, which commonly fail to verify the information before releasing it.¹⁰ These biased media reports may further aggravate tensions.

In short, only by adopting better strategies to deal with cultural and organizational factors in the workplace and better cooperation between occupational and public health stakeholders can the health of HPs be improved. COVID-19 poses a great challenge to global public health, and HPs risk their lives to save patients. We think it is time to take action to stop medical WPV.

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Conflict of interest

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