



Female house surgeon stabbed to death: High time for a multi-pronged action plan to prevent and manage violence against Health care workers

The World Health Organization (WHO) has described violence and harassment in the healthcare sector as episodes of threatening, abuse, or assault toward healthcare workers (HCWs) in situations pertinent to their work [1]. A recent heart-wrenching incident in Kerala, India of a female house surgeon stabbed to death by an alcoholic and drugged assailant, has staggered the medical and other healthcare fraternity [2]. Although occupational violence affects various community occupational settings, healthcare and social services remain especially susceptible to high loads of occupational violence, accounting for more than a quarter of all occupational violence incidents. Healthcare workers (HCWs) are exposed to a significant occupational burden that has been exaggerated after the COVID-19 pandemic's emergence. Ramzi et al. have demonstrated the global prevalence of workplace violence to be as high as 47% during the pandemic, with a significant burden on the HCWs' quality of life. Occupational violence is a real threat to HCWs, especially in serving high-risk sectors (e.g., emergency departments) in developing countries. Multiple interventions (mainly educational) have been postulated to mitigate and manage patient violence in healthcare; however, their effectiveness is still doubtful. Recently, an Indian doctor met a drastic end by being stabbed to death by a former patient. The following correspondence will discuss the different aspects of healthcare-related occupational violence.

1. Workplace violence worldwide vs. India

Workplace violence against HCWs is a global issue that has been bothering the fraternity for a long. In the United States (US), there is around 73% occurrence of non-fatal work-related injuries and violence, among which 70–74% occur in the healthcare setting [3]. About 23% of physicians in Germany are continuously exposed to severe waves of aggression. Between 2016 and 2017, United Kingdom health authorities reported more than 50,000 assaults against HCWs. In Poland, Slovakia, the Czech Republic, and Turkey, reports of physical or verbal abuse are high in 2020, 50% of physicians in Italy have reported verbal abuse. The situation in the developing countries is not isolated from the worldwide situation. Over 30 South African hospitals reported serious violent events in 2019. As reported, there is as high as 73% prevalence of violence against emergency HCWs [4].

Despite being underreported, the incidents of healthcare violence in India are exceptionally high compared to other non-conflict zones. In India, more than two-thirds of physicians have been exposed to some type of workplace violence. It has been estimated that India contributes to 3.4% of worldwide reported incidents of violence against HCWs. The underlying causes are needed to be thoroughly determined to stop such events from happening.

2. What leads to workplace violence against HCWs?

There are an array of various reasons that ultimately lead to episodes of violence against HCWs. Most of the nationwide reported violent incidents are related to real or apparent non-improvement or worsening of a patient's condition and subsequently the perception of "wrong treatment given". Additionally, the low employment rate of physicians in India has created a significant stretch to a loaded healthcare system, further impairing healthcare quality [5].

Physician-related factors behind such violence are miscommunication at any level of explaining etiology, investigations, and treatment options are included. Dissatisfaction and disagreement with physicians on the course of treatment happen very often. However, patient-related factors also play a major role in such happenings. The patient and their attendants become highly vulnerable when faced with critical situations. In this scenario, empathy and humane behavior are required instead of challenges by the doctor or staff. Overcrowding and long waiting time, multiple visits to get investigations done, floor beds, and poor hygiene and sanitation contribute to such anger.

Hospitals often do not pay much attention to security. Community as a whole also plays a pivotal role in this in which weak and ineffective laws and a lack of faith in judicial process exist that ultimately forces a common man to take the law into his/her hands.

3. Identifying predictors, barriers, and facilitators of violence

Certain predictors can help to identify high-risk patients who can commence violence. In a study by Kumari et al., mental health issues in patients were identified to be a high-risk predictor of violence. Similarly, the study revealed that around one out of five patients who are admitted to acute psychiatric units can commit violence. Moreover, young HCWs who are working longer hours in shifts are at a higher risk [6].

The key is to remain alert to this eventuality. The STAMP (Staring, Tone, Anxiety, Mumbling, Pacing) approach can alert physicians by observing warning signs. In this scenario, well behavior of staff, understanding of patient psychology, and promptness in care can act as barriers to violence. Apart from many initiatives from govt. under-reporting one well-known facilitator of violence is the lack of reporting. This leads to hindrance towards easy identification of problem areas. The underreporting is due to the perception that no action will be taken. Some of the personality-related factors of the care staff such as the display of 'bad attitude', and rudeness also contribute to violence.

4. Interventions targeting healthcare-related occupational violence

The interventions required are mainly the prevention of such activities through the improvement of the doctor-patient relationship and enforcement of laws, betterment of treatment facilities with a more humanitarian approach, and lastly generation of resilience methods involving modes of bringing back the psychological normalcy among the HCW victims [7]. Healthcare-related occupational violence has traced growing attention among different decision-making sectors in India. After increasing violence against HCWs during the pandemic, the Indian government has issued a new policy considering offensive acts against HCWs a punishable act that may be subjected to seven years of imprisonment. Especially, special education and training are required for the residents, physicians, and surgeons when dealing with psychiatric, drugged, and alcohol-intoxicated patients to avert serious repercussions. Hsieh et al. have demonstrated that smartphone-delivered biofeedback training has decreased depressive symptoms in nurses exposed to abuse [8]. Resilience strategies involving such technologies need to be developed to bring back psychological normalcy among the HCW victims.

