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# Violence at Healthcare

## Sağlık Hizmetlerinde Şiddet

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**ABSTRACT**

Violence, a problematic phenomenon experienced in different forms (physical, verbal, symbolic, sexual, etc.), is increasingly prominent in sociological analysis. Violence is an unwanted aspect of everyday life experience; it is common in traffic incidences, in the family, in the workplace, and in personal interactions almost everywhere. In recent years, women and health professionals (doctors and non-doctors) in particular have been subjected to violence. Violence against women and children has become remarkably commonplace. An increase in violence against physicians and healthcare professionals as part of this more hostile environment could be observed.Violence against doctors is now a global problem.The well-being of health workers has been disrupted not only by the changing dynamics in doctor-patient relationships, but also by the general environment of insecurity. All forms of violence must be condemned; not only healthcare workers but also the decion makers have to deal with the issue of violence collectively and systematically.

**Key words**: Health, violence,violence towards healthcare proffesionals

**ÖZET**

Şiddet farklı şekillerde (fiziksel, sözel, sembolik, cinsel vb.) yaşanan sorunlu bir olgudur ve sosyolojik incelemelerde giderek daha fazla öne çıkmaktadır. Şiddet günlük yaşam deneyiminin bir parçası olmamalıdır; ancak trafikte, ailede, işyerinde sıkça karşılaşılır ve neredeyse her yerde kişisel etkileşimler gerçekleşir. Son yıllarda, özellikle kadınlar ve sağlık çalışanları (doktorlar ve doktor olmayanlar) şiddete uğramaktadır. Bunun en çarpıcı örneği kadına ve çocuğa yönelik şiddettir. Çevremizdeki bu düşmanca çevrenin bir parçası olarak, hekimlere ve sağlık çalışanlarına yönelik şiddetin arttığını gözlemliyoruz. Doktorlara karşı şiddet artık küresel bir sorundur. Sağlık çalışanlarının refahı yalnızca doktor-hasta ilişkilerindeki değişen dinamikler tarafından değil, aynı zamanda genel güvensizlik ortamı nedeniyle de bozulmuştur. Şiddetin tüm biçimleri kınanmalıdır; şiddet konusu yalnızca sağlık çalışanları değil aynı zamanda karar koyucular tarafından da örgütlü ve sistematik olarak ele alınmalıdır.

**Anahtar sözcükler**: Sağlık,şiddet, sağlık çalışanlarına yönelik şiddet

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## INTRODUCTION

Violence is a problematic phenomenon experienced in different forms (physical, verbal, symbolic, sexual, etc.) and is interdisciplinary dimensions, and they are increasingly prominent in the sociological analysis of everyday life experience and social change. [1]

Violence should not be part of everyday life experience; but is frequently encountered in traffic, in the family, in the workplace, and is almost everywhere personal interactions take place.In recent years, violence has become particularly visible to women and health care workers (physicians and non-physicians).The most striking example is violence against women. [2] Social violence in enviroinment, and the increase in violence against physicians and health professionals are observed and reported. [3]

## METHODOLOGY

This review is aimed to give information to the primary-care health workers about the definition of violence, the reasons of violence and the possible preventive methods and literature search was done using PubMed, Google scholar, and Scopus databases for the key terms "violence," "health care violence," "medical violence," and/or "primary care physicians". All the relevant articles were included to support the argument for this narrative review.

## ETIOLOGY

Violence is an outburst of anger combined with frustration among patients' relatives. Whenever the healthcare workers face the demise of those close to them, most of them go through phasic alterations of mind, and pass through five main stages of grief: denial, anger, bargaining, depression, and finally acceptance. People exhibit the displacement of anger and denial to cope with the situation, and it is the emotion transfer from one situation or person to another that is the main reason for violence against doctors and other health staff. Advanced medical care technology has revolutionized medical care outcomes on the one hand; however, it has led to high expectations of 100% cure among patients and relatives. The difference between these high expectations and actual realities on the ground, is the main root cause of this issue. Other incidents, including blaming the doctor, even when the relatives have waited until the final stage of the disease to seek treatment to avoid substantial medical bills. Another contributing factor increasing violence is the poor image of medical professionals projected by media, leading to the general belief that healthcare delivery has become a business, and the patients are consumers to be exploited for profit. Corporate hospitals try to negotiate with the patient groups outside the institution of law to retain their social status. A literature search shows workplace violence results mainly from doctor–patient mistrust, changing dynamics of the doctor–patient relationship, although the other factors cannot be ignored. [4]

