

## Original Research Article

# Work place violence against resident doctors of a tertiary care hospital in Delhi, India

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## ABSTRACT

**Background:** Workplace violence is much prevalent across the globe in almost all institution dealing directly with general public and hospitals are no exception to it. Hospitals have high incidence of work place violence because it caters a service which attaches the emotional aspect of the patient and their escorts. The present study aims to evaluate this important issue qualitatively and quantitatively.

**Methods:** Hundred resident doctor of clinical discipline were interviewed, and response filled in pre-designed questionnaire between 1<sup>st</sup> February 2017 to 28<sup>th</sup> February 2017.

**Results:** A large portion of study population i.e.68% was worried about violence at the work place. Junior residents faced both physical (10.9%) and psychological violence (84.3%). Very few participants out of the study population (8%) have training in managing conflicts. About 92 (61.3%) respondents were not aware of any violence prevention policy at their workplace, 45 (30%) had no idea whether it exists or not.

**Conclusions:** A significant proportion of the violence encountered in the clinical setting is perpetrated by relatives of the patients and it is more prevalent when gang members are present, especially in evening and night time. Most of the physical aggression and a significant proportion of the verbal aggression experienced by doctors are the result of negative media guide, poor communication, and long waiting period, presence of gang members and generally regard clinical issues arising from patient care. Training the resident doctors in good working practices, effective communication and alternative methods of resolving conflicts is generally seen as the way to reduce the likelihood of this type of aggression.

**Keywords:** Doctors, Hospital, Resident, Risk factors, Workplace violence

## INTRODUCTION

Workplace violence is much prevalent across the globe in almost all institution dealing directly with general public and hospitals are no exception to it. Hospitals have high incidence of work place violence because it caters a service which attaches the emotional aspect of the patient and their escorts. Whenever the patient party develops a perception of breach in service in part of doctor or any

other health care provider, there generates a sense of dissatisfaction. Some of them respond to it by emotional outburst leading to violence in the form of physical retaliation or verbal abuse.

In the USA, the NIOSH notes that the public place where most violence toward employees is observed is hospitals.<sup>1</sup> In other words, healthcare workers are the professionals who are the most vulnerable to workplace violence.<sup>2</sup>

Workplace violence in the health sectors is defined as the incidents where staffs are abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.<sup>2</sup> The WHO definition of workplace violence includes physical violence and psychological violence.<sup>3</sup> Physical violence consists of hitting, kicking, shooting, barring, pushing, biting, sexual harassment and rape. Psychological violence is an intentional act against a person or a collective force that results in physical mental, spiritual, moral and social damage that includes verbal abuse, threats, insult, and harassment.<sup>3</sup>

Violence against doctors is on a rising trend in hospitals across India. Most of the violent situations are faced by the resident doctors who are the respondents at the emergency department or dealing with people at odd hours. Although it is not as high as many other nations like China but when compared to other developed nations like USA and UK, work environment is very unsafe in India. Preliminary findings of an ongoing study by the Indian medical association (IMA) have revealed that over 75 percent of doctors in India have faced some form of violence at work.<sup>4</sup>

According to this report, maximum violence is faced by the doctors when providing emergency services, with as many as 48.8% of such incidents reported from intensive care units (ICUs) or after a patient had undergone surgery. There is a six-fold increase in the proportion of physical violence occurring each year, the proportion in 2012 (8.3%) was almost double that of 2008 (4.5%).

In USA greater than 13% increase in physical assaults reported in 2010 as compared to 2009. In a study conducted in 2009, in Al-Hassa, Saudi Arabia, it was found that about 28% of the 1091 workers studied had been exposed to at least one violent event in the previous year, 92.1% of this was emotional and 7.9% physical.<sup>5</sup> The above data is not a true indicator of actual prevalence of work place violence because most of the time it goes unreported due to various reasons like feeling of shame, guilt, unaware of reporting procedure, lack of policy etc.

Workplace violence leads to a stressful working climate. It not only hurts physically but has a lasting impact on the morale, self-respect, confidence, value system of the victims and their colleagues, which negatively influences the creativity and efficiency of human resource of the hospital.<sup>6</sup> The purpose of present study was to identify factors associated with the incidence of work place violence, so that preventive measures can be taken to reduce the circumstances that ultimately results in conflict and violence.