The Union Ministry of Health & Family Welfare has taken several measures to prevent this violence. These include the installation of CCTV cameras, Quick Reaction Teams with effective communication, centralized control room for quick response, legislation protecting doctors in every hospital and police station, Nodal Officer for monitoring medical negligence, betterment of infrastructural facilities and medical equipment, etc.

Despite all these, the number of violence is increasing day by day in India. Looking into the scenario of China, where the prevalence of violence against doctors was 42%–83%, the introduction of various

policies has aided to reduce this number. In China, a survey has revealed that among the cases of medical disputes from 2014 to 2018, 76.9% were due to the lack of medical humanistic care. Several new policies have been introduced such as setting up of a “listening window” for outpatient humanistic care and collection of suggestions from patients and their families, and formulation of an information-based decision-making system that has shortened the waiting time in queues by 33%. Moreover, Online medical platforms have been created, containing information on healthcare professionals from hospitals across the country, and provide online services that have aided in creating a harmonious doctor-patient relationship. Fig. 1 represents the current scenario of violence against HCWs in India and the strategies to overcome the same. Incorporation of such policies can be effective from the Indian perspective where violence against doctors is raising day by day. Only law and order can not control these violent episodes rather humanistic approaches are high in need.

5. Conclusion

Workplace violence represents a real threat to the healthcare sector in India. Multipronged interventions targeting the safety of HCWs are warranted to decrease the unacceptable rates of violence in the different Indian states. There is a need for a positive work environment by establishing appropriate regulations. Education in the prevention and control of violence will reduce the risk of violence. The introduction of security systems and the amendment of policies for the prevention of violence are necessary. Prevention, better treatment options, and resilience as a whole would act as the key factors in this regard to generate a multi-pronged action plan for a better work environment for HCWs.

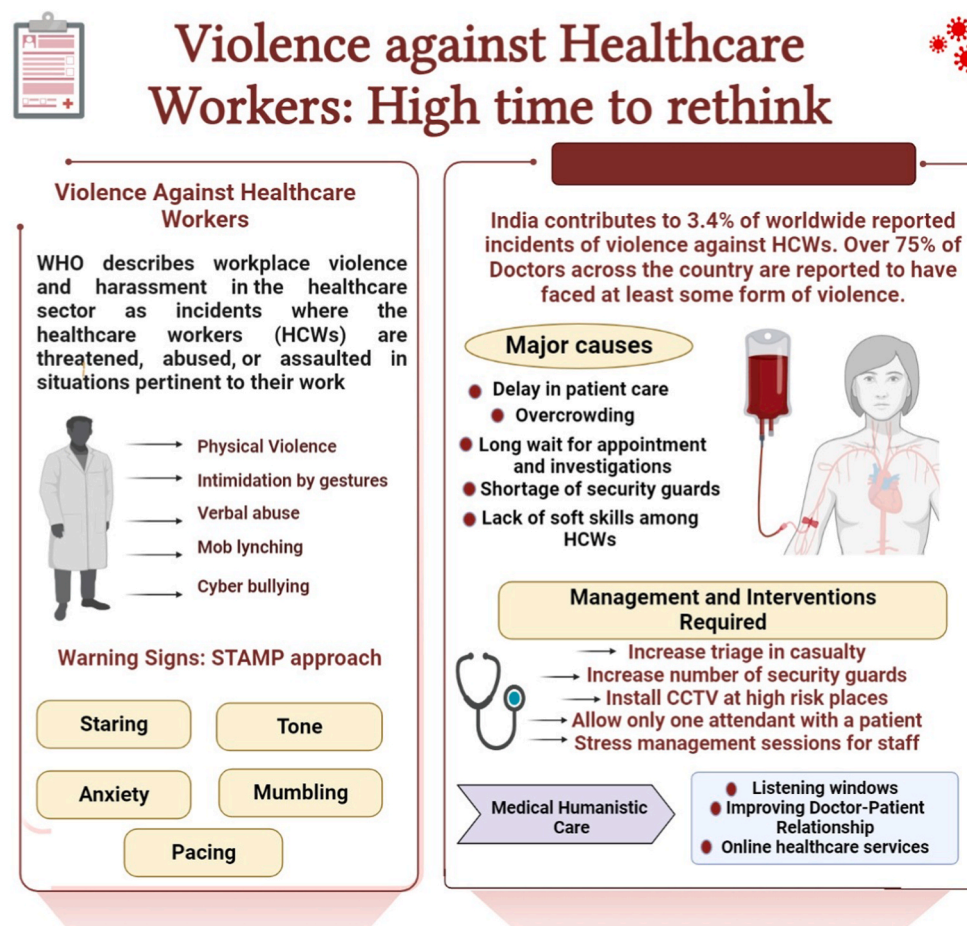


Fig. 1. Current scenario of violence against HCWs in India and the strategies to overcome.

Data statement

The data in this article is accessible to the public and is not sensitive in nature.

Author disclosure form

The following information is required for submission. Please note that failure to respond to these questions/statements will mean your submission will be returned. If you have nothing to declare in any of these categories, then this should be stated.

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Author contribution

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Md. Aminul Islam: Study concept, Data collection, writing the paper, review, and editing

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