History of Physician–Patient Bonding For ease of understanding, this is described in five stages as follows:

a. Ancient Egypt (approximately 4000–1000 B.C) [5] described the physician–patient relationship evolved from the priest-supplicant association. The paternalistic approach was popular. At that time, healers used to play the dual role of magicians as well as priests in order to dominate the helpless, sick, and moribund, and their near ones. Egyptian medicine was based on a paternalistic type and activity, and passivity type of relationship between doctors and patients'; the doctors directed and patients obeyed orders without any question or doubt. [4]

b. The era of Greek enlightenment in 5$^{th}$ century B.C. The empirical-rational approach was adopted. This meant that they depended more on observation, and trial, and error. They abandoned magical and religious justifications, and instead developed the relationship of guidance, cooperation, and to a lesser degree, a mutual relationship approach. They advised the patient during counseling, similar to an adult-adolescent relationship. The Hippocratic Oath raised medical ethics above self-interest, irrespective of class, and status at that time. [4]

c. Medieval Europe and the Inquisition (1200–1600 A.D.) – After the collapse of the Roman empire, religious and supernatural world beliefs were restored. After the crusades and witch hunts, the doctor– patient relationship regressed, and the doctor regained the role of father figure, similar to the Egyptian gave others, and the patient obeyed. [4]

d. French revolution – the French revolution ended the situation in which underprivileged populations were inhumanely imprisoned. Again, a change of the doctor–patient relationship progressed towards greater equality. [4]

e. Modern era (1700 onwards) – In the early 1700s, there were very few doctors, and they treated only upper-class patients. This model was called “symptom-based model of illness,” and the doctor played a dominant role. In the late 18th century with the rapid development of science, especially progresses in microbiological and surgical skills, the “biomedical model of illness” emerged and it superseding the “symptom-based model.” At this time, the paternalistic model persisted. With the emergence of psychosocial theories (Breuer and Freud) in 1955, however the mutual participation relationship was restored. The practice of medicine was renamed as patient-centered medicine. Michael Blaint, in 1964, proposed the idea of “doctor as a drug.”, based on the dynamic relationship between the doctor and the patient. According to him, the doctor–patient relationship is a “mutual investment.” He believed that, because the doctor was able to obtain the patient’s details, the clinician could improve communication skills with patients. It resulted in more efficient consultation, which eventually provided a better understanding of the patient’s requirements. This was a key change, missing in the previous era. From the above discussion, the fluctation of the doctor-patient relationship could be concluded by the time. These ere poptrayed sometimes as God, and sometimes as evil according to the changing scenario. [4]

The review of violence in healthcare revealed that, of all types of violence directed towards healthcare workers, violence was most commonly shown by relatives of the patients, followed by the patients themselves[6]. In recent years, violence has unfortunately became an element and an inevitable part of the health care working environment. Every day different incidents of violence from different regions are reported, constituting an "epidemic of violence". On April 17, 2012,. The murder of Ersin Arslan by a patient in Gaziantep has created a justifiable indignation in the physician's office and in the healthcare center in Turkey. As a reflection of this interest, regulations and guidelines on violence against health workers were published. [7]

The patients' rights regulations, introduced in 1998, Turkey have been implemented virtually in all Turkish hospitals since 2004. The "184 telephone line", designed as "Patient Rights Units" and "Ministry of Health Communication Center" was established to solve patients’ problems with health care services. It has become an effective and widely used complaint communication and intervention platform for patients and their relatives. All said and done, we do acknowledge that healthy criticism increases job satisfaction and productivity. But, 184 phone line and the other lines gave service for patients not for the security of physicians or the rights of healthcare workers. However, it has become possible for individuals to gain more information through popular health programs, which are widely broadcast by the media and the internet, and intense media interest in health / illness. This has led to the emergence of a new, more demanding and questioning patient type not previously observed in the health care system. [7] By the pandemic of COVID-19, “184 complaint telephone” converted into a helpline for the emergencies and/or the information for the COVİD-19 suspicious patients.[8]

**The conflicts between primary care physicians and patients**

1. Patient’s grievances – Unnecessary investigations, delay in attending to the patient, and request for advance payments or withholding a dead body after demise under a final settlement of billing.

