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Violence Against Healthcare Professionals; Is It A New Pandemic?

Sağlık Çalışanlarına Yönelik Şiddet; Yeni Bir Salgın mı?

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Abstract

Aim: Although violence is a public health problem in the workplace as well as in society, its incidence is increasing. Violence and fear of exposure reduce the quality of the health service provided, which negatively affects the employees, and paves the way for the emergence of new violence. Our aim in this study is to know the frequency, type and demographic data of violence against healthcare professionals that we see almost every day, and to make these events preventable with the precautions to be taken and the cause of these events.

Material and Method: The data in this study includes 359 incidents of violence against healthcare workers from January 2018 to the end of June 2022. The date and time of the white code notifications, the gender, age, duty of the health worker who was exposed, the hospital unit where the incident took place and the type of violence were recorded. These data were grouped and analyzed.

Results: It was observed that the number of physicians exposed to violence constituted the majority with 207 (57.7%). 224 (62.4%) of the attacks were recorded as verbal violence, 31 (8.6%) physical violence, and 104 (29.0%) both verbal and physical violence. There was a statistically significant increase in violence cases after the pandemic in the Emergency Department.

Conclusion: Violence against healthcare professionals has not changed compared to before the pandemic, unlike the number of patients that decreased during the pandemic. This shows us that violence in health is a viral contagious situation like COVID-19. As all infectious diseases can be prevented with early intervention, treatment or preventive methods, social behavior patterns also need early intervention and protective methods without stereotyping.

Keywords: Violence, COVID-19, healthcare

Öz

Amaç: Şiddet, toplumda olduğu gibi işyerlerinde de bir halk sağlığı sorunu olmakla birlikte yaşanma sıklığı giderek artmaktadır. Sağlık çalışanlarının maruz kaldığı şiddete ilişkin yurt içi ve yurt dışında pek çok çalışma yapılmıştır, bu çalışmalardan birinde sağlık kurumunda çalışmanın diğer iş yerlerine göre şiddete uğrama açısından 16 kat daha riskli olduğu gösterilmiştir (1). Sağlık çalışanları her an şiddete maruz kalacağını düşünerek sürekli bir tehdidin varlığından endişe etmektedir. Şiddet ve maruz kalma korkusu, çalışanlardaki olumsuz etkileri sunulan sağlık hizmetinin de kalitesini düşürerek yeni şiddet olaylarını ortaya çıkarmaya zemin hazırlamaktadır.

Gereç ve Yöntem: Birinci basamak, devlet hastanesi ve üniversite hastanesi çalışanlarının dâhil edildiği bir çalışmada sağlık çalışanlarının yaklaşık yarısının %50,8 (erkeklerde %48,4 ve kadınlarda %52,5) son bir yılda şiddete uğradığı belirtilmiştir (2). Sağlık çalışanlarına yönelik yaşanan şiddet olaylarının bildiriminin oldukça az oranda yapıldığı, sadece yaralanma ve ölüm gibi ciddi olayların şiddet olarak değerlendirilip diğerlerinin bildirilmediği yapılan bazı çalışmalarda öne çıkmaktadır (3).

Bulgular: Beyaz Kod Uygulaması 6 Nisan 2011 tarih ve 27897 sayılı Hasta ve Çalışan Güvenliğinin Sağlanmasına Dair Yönetmelik ile tesis edilmiş olup (4), en son 16 Mart 2016 tarih ve 11045126-010.06 sayılı Türkiye Cumhuriyeti Sağlık Bakanlığı Hukuki Yardım ve Beyaz Kod Uygulaması Genelgesi ile düzenlenmiştir ve halen yürürlüktedir (5). Bu uygulama ile kamu ve özel tüm sağlık kurum ve kuruluşlarında gerçekleşen şiddet olaylarının izlenmesi, gereken müdahalenin yapılması ile olayın takip edilmesi, adli mercilere iletilmesi, beraberinde; gerçekleşen olayların analizinin yapılarak ilgili sağlık kurumuna özgü tedbirlerin alınması için çalışma yapılması amaçlanmaktadır. Beyaz kodun kapsamı, hastane personeli, hastalar, hasta yakınları ve ziyaretçilerden oluşmaktadır.

