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Reducing Violence towards Healthcare Professionals

The Role of Voluntary, Community Organisations

ABSTRACT
There is a rising trend of violence against healthcare professionals across the world, especially after the COVID-19 pandemic. Many countries report between 43-75% of professionals experiencing at least one incident in any annual survey. The most recent incident of doctors and healthcare staff in a Manchester City General Practice raised alarms. As the healthcare infrastructure and services are severely stretched following the disruption of 2020, there are more reasons for disquiet and frustration from the public. The media and political portrayal of primary care physicians as not caring enough to provide face-to-face appointments in the UK is believed to increase the public angst. There are protests from professional organisations but this is not heard by the public.
In any violence prevention strategy, a multi-system approach is critical. While tackling misinformation is essential, so is the tackling the root causes, the waiting lists and a balanced information to the public. Political and organisational leaders need to be visible and vocal in explaining why the healthcare infrastructure is beyond breaking point. This will justify the additional resources needed and reduce the frustrations of the public, in need of care.
There is also a vital need to help new doctors and nurses as well as all frontline staff in violence dissipation techniques, self-preservation. The Voluntary community organisations including those that support professional groups have a vital role to play. The NHS People Plan has recommended that VSCEs should join robust and reliable partnerships with Integrated Care Organisations in developing strategies and interventions. There is more work to be done. This article is a call for action and invites all VSCEs interested in the reduction of violence against staff to join with employing organisations to set up collaborative working groups with specific actions to implement. This is essential to reduce harm and reduce the demoralisation of an already burnt-out healthcare workforce.

Key words
Violence against healthcare professionals, NHS Employers, Burn-out

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The unfortunate incident of a General Practice in Manchester being attacked by an irate member of the public in Manchester this week, resulting in serious bodily harm to a doctor and healthcare staff has alarmed many within the profession and the public. Dr Manisha Kumar, a medical director at Manchester Health and Care Commissioning remarked, *'We are sadly used to aggression but this was life threatening. This is not okay.'* [1] This simple observation does underline that aggression and violence towards healthcare staff is an uncanny reality of life.

When every country in the world recognises the rising incidence of physical violence and verbal aggression against healthcare workers (HCW), from patients or their relatives- it is certainly an issue that should concern the healthcare system leaders. A survey conducted by the Indian Medical Association in 2018, reported that 75% of doctors had experienced at least one instance of violence in the line of duty. [2] The United States, China [3] and the UK are no different in their experience. A survey in the UK in January 2020, before the COVID-19 pandemic found that 43% of 644 doctors saw physical violence or verbal abuse towards colleagues. [4] Although 32% of violent deaths of healthcare workers investigated in the USA from 2003-2016 (n=62) were due to homicide and perpetrated by a patient, relative or someone close to the patient - there was a larger proportion of deaths due to self-harm.[5] Emergency department staff, first responders, nursing or care home workers and psychiatric unit staff [6,7] are more at risk of physical violence.

Covid-19 pandemic

The risk of violence and reported incidents rose sharply after the pandemic, when health services were stretched to and often beyond breaking points in large swathes of countries across the world. [8] Most frequent reasons included mistrust in HCWs, belief in conspiracy theories, hospitals' refusal to admit COVID-19 patients due to limited space, COVID-19 hospital policies, and the death of the COVID-19 patients. Protests by doctors and other HCWs for provision of adequate PPE, better quarantine conditions for doctors with suspected COVID-19, and better compensation for doctors on COVID-19 patient duty resulted in police violence towards HCWs. [9] However, misinformation in respect of COVID-19 and adverse care outcomes led to an increase in violence against medical practitioners in low or middle income countries such as Bangladesh, India, Pakistan, Syria and Sudan [8]. In UK primary care settings, a perception of reduced face-to-face consultation availability has been cited as a reason for frustration and abusive behaviour.[10]

Experience of minority professionals

There is another angle to the violence experienced by healthcare professionals. This is the influence of gender, colour, religion and ethnicity.[11] The physical violence reported by minority ethnic and psychological abuse reported by female healthcare professionals is significantly worse than their peers. [12,13] A study of over 12,000 workers over the 6-year study period demonstrated the higher risk of violence towards professionals who were female (82%) and inpatient nurses. [14,15]