The prevalence and nature of work place violence against Health care workers vary considerably across the globe. Qualitative and quantitative analysis of this critical situation is very important and will form the foundation

for addressing this alarming situation. The regional and hospital specific data on various factors leading to these unfortunate incidences will go a long way in management of this menace. This study was undertaken to investigate and analyses the present situation in a tertiary care teaching hospital on nation capital region of Delhi. Our institution is a 1200 bedded tertiary care teaching hospital in central Delhi. Like most other government hospitals in India, it has crowded OPDs, busy emergency departments and our hospital is no exception to work place violence.

The objective of this study was to identify the risk factors associated with work place violence.

## **METHODS**

Study location for this experiment was Dr. Ram Manohar Lohia Hospital New Delhi. Study population included resident Doctor of Clinical, discipline of Dr. Ram Manohar Lohia Hospital, New Delhi who were directly involved in patient care and worked in this institute for more than 12 months.

Study type was the descriptive questionnaire survey. A cross sectional study was designed between the period from which this study was performed from 1<sup>st</sup> February 2017 to 28<sup>th</sup> February 2017. Data were collected by direct questionnaires given to the study population fill up answers. Sampling method was the stratified sampling. The target population consists of resident Doctor of Clinical departments of Dr Ram Manohar Lohia Hospital, New Delhi. The sample size was 100 in the present study.

### **Exclusion criteria**

- Resident doctors of non-clinical and para-clinical departments who were not in direct contact with the patients were excluded from the study.

### **Type of questionnaire**

Self-administered questionnaire, with format containing both open and closed ended questions.

### **Pretesting and validation**

Pre-testing and validation done by conducting pilot survey on 10 resident doctors and collected data analysed, which is providing desired information.

### **Measures**

The purpose of the study was informed to each participant and they were also informed of the fact that each of them was free to withdraw any time. Assurance was given to them concerning confidentiality. A written informed consent was obtained from each participant an anonymous, self-administered questionnaire was given to 150 participants and 7-day time was given to carefully read, fill up the answers and questionnaire was collected

back. The content validity of the questionnaire was examined prior to initiation of the study. Content validity index was found to be 0.91. Cronbach's alpha coefficient was 0.80. The questionnaire used is developed based on a literature review and a modified version of the questionnaire developed in 2003 by the International labour office (ILO), International council of nurses (ICN), WHO, and Public services international (PSI) joint program.<sup>3</sup>

As our interest of study is the risk factors of WPV, authors have deleted, added and modified some of the question of the original questionnaire in order to fit the objective of present study, working scenario of our institution and the study population. Therefore, the modified questionnaire has three sections: personal and workplace data, physical workplace violence, psychological workplace violence. After collecting the questionnaire back from the participants, first 100 valid one was taken into study and analysed using appropriate statistical method as described below.

**Statistical analysis**

Data was compiled on a MS-Excel sheet. Marked responses of the participants were arranged in the Excel sheet as follows; then the data was analysed using analysis tool Pak (an add-on extension software of Microsoft excel)

Standard definitions adopted from WHO were used to define the types of violence, according to which physical violence was described as the use of physical force against another person or group that results in physical, sexual or psychological harm. This includes beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching. Intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral or social development was labelled as emotional violence and includes bullying/mobbing, harassment and threats. Similarly, verbal violence (also known as reviling or "verbal bullying") was defined as a negative defining statement told to the victim or about the victim, or by withholding any response, thereby defining the target as non-existent.

**RESULTS**

Present study tried to elucidate the various aspects related to episodes of violence encountered by the doctors during their working hours in last 12 months.

In present study 72% of respondents are male and 28% are female. While comparing work experience it was found that junior resident faced both physical (10.9%) and psychological violence (84.3%) more frequently than

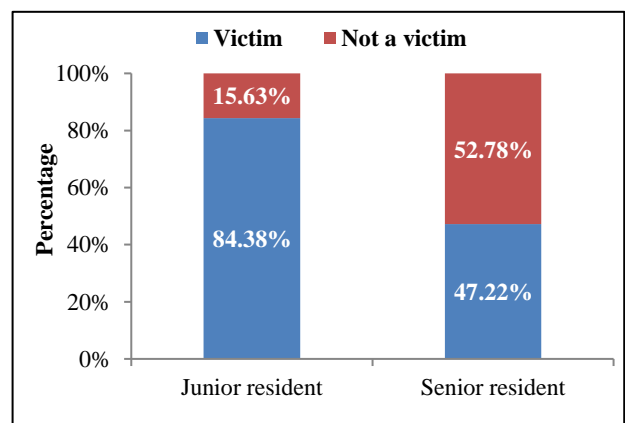
the senior residents (Figure1). While asked about reporting system, majority (70%) don't have any idea about the existence of one in the hospital, 19% don't know and rest 11% who know about it, most of them don't know how to use them.