Sonuç: Bu çalışmadaki amacımız artık neredeyse her gün gördüğümüz sağlıkçıya şiddet haberlerinin dışında bu şiddetin sıklığını, tipini ve sağlık çalışanları açısından demografik verileri bilmek, ölçülebilir hale getirmek, bu olayların sebebine ve alınacak önlemlerle bu olayları önlenebilir hale getirmektir.

Anahtar Kelimeler: COVID-19, şiddet, sağlık çalışanı

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INTRODUCTION

Although violence is a public health problem in the workplace as well as in society, its incidence is increasing. Many studies have been carried out in Turkey and abroad regarding the violence that health workers are exposed to, and in one of these studies, it was shown that working in a health institution is 16 times more risky in terms of being exposed to violence compared to other workplaces.[1] Health workers are worried about the existence of a constant threat, thinking that they will be exposed to violence at any moment. Violence and fear of exposure reduce the quality of the health service provided, which negatively affects the employees, and paves the way for the emergence of new violence.

In a study that included primary care, public hospital and university hospital workers, it was reported that approximately half of the health workers, 50.8% (48.4% for men and 52.5% for women) had been subjected to violence in the last year.[2] It is prominent in some studies that the reporting of violence against healthcare workers is very low, only serious events such as injury and death are considered as violence and others are not reported.[3]

The White Code Implementation was established with the Regulation on Ensuring Patient and Employee Safety dated 6 April 2011 and numbered 27897[4], and was last regulated by the Ministry of Health Legal Aid and White Code Implementation Circular dated 16 March 2016 and numbered 11045126-010.06 and still in effect.[5] With this application, monitoring the violence that takes place in all public and private health institutions and organizations, following the incident with the necessary intervention, forwarding it to the judicial authorities, together with; It is aimed to make an analysis of the events that took place and to work on taking precautions specific to the relevant health institution. The scope of the white code consists of hospital staff, patients, relatives and visitors.

Our aim in this study is to know the frequency, type of violence and demographic data in terms of health workers, to make them measurable, to make these events preventable with the measures to be taken and the cause of these events, apart from the news about violence against healthcare professionals that we see almost every day.

MATERIAL AND METHOD

This retrospective observational study was conducted in a hospital serving as a Training and Research Hospital in a city with a population of 4.4 million. The data in this study includes violence against healthcare workers from January 2018 to the end of June 2022. 359 reported white code cases within the specified date range were included in the study. The date and time of the white code notifications, the gender, age, duty of the health worker who was exposed, the hospital unit where the incident took place and the type of violence were recorded. These data were grouped and analyzed. At the same time, the recorded data were divided into 2 groups as before and after the pandemic. While grouping, 11 March 2020, the pandemic declaration date of the World Health Organization, was accepted as the starting time. The study was carried out with the permission of Izmir Katip Celebi University Ethics Committee (Decision No: 0332). All procedures were carried out in accordance with the ethical rules and the principles of the Declaration of Helsinki.

Statistical Analysis

The data were evaluated in the statistical package program of IBM SPSS Statistics Standard Concurrent User V 26 (IBM Corp., Armonk, New York, USA). Descriptive statistics were given as number of units (n), percent (%), mean ± standard deviation ($\bar{x}\pm ss$), median (M), minimum (min) and maximum (max) values. The normal distribution of the data of numerical variables was evaluated with the Shapiro Wilk test of normality. Comparisons of the two groups were compared with the Mann-Whitney U test, since the data did not fulfill the normal distribution conditions. Pearson and Fisher exact tests were used to compare categorical variables with each other. A p value of <0.05 was considered statistically significant.

RESULTS

A total of 359 incidents of violence against healthcare workers in 5 years were included in the study retrospectively from June 2022. The number of healthcare workers who were exposed to violence before the pandemic was 187 (52.1%) and 172 (47.9%) after the pandemic. It was observed that the majority of violence cases were experienced in the emergency service (32.0%) and laboratory and imaging units (22.3%). It was observed that the number of physicians exposed to violence constituted the majority with 207 (57.7%). Of all the healthcare workers who were exposed to violence, 206 (57.4%) were male and 153 (42.6%) were female. The age range of health workers who were exposed to violence ranged from 22 to 66. Of those who resorted to violence, 178 (49.6%) were observed as the patient who applied for examination, and 146 (40.7%) were observed as the patient's relatives. 224 (62.4%) of the attacks were recorded as verbal violence, 31 (8.6%) physical violence, and 104 (29.0%) both verbal and physical violence (**Table 1**).