Determinants of Violence towards healthcare professionals

The likely drivers of violence are thought to be discontent with the service provided, health related or personal problems, and alcohol or substance abuse amongst the perpetrators. [16,17], poor administration, miscommunication, infrastructural issues especially differences in services between hospitals, and negative media portrayal of doctors.[18] Misinformation leading to a gap between expectation and reality (in relation to healthcare) is one of the key factors. Healthcare

professionals in mental health services or emergency medicine departments received more violent threats and sexual harassment than physicians in other departments. [19] Midwives tend to suffer the highest risk of experiencing aggression. [20] The treatment room is the most common place where the violence is known to occur.

Under-reporting is common and reported figures are likely to be gross underestimates. Only a minority of the professionals who experienced violence actually reported it. Being accustomed to workplace violence is the most stated reason for not reporting violence to the hospital administration or the authorities.[21] Among the HCW professions, nursing was the profession, in which HCWs were more prone to experience a violent episode, while male medical doctors were more prone to report violent episodes than female medical doctors. Moreover, female HCWs experienced more verbal violence (insults) than male HCWs did, while male HCWs experienced more physical violence (bodily contact) than female HCWs did. [22]

Consequences of Workplace violence

The studies identified seven categories of consequences of workplace violence: (1) physical, (2) psychological, (3) emotional, (4) work functioning, (5) relationship with patients/quality of care, (6) social/general, and (7) financial. Psychological (e.g Post traumatic stress, depression) and emotional (e.g., anger, fear) consequences and impact on work functioning (e.g., sick leave, job satisfaction) were the most frequent and important effects of workplace violence. [23]

Solutions

WPV for healthcare professionals is a preventable public health problem that needs urgent and comprehensive attention. Those in healthcare leadership can: 1) obtain hospital commitment to reduce WPV; 2) obtain a work-site-specific analysis; 3) employ site-specific violence prevention interventions at the individual and institutional level; and 4) advocate for policies and programs that reduce risk for WPV. [24] In general, primary prevention is best conceptualized using systemic- and individual-specific approaches.

On a systemic level, the display of zero-tolerance policies such as the NHS zero-tolerance posters might have a deterrent effect, although the efficacy of this has not been established. As the health service outcomes depend on excellent communication and trusting relationships between the care-giver and patients, the use of segregation, restrictive spaces, and visible security presence usually undermines this relationship and in some circumstances is known to aggravate the risk of violence. Majority of healthcare settings, however, do not have these facilities which make primary prevention more challenging. Healthcare professionals also live in public spaces, therefore personal risk does extend beyond the workspace. Additionally, predicting violence is difficult, and formal violence risk assessment instruments have relatively poor positive predictive value in populations. Violence prevention in respect of the pandemic is more complex. Some countries such as India, have passed stringent laws against health care violence during the pandemic [8] and others such as Sudan, are developing a specific police response system.

Secondary prevention aims at escaping or de-escalating an evolving violent situation. In an acute situation where violence is imminent, it might be necessary for the professional to exit the consultation to seek help [25] or be within visibility of other staff members. In many secure psychiatric units dealing with patients with a history of violence, there are systems and protocols for such eventualities. In the consultation, a range of techniques such as allowing the patient space to vent, preventing an increase in arousal by using empathy, and maintaining a calm tone of voice are effective.[25] This requires specific training and role-playing to master. Healthcare workers, students and trainees would benefit from formal de-escalation and personal safety training as part of workplace inductions.

One of the first lessons I remember learning during my first on-call ever as a junior doctor in Kolkata Medical College Hospital, was the art of self-defence. While assisting my senior house officer in resuscitating a patient who (even to my inexperienced eye) was clearly dead, I noticed the

strict adherence to the principles of an elaborate cardio-pulmonary resuscitation process being enacted. My quizzical look was answered by a slight nod of the head pointing me towards the 3 large, burly men who were crowding round the bed and pointing menacingly at the hapless trio of doctors and nurses undertaking the resuscitation. Although by that time, the patient was beyond our help, the enthusiasm with which we 'tried our very best' was rewarded with gratitude. The slippery slope from gratitude for trying your best to being blamed for the inevitable demise and then having to pay for it with physical harm- is all too familiar to many. That early lesson has helped me several times in my career to date.