Very few participants out of the study population (8%) have training in managing conflicts. 10% of the study population encountered physical violence during last 12-month duration of their job in this hospital and most of them have faced it once.1% of them faced it more than once.

Out of them verbal abuse was most common and encountered in 71.8%, followed by threatening in 64.8%, followed by bullying/mobbing in 33.8% and verbal sexual harassment in 9.9% cases. When asked about their opinion on the cause of incident (Table 1), most common reason reported by 80% respondents was negative media guide, followed by poor communication which led to conflict in 70%, dissatisfaction with doctors and nurses' work was reported by 60%, no improvement in patient's condition and presence of gang member were the responses from 50%.

Long waiting time was reported only by 40%. Relative of the patient were reported to be the most common perpetrators in 80% and 57.7% followed by patients themselves in 20% and 33.8% followed by general public in 0% and 8.4% cases of physical and psychological violence respectively.

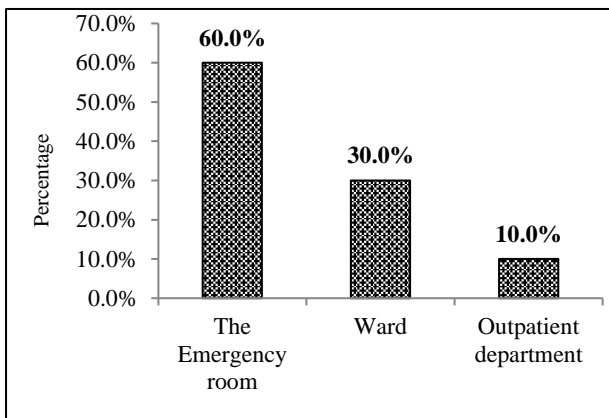
Most of the incidents of physical violence occurred in the emergency room (Figure 2 and 3) i.e.70.4% followed by outpatient department and ward being 11.2% times each. 70.4% faced psychological violence in the emergency room, 11.3% in the outpatient department, and 11.3% in ward, 4.2% in the corridor, 1.4% at the nurse station and 1.4% on the way to office.



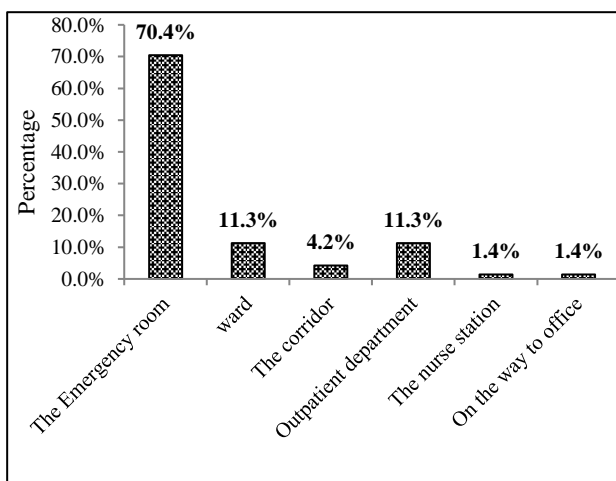
**Figure1: Percentage distribution of psychological violence among junior and senior residents.**

**Table1: Causes of workplace violence and percentage of victims think it to be one of the causes of the incident.**

Cause of incident	% of victims of physical violence	% of victims of psychological violence
Negative media guide	80.0	73.2
Mental disorder of patients	10.00	40.8
College instigated	20.0	21.1
Presence of gang member	50.0	54.9
Poor communication	70.0	63.3
The requirement of patients and relative did not meet	40.0	39.4
High medical expenses paid by own	0.0	0.0
Patient died after the rescue invalid	30	33.8
No improvement in patients' condition	50.0	18.3
Long waiting time	40.0	61.9
Seek financial compensation	10.0	0.0
Not satisfied with doctor's work	50.0	23.9
Not satisfied with nurse's work	60.0	18.3



**Figure 2: Percentage distribution of physical violence at different workplaces inside the hospital.**



**Figure 3: Percentage distribution of psychological violence at different workplaces inside the hospital.**

The reported timing of physical violence was found to be from 18.00 to 24.00 hour by 30%, from 24.00 to 7.00 hr. by 30% respondents. When asked about the response of the victims to the physical violence the replies were; 70% told the perpetrator to stop and tried to defend themselves physically, 40% took no action, confided in family and friends and sought the help of the student's union, and only 30% reported it to their senior staff. The study subjects who consider the event to be preventable were 80% and 73% of the victims of physical and psychological violence respectively. 40% of them got injured by the physical violence and 60% took time off from work as a result of the incident. 80% in their response revealed that some action was taken to investigate the cause of physical violence, 20% replied no to the question.