According to **Table 2**, the age at exposure to violence was statistically high before the pandemic ($p<0.001$). As seen in **Table 3**, no statistical difference was found in the areas where the event occurred before and after the pandemic ($p>0.05$). The rates of health personnel who were attacked did not change statistically before and after the pandemic ($p>0.05$). Gender variable was similarly distributed in the groups ($p>0.05$) (**Table 3**). A statistically significant

decrease in physical violence was observed after the pandemic (p=0.028). Persons and communities who resorted to violence were the same before and after the pandemic (p>0.05). A statistically significant increase was found in cases of violence in the Emergency Department after the pandemic (p=0.009). There was no change in the rates in other units (p>0.05).

Table 1: Descriptive Values

Variables	Statistics
Group	
Pre-Pandemic	187 (52.1)
Post Pandemic	172 (47.9)
Crime Scene, n (%)	
Eye Clinic/Polyclinics	21 (5.8)
Surgery (Brain and General)	28 (7.8)
Cardiology Polyclinic	18 (5.0)
Emergency	115 (32.0)
Nephrology/Urology Polyclinics	10 (2.8)
Gastroenterology Polyclinic	10 (2.8)
Orthopedic Clinic	23 (6.4)
Obstetrics and Gynecology Clinic	16 (4.5)
Other clinics	38 (10.4)
Laboratory and Other Units	80 (22.3)
Title, n (%)	
Physician	207 (57.7)
Nurse/Midwife	68 (18.9)
Security guard	27 (7.5)
Data Registrar	40 (11.1)
Officers and Technicians	17 (4.7)
Gender, n (%)	
Male	206 (57.4)
Female	153 (42.6)
Age	
$\bar{x}$±ss	36.35±8.17
M (min-max)	34 (22-66)
Perpetrators of Violence, n (%)	
Patient	178 (49.6)
The relatives of the patient	146 (40.7)
Patient and Relatives	35 (9.7)
Attack Type	
Physical Violence	31 (8.6)
Verbal Violence	224 (62.4)
Both Physical and Verbal Violence	104 (29.0)

$\bar{x}$:Mean, sd: Standard deviation, M: Median, %: Percent of Rows

Table 2: Age Comparison Before and After the Pandemic

	Groups		Test Statistics	
	Pre-Pandemic M (min-max)	Post-Pandemic M (min-max)	z value	p value
Age	36 (22-66)	32 (23-61)	4.164	<0.001

M: Median, z: Standardized Mann-Whitney U test

Table 3. Comparison of data before and after the pandemic

	Groups		Test statistics	
	Pre-pandemic n (%)	Post-pandemic n (%)	χ^2 value	p value
Crime scene				
Eye clinic / clinics	9 (42.9)	12 (57.1)		
Surgery (brain and general)	15 (53.6)	13 (46.4)		
Cardiology polyclinic	12 (66.7)	6 (33.3)		
Emergency	47 (40.9)	68 (59.1)		
Gastroenterology polyclinic	7 (70.0)	3 (30.0)	19.474	0.143
Orthopedic clinic	13 (56.5)	10 (43.5)		
Chest diseases	7 (100.0)	0 (0.0)		
Obstetrics and gynecology clinic	8 (50.0)	8 (50.0)		
Other clinics	20 (48.8)	21 (51.2)		
Laboratory and other units	49 (61.3)	31 (38.8)		
Title				
Physician	102 (49.3)	105 (50.7)		
Nurse/midwife	9 (52.9)	8 (47.1)		
Security guard	11 (40.7)	16 (59.3)	4.892	0.298
Data registrar	24 (60.0)	16 (40.0)		
Officers and technicians	41 (60.3)	27 (39.7)		
Attack type				
Physically	23 (74.2)[a]	8 (25.8)[b]		
Verbal	115 (51.3)[a]	109 (48.7)[a]	7.151	0.028
Both physical and verbal violence	49 (47.1)[a]	55 (52.9)[a]		
Perpetrator of violence				
Patient	88 (49.4)	90 (50.6)		
The relatives of the patient	85 (58.2)	61 (41.8)	4.479	0.090
Patient and relatives	14 (40.0)	21 (60.0)		
Crime scene				
Urgent	46 (40.0)[a]	69 (60.0)[b]		
Policlinic	91 (54.8)[a]	75 (45.2)[a]	11.757	0.009
Service/intensive care	26 (63.4)[a]	15 (36.6)[a]		
Imaging/lab	13 (35.1)[a]	24 (64.9)[a]		
Gender				
Male	110 (53.4)	96 (46.6)	0.332	0.594
Female	77 (50.3)	76 (49.7)		