A qualitative study from London reported that receptionists in GP practices were found to be most at risk, due to exclusion from team meetings and lack of peer support and advice. [26] The authors found that 'negative management tactics, such as patient appeasement or exclusion, were the norm'. A real commitment from leaders is needed and be understood by frontline staff in order to encourage reporting and implementation of the 'zero tolerance' policies which exist on paper.

Tertiary prevention (after the incident) includes accurate recording of the incident in the patient's clinical notes and clinical alerts. Having an incident debrief with practice staff, including, sometimes an independent experienced colleague, can help establish learning points in respect of how an incident was managed. Decisions about the ongoing care of the patient by a different practitioner within the same clinic or at a different clinic might need to be taken based on the seriousness of the violent episode.

In the UK, there have also been calls for a systematic response from Clinical Commissioning Groups to respond to the increased reports of pandemic-related violence with a consistent approach and for increasing the availability of occupational health measures for the doctors involved.[10] Therefore most recommendations on the management of workplace violence include the development of participative, gender-based, culture-based, non-discriminatory, and systematic strategies to deal with issues related to violence.

Trade Unions & Voluntary sector partnerships

Partnership working between the voluntary sector, local government and the NHS is crucial to improving care for people and communities. The British Medical Association and Royal College of Nursing as the largest trade union organisations in the UK, play an important role in supporting their members, encouraging specific policies and protocols to be developed and monitoring when such incidents of violence against professionals is on the rise. [4] There is more to be done and we see a need for collaborative working with the voluntary sector.

The NHS People's Plan [27] highlights the need for closer working across public and voluntary sectors to address the wider determinants of health, which in turn could impact on the demand on primary and acute services. Voluntary, Community and Social Enterprise (VCSE) involvement and leadership has been key to developing rich partnerships within local health and care systems. We know that it is through the support of the VCSE sector that Integrated Care Systems (ICS) have been able to make progress towards addressing health inequalities and improving public health.

COVID-19 has acted as a catalyst for even greater integration of VCSE services and time and resources are progressively being directed towards facilitating access to educational resources, reducing social isolation and delivering preventative interventions for crime reduction. One such example of a community voluntary organisation supporting Filipino nurses in the UK was expanded during the pandemic to help families too. [28]

VCSE organisations are often embedded in neighbourhoods and have a unique advantage when it comes to engaging the most at-risk and rarely heard communities. They play a key role in facilitating dialogue between the system and its residents, making sure that services are co-produced with purpose, with residents at the heart of service provision. The voluntary sector works in three main ways. The first, and by far the largest area of work, is service delivery to support individuals in the criminal justice system and their

families. The second – often in combination with the first - is campaigning and advocating in order to reform the criminal justice system. Finally, there are self help organisations, set up to share experiences and support amongst peers, which are usually local and volunteer run.[29] This type of resource is largely missing for women and minority ethnic professionals in the UK NHS.

For the VCSE to achieve its full potential in the delivery of integrated care, it needs to be recognised fully as a part of the system.[30] In April 2018 the UK Government published its Serious Violence Strategy which represents a step change in how to think and respond to serious violence, establishing a new balance between prevention and law enforcement. It declared a call to action to partners from across different sectors to come together and adopt a whole-system multi-agency approach to tackling and preventing serious violence at a local level, often referred to as a 'public health approach'. The Government introduced a range of initiatives including: a new statutory duty on public sector agencies and bodies to prevent and tackle serious violence, which will help create the conditions for collaboration and regular communication to share data and intelligence to understand and tackle the root
causes of serious violence. [31] This strategy and the public duty applies equally to instances of violence against healthcare professionals and rests with NHS Employers.

We are aware of the initiatives that the women's forum of the British Association of Physicians of Indian Origin are initiating to reduce personal violence towards women specially around commuting to and from work, which is also on the rise. Although the intention remains from policy makers to engage 'a whole system approach' to tackling violence, there needs to be more engagement from both sectors. We propose setting up a reducing violence working group and a roundtable for developing consensus between NHS Employers, Clinical Commissioning Groups and Social care providers including local authorities. This is a call for action before more lives are lost and a weather-beaten workforce is further demoralised.

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