2. Doctor’s grievances – Commercialization of medical education due to the rapid growth of private medical colleges with inadequate infrastructure, and shortage of faculty staff, as per the medical council of India (MCI) standards. Education in these private medical colleges is so expensive that most doctors intend to work in cooporate sectors to recoup the investement in their careers, corporate hospitals have protocols on how to proceed with a patient of a particular disease. In this situation doctors are hesitant to file a complaint or the first information report against the abusive relatives, as justice, is a slow process, and further, usually these assault cases are mob driven; there is no convictions for assaulting a doctor due to inactivity of judicial system and police officials; further MCI, state medical councils are the bodies for registration, and record keeping which has not intervened in any of the assault cases which have surfaced in the past. Due to all these factors, doctors are hesitant to take risky decisions, even though these might have been better for the patient in longterm.

3. Workplace factors – The patient-doctor relationship is adversely affected by workplace factors such as communication barriers, physical barriers, political pressure, the influence of relatives, and heavy workload.
4. Macrolevel factors which include:

a. Failure of the government healthcare system: Factors, such as government health policy, i.e., allocation of funds for health, free medicines, and fixed timings of the outpatient department (OPD), are also an important determinant. For example, in a government primary or secondary healthcare settings, the patients are being provided with free medicines; however, due to inventory issues, the medicines may not be dispensed immediately and a convenient target for frustration irrespective of the political interplay of factors. The public healthcare system in India follows the welfare model as the majority of people is poor and lack any health insurance. Due to subsidized medical care, Indian healthcare institutions (government run) are swamped with patients with their attendants. Some medical officers are caring for an average of 100 patients per day. It is obvious that the quality of care will be get compromised if the doctor has to see 100 patients in a fixed period. This high-intensity situation in the OPDs imparts a pseudoperception of negligence which leave patients and relatives, unsatisfied as doctor–patient interaction time suffers. Due to long wait times, any inappropriate interaction or delay in attending to patient triggers anger. As most of the patients are uninsured, the shock of diagnosis and consequent economic disaster may create emotional turbulance.

b. Doctor–patient or Google-patient relationship: Disease-related information accessed through the internet is often free, yet dubious. It provides people with quick access to health-related information. It can potentially empower the patient, and facilitate the mutual relationship approach, i.e. adult–adult interaction. Relevant health-related information is available on social media groups such as WhatsApp and Facebook, providing information before a formal consultation with doctor, patients and their family access the information. This cannot be entirely attributed to the mistrust of the treating physician; however, they feel its better to be fully equipped with medical knowledge of the symptoms before speaking to the doctor. It showed encouraged by the doctors only if patients refer to authentic official sites for information; however, in reality, patients often gain confused understanding of their symptoms. This misinformation negatively affects the doctor-patient relationship. [4]

**Causes of Violence From Physicians' Point of View**

Violence against health workers is related to many factors. When assessed from the physician's perspective, the most important reasons for increased violence at healthcare centers in recent years are health politics, in which physicians are often targeted in this process. In this frame, it is frequently pointed out by the physicians that the health problems begin before consultation are unfairly blamed on physicians. In this case, the feeling of injustice is expressed very strongly. [7]

**RISK FACTORS & FIELD EXPERIENCES FOR VIOLENCE**

**Risk factors; Gender, Age, Status**

In general, most research reported doctors and nurses are at high risk. Their risk has been compared to that faced by police and other law enforcement workers. [9] Women are at higher risk of verbal and physical harassment in Turkey [10], although Gascon et al. reported that was not a significant factor in Spain [9]. However, in some studies, it has been found that victimization due to verbal and physical violence is positively correlated with male gender, and sexual harassment, with female gender. [6, 11] In general, women are more at risk in Turkey of both verbal violence, physical violence than men.[6]
In addition, younger people (<39 years), general practitioners and nurses are the other risk groups in terms of violence. [12, 13]

**Health Care Unit and Occupational Area**

The most important cause of violence in Turkey are organizational problems of the health unit.[6] Emergency Service health care workers who attend accidents are different from other employees as they are exposed to injury risk as well as violence.[13] The level of exposure to violence in primary health care institutions and in state hospitals is significantly higher.[12, 13] On the other hand, employees in primary health care institutions have a significantly greater exposure to professional violence outside of health care facilities compared to their colleagues working in hospitals.[14] However, in some research into physical assault of those; it was found that working in emergency service was positively correlated with patient-related threats and verbal aggression.[15]
Studies indicate that violence occurs most often during daylight hours, in patient rooms, and often in the first hour of the patient's visit to the health unit. [6]

**Habits and Dependencies**

Drug intake and alcohol use are among the most common causes of violence. There is also a positive correlation between anxiety and psychiatric illness and violence. [11]
Long waiting hours, and lack of information are some of the frequently cited reasons for violence, but it's not clear how much these are responsible.