%: Row, χ^2: Chi-square test statistic

DISCUSSION

Due to the increase in the population, the spread of diseases and the lack of sufficient number of health personnel, violence against health workers is increasing day by day in our country as well as all over the world. Although the violence applied causes physical or psychological damage to the health worker, it also seriously affects the efficiency and continuation of the health service, which is already done with devotion.

In this study conducted in Izmir, no significant difference was observed in the rates of giving white codes before and after the pandemic. The fact that the white code rate does not change even in the event of an epidemic that poses a global threat to the world makes us think that violence is a habit

rather than an instant reaction. When the gender exposed to violence was evaluated in the study, no statistically significant difference was found between male and female gender, unlike other studies conducted in Turkey.[6] In the 5-year analysis, there was no significant difference between the areas where the white code was given. However, we were surprised that other units such as the laboratory and radiology ranked second in terms of frequency, after the place where contact with patients and their relatives is easiest, such as the emergency department. These data are different from other studies.[7] However, we think that this situation is due to the increase in the frequency of contact with patients and their relatives during the waiting period for the results of laboratory tests, computerized tomography scans, that is, the results of the related branches used in diagnosis and treatment follow-up with the effect of the pandemic. This is a result of the pandemic, contrary to previous studies.[6,7] Another result is the age of the health personnel. It has been observed that the age of health personnel who gave white code has decreased significantly, and this may be the result of the fact that doctors over 55-60 years old work more passively or withdraw from work due to this pandemic.

When crime scenes are compared, white code, which is more common in the outpatient clinics before the pandemic than in the emergency services, is more common in the post-pandemic emergency room. This situation can be interpreted as the decrease in the number of patients applying to outpatient clinics outside the emergency department and the number of doctors working in related units due to the pandemic. In the study, it was stated that the number of applications to the neurosurgery outpatient clinic decreased during the pandemic process, and that the rate of diagnosis from emergency services increased as a result of the system.[8]

When the duties of health workers are compared, it is observed that doctors are more exposed to violence, parallel to previous studies.[6] but with a more serious intensity and difference. This situation is in parallel with the data in crowded countries such as India and China.[9-11]

If we look at the type of violence, we observed that verbal violence was significantly higher in our study in parallel with other studies.[6] When compared before and after the pandemic, it was observed that physical violence decreased significantly more. This may be the result of the avoidance reflex, which is inherent in the pandemic, avoiding physical contact.

Violence against doctors and other healthcare professionals has not changed compared to before the pandemic, unlike the number of patients that decreased during the pandemic. This shows us that violence in health is a viral contagious situation like COVID-19. As all infectious diseases can be prevented with early intervention, treatment or preventive methods, social behavior patterns also need early intervention and protective methods without stereotyping. Many solutions have been proposed to overcome this situation, Physicians and other health professionals have certain responsibilities, as well as by patients and their relatives, political parties, hospital authorities, legislative mechanisms, media and government to see the improvement of health services and the reduction of violence against doctors. responsibilities must be assumed.

Limitation

This study was conducted in a single center and retrospectively, white code notification was made and then the reports that were withdrawn by consensus and the violence that occurred without the white code were excluded from the study. Another limitation is that healthcare professionals do not report all incidents of violence for social and psychological reasons.

CONCLUSION

In this study, we observed retrospectively that there was no decrease in white code and therefore violence events before and after the pandemic. A detailed countrywide longitudinal study is needed to understand the prevalence, nature and regional differences of violence against doctors in Turkey.

ETHICAL DECLARATIONS

Ethics Committee Approval: The study was carried out with the permission of Izmir Katip Celebi University Ethics Committee (Decision No: 0332).

Informed Consent: Because the study was designed retrospectively, no written informed consent form was obtained from patients.

Referee Evaluation Process: Externally peer-reviewed.

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