Out of them, in only 20% cases, matter was reported to police, verbal warning was issued by the hospital authority in 40%, care was discontinued 10%, attacker faced no consequences in 10% and 20% have no idea about consequences to the attacker. For psychological violence, 72% of victims said that no action was taken to investigate the cause of psychological violence and 25% don't know whether any action was taken or not. Majority 56.3% of offender faced no consequences, 23.9% issued verbal warning and care was discontinued in 2.8% of cases and 16.9% don't know the consequences to perpetrator. So not a single response came in which the aggressor is prosecuted for the crime he committed. None of the victims of physical violence said that their supervisors offer to provide them counselling, which was provided to 19.7% of victims of psychological violence. While seniors offer to provide them with opportunity to speak /report it in 20% and 12.7% of cases of physical and psychological violence.

Most of the victims of physical violence found it dissatisfied or very dissatisfied by the manner the incident was handled, which is obvious from the answers to the previous questions. Reason for not reporting the incident of physical assault was found to be; ignorance about the reporting system in 80%, 70% felt ashamed to discuss it, 40% thought it useless to report, 40% were afraid of negative consequence, and 20% thought it was not important. 65 of the 100 doctors have witnessed incidents of physical violence, 19 of them more than once, but none of them have reported it ever. The different responses of the doctor to the episode of psychological violence were as follows; 60.6% told the offender to stop, 50.7% took no action, 47.9% tried to ignore it and 46.5% reported it to seniors. Most of the doctors are either dissatisfied (69%) or highly dissatisfied (21.1%) by the manner the incident was handled. When asked the reason for not reporting the responses were; 43.7% consider it useless to report which shows the feeble trust of the respondents on the system, 39.4% thought reporting was not important, 42.3% felt ashamed, but the leading cause for not reporting was 73.2% don't know how to report it.

## DISCUSSION

Authors' institution is a tertiary care hospital located in the capital of our country, its catchment area is not confined by a limited geographical boundary, and the population of patient consists of local residents of Delhi as well as those referred from other states.

Previous research has found that age was a risk factor for workplace violence in general hospitals. As present study population consists of resident doctors whose age group range is narrow (from 24 years to 31 years), it was not found to be significant as a risk factor. In the study conducted by Kumar M et al, proportion of female doctors being victim of Violence was more often than the male i.e. 51% Vs 45%. However, in present study 14.2% female encountered physical violence which is comparable to the male counterpart (8.3%), and with respect to psychological violence male were victimised more often (76.0%) than female (23.9%).<sup>7</sup> Present study results show that junior residents have encountered WPV more often than senior residents. It may be because of relative inexperience in clinical acumen, communication skill, pressure handling, conflict management and also the relatively lower trust on them from the patient party. Incidences of violence were more during the evening and night shift. No significant difference in incidences of WPV found among those working with different age groups and sex. A large portion of study population i.e. 68% was worried about violence at the work place. While data regarding reporting of WPV, training to tackle it are very demoralizing. Due to this majority of the incidences go unreported, resulting in no consequence to the perpetrator, which encourage them to repeat such activities. Very few participants out of the study population (8%) have training in managing conflicts,