**Conclusion and Recommendations**

Doctors are no more considered demigods or authorities in their field; on the one hand, there is a valid reason for this because of the changes in the field; however, on the other distrust is spreading to the whole community of physicians. Medical decisions are being altered by the availabilities of Wikipedia references on the related disease, the suspiciens of the patient's caregivers, doctors practicing defensive medicine to avoid risk and their preferance for jobs in corporate hospitals. People blame doctors without examining the root causes of problems. Routinely, the news of patients' relatives assaulting doctors, inflicting grievous injuries, which attracts little attention could be heard. It is important to take the responsibility to save the saviors. Solutions to reduce the incidents of violence against the doctors include improved trust between the patient and the doctor, and to vicus problems in terms of various other socioeconomic problems plaguing the market-oriented society. Deteriorating doctor–patient relationship is the symptom of social degradation, increasing intolerance, and increasing distrust. Hence, all these factors need to be addressed horizontally; medical education needs strengthening, crucial gaps in communication between doctors and patients, need addressing the number of patients per doctor, the root cause of the majority of problems, needs to be reduced an emphathetic attitude needs to be taken toward patients, and stricter laws for both medical negligence and violence against doctors need to be enacted. The medical curriculum should certainly incorporate necessary communication skills. Media can play a role in improving the image of doctors and the medical profession, projecting role models rather than negligence cases reinforce value of the ethical practices in young minds. Furthermore, violence against doctors should be made a nonbailable offense, increasing the trust of physicians in the judicial system may cause the next generation of brilliant students to turn away from this unforgiving profession. [4]

Additionally, some undesirable results should be expected when the "Health Transformation Program" emphasizes performance, score, transaction, competition, inward closure, profit and made these business concepts a part of physicians' lives against their will. Physicians and health professionals could find changing working conditions and a changing health environment with such a transformation. As a result, applied policies, reduced physicians' happiness, hope, and inreased concern for the future.

The paternalistic patient-physician interaction model has largely lost its validity.In this context, it should be noted that the patient model expectation of democratic interaction within the framework of equality with the physician, is dominating health issues. The traditional values of general practice has developed from 1960's till todays modern speciality of family medicine. [16] Begining of 1990 Barbara Starfield described the basic structure of family medicine practice as "*first contact care, continuity, comprehensiveness, and coordination*". In 2000, Royal New Zealand College of General Pactitioners reported the principles of family medicine as:

-relationship over time
-comprehensive primary care
-coordination of care
-person-centered approach
-acute and chronic health problems
-equitable resource utilization
-family, community oriented care

While family physicians are on the frontline, in full-time clinical practice and care for the individual and family all life cycle, the attitude can only be performed by the '*actions that arise out of love and kindness, not duty and fear*.' The expectations from the healthcare system lie at the heart of the crisis of violence. Core principles of the family medicine dicipline are well-structured and should be supported by the stakeholders, laws, proffesional associations and the community. [17]

COVİD-19 pandemic makes all citizens of the world "clap" and support all healthcare workers, after a while the violence-elephant in the room- has araused again in the name of a patient that spit to the face of a nurse and/or a physician and a relative smashed a fist at the face of a hospital guard. Maybe the individuals have showed their attitudes that they had already shown to their families to the healthcare workers: the number of the murdered women is increasing, the ratio of the tortured children as

well. The “violence culture” of the society should change.

This is replacity a system where patient submit unconditionally to the physicians’ authority, and are grateful and thankful. This increasing problem can only be solved when health policies are compatible with the "holistic model" and "comprehensive approach" of the core competencies of the family physician while management of ”the fear mongering” methods drift apart from not only the community but also the healthcare workers. Improvement should be considered for the legacy and rights such as to bring compensations to reasonable levels and the night shifts more humanistic conscience.

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