which is a part of their curriculum in psychiatry, not separate training to manage aggression and violence and most other don't have one. This is comparable to the result of study by Kumar M et al, where they found it in 6.4% of respondents.<sup>7</sup> In his study About 92 (61.3%) respondents were not aware of any violence prevention policy at their workplace, 45 (30%) said they had no idea whether it exists or not, while only 13 (8.7%) knew of the existence of any such policy at their workplace. Looking to the trend of growing WPV 87% respondents are willing to participate in training to manage aggression and violence. This is a very healthy and progressive attitude shown by the resident doctors and health care system should provide counselling and training programme to resident them in order to make them more familiar with the pathogenesis of WPV and to manage it timely and efficiently. Incidence of physical violence are comparable with the study done by Xing K et al, they found that 12.6% of their population had incidence of physical violence and Kumar M et al, in their study observed that in 8.5% of population.<sup>7,8</sup> This survey revealed that incidents of psychological violence are far more common than the physical violence. Ori J et al, found that verbal threats 56.11% were the most common type of violence experienced and Sexual harassment contributed 55% of the cases.<sup>9</sup> The reasons for the violent incidents found in the study are different. Negative media guide was found to be the most common cause, which is creating a negative image of the healthcare system in the eye of general public, which is destroying patient-doctor trust significantly. Poor communication skill is another leading cause for obvious reason. Other causes were non-improvement of patient condition, and long waiting time. A variety of causes responsible for instigating a violent episode have been revealed in different studies. Study by Iluz TC et al, (Israel) observed that the most common causes of violence were long waiting time (46.2%), dissatisfaction with treatment (15.4%) and disagreement with the physician (10.3%).<sup>10</sup> Koukia E et al, (Greece) also observed violation of visiting hours by the visitor (88.8%), long waiting periods 86.4%), visitors' psychological problems (83.2%) and smoking prohibition in the waiting areas (82.4%) as the precipitating factors.<sup>11</sup> Long waiting periods (73.5%), delayed medical provision (45.6%), violation of visiting hours and patient's dissatisfaction with nursing care (41%), psychological stress (38.4%) and denial of hospital admission due to limited availability of beds in the wards (31.1%) were pointed out to be possible causes of violence in the study done by Kumar M et al.<sup>7</sup>

Most of the incidents of physical violence occurred in the emergency room which is similar to the report of DuHart et al, where he reported that 78% of emergency department physicians nationwide report being the target of workplace violence in the year 2000.<sup>11</sup> This may be due to the fact that emergency department is often overcrowded with poor doctor to patient ratio and also receives the most of serious patients. During the evening and night time there are relatively a smaller number of

senior doctors. So, managing serious patient in an over crowded high pressure area by relatively inexperienced doctor may be the reason for higher incidences of conflict in those areas. Similar results were observed by Magnavita et al.<sup>12</sup> Main reason for violence in outpatient department may be due to long waiting time. The data regarding the response of the victim and the hospital towards the perpetrator suggest that there is a huge gap in the reporting and redressal system against workplace violence in the hospital. In most of the instances either ignorance, lack of courage and lack of universally accessible and effective reporting system, the incident was gone unreported. Even if in a small number of reported cases did not meet to a satisfying outcome or action against any perpetrator. Abused workers suffer higher job stress, greater psychological distress; have a greater sense of injustice and lower social support than other workers.

Present study indicates that the problem exists, and that prevention is essential. Training the resident doctors in good working practices, effective communication and alternative methods of resolving conflicts is generally seen as the way to reduce the likelihood of this type of aggression, especially if it is accompanied by organizational and environmental safety measures. It was also found there is nonexistence of policy for reporting, counselling, investigating the cause and prosecuting the perpetrator at the ground level. Moreover, due to multiple reasons, the responses of the victim to the incident were found inappropriate in majority of cases. These should therefore be integrated with specific intervention targeted at root causes such as conflict in the workplace. The association of violence with psychosocial variables indicates the need for far-reaching changes in health care organization that should include decision-making procedures, work climate and support, and relations between workers.

## CONCLUSION

Violence at work is a tip of iceberg phenomenon and in most of the health care facilities there is no policy for reporting and prevention. Even if there is a policy there is wide spread ignorance among the residence doctors about it leading to under reporting. Most of the physical aggression and a significant proportion of the verbal aggression experienced by doctors are the result of negative media guide, poor communication, and long waiting period, presence of gang members and generally regard clinical issues arising from patient care. Training the resident doctors in good working practices, effective communication and alternative methods of resolving conflicts is generally seen as the way to reduce the likelihood of this type of aggression, especially if it is accompanied by organizational and environmental safety measures. Our experience indicates, however, that a significant proportion of the violence encountered in the clinical setting is perpetrated by relatives of the patients and it is more prevalent when gang members are present,

especially in evening and night time. Traditional methods, such as the development of personal safety skills and de-escalation techniques, or institutional policies and environmental design may not be sufficient to solve the issue like negative media guide, mental disorder of the patients or their escorts. Counteracting violence requires strong commitment on the part of both resident doctors and management.

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