Original article

Exposure of Physicians to Workplace Violence

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Abstract

Introduction: The main goal of the research was to determine whether the doctors who work at the Clinical Medical Center Osijek are exposed to violence in the workplace, in what form of violence, whether there are differences in exposure between doctors according to age, gender and depending on whether they are specialists or residents.

Participants and methods: This study is organized as a cross-sectional study. 101 doctors employed at the Clinical Medical Center Osijek participated in this research. The data were collected by answering an anonymous online questionnaire.

Results: The majority of respondents who were exposed to violence at the workplace indicated that they had experienced verbal abuse (41.6%), followed by mobbing (21.8%), physical (5%) and sexual abuse (3%).

Conclusion: Due to the small sample of the study, there are no significant differences in the distribution of respondents according to exposure to any form of violence in relation to gender, age or whether they are residents or specialists.

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Introduction

1.1 Types of violence in the physicians' workplace

Workplace violence is present in almost all working sectors and its workers, but health department holds a significant share of violence especially towards primary healthcare providers such as doctors and nurses (1). Studies show how health department constitutes almost a quarter of all workplace violence and 73% of all non-fatal injuries (2). A physician can experience workplace violence from patients, members of the patient's family or healthcare facilities' visitors, but the perpetrator is mostly patient (3). Healthcare workplace violence can be in a form of physical violence, verbal, sexual, threats and bullying. Mobbing is referred to abuse by colleagues, superiors or bosses. It's usually a consequence of established hierarchy at the workplace which causes imbalance in relationships between colleagues. The high stress levels, heavy workload, and competitive environment in the healthcare sector often led to a lack of administrative support, indirectly encouraging this type of violence (4).

1.2 Risk factors and consequences of workplace violence

Risk factors for violence against physicians have been identified and are categorized into groups depending on whether they are related to the patient, the physician, the organization of the work environment, or society, including patients with mental illnesses, addictions, or behavioral disorders, as well as healthcare system overload (1, 5, 6, 7). Prolonged time in the waiting room and the feeling of neglect can lead to patient's frustrations and mistrust worsening their relationship with physicians (8). Stress and administrative tasks lower the quality of provided healthcare while lack of physician's communication skills and empathy can trigger patients' negative reactions (9). Social factors include lack of respect, language and cultural barriers and distrust exacerbated by the negative media portrayals. Experienced violence can adversely affect a doctor's physical and mental health, it can cause depression, insomnia, PTSP, anxiety, burn-out syndrome. It can limit physician's work efficiency, job satisfaction and even result in leaving medical profession. Over a longer period of time, it can result in disruption of the overall functioning and efficiency of the health system (10, 11, 12, 13).

1.3 Epidemiology of violence in the healthcare sector

World Health Organization has estimated that between 8% and 38% of health workers experience some form of workplace violence but it must be taken into consideration that most of the time workplace violence is unreported. Studies have shown how the most common type of workplace violence in healthcare is verbal abuse (61.2%), then psychological (50.8%), threats (39.5%), physical (13.7%) and sexual abuse (6.3%) (2). In the last few years there has been an increase in violence toward the physicians which correlates with the COVID-19 pandemic (14, 15). Physicians were faced with the additional challenges such as lack of personal protective equipment, pressures to diagnose and treat patients with COVID-19, communication issues between patients, their families, and physicians, and fear of the unknown disease and its consequences (14). European countries which have the biggest increase in healthcare workplace violence are Germany, Spain, United Kingdom and Italy (14, 15, 16, 17). Violence against physicians is also not uncommon in Croatia. In 2016, the Croatian Medical Chamber conducted a survey on violence against doctors during their working hours, revealing that 93% of the surveyed physicians experienced some form of verbal or physical violence at work. Physical attacks on doctors occurred in 22% of healthcare institutions in Croatia (18).

Aims of this study are to determine whether physicians are exposed to violence during working hours, to investigate potential differences in exposure based on gender and age of the participants, to assess disparities in exposure between residents and specialists, and to determine physicians' perceptions of workplace safety.

Participants and Methods

The study was structured as a cross-sectional study (19). The participants were physicians employed at the Clinical Hospital Center Osijek and a total of 101 participants took part. The survey was conducted from July to June 2023 via an anonymous online questionnaire which was sent to the participants' email addresses. It was distributed officially through the administration of each hospital department; however, the exact number of employees who received it is unknown. The questionnaire was based on the WHO's free survey intended for wide use published in 2003 (20) and was compound of six parts: sociodemographic data (including the questions about concerns related to workplace violence and whether they are familiar with the procedure for filing a report), questions about physical violence, verbal, sexual, mobbing and employer's strategies regarding health and safety. Categorical data were presented as absolute and relative frequencies. Differences in categorical variables were tested using Fisher's exact test. Normality of the distribution of numerical variables was tested using the Shapiro-Wilk test, and due to non-normal distribution, data were described using median and interquartile range. All P-values are two-sided. The significance level was set at Alpha = 0.05. Statistical analysis was performed using MedCalc® Statistical Software version 22.006 (MedCalc Software Ltd, Ostend, Belgium; https://www.medcalc.org; 2023).

Results

The study was conducted on 101 participants, of which 37 (36.6%) were men and 64 (63.4%) were women. The median age of the respondents is 41 years, ranging from a minimum of 25 to a maximum of 64 years. Out of the total number of participants, 84 (83.2%) are specialists. Considering how long have they been employed at the Clinical Medical Center Osijek, 36 (35.6%) participants have been working between 10 and 20 years. Due to working in a demanding job, 9 (8.9%) respondents regularly or occasionally take tranquilizers. On a scale of 1 to 5, where a higher number indicates a higher level of concern about workplace violence, 44 (43.6%) respondents are not concerned (marked 1 or 2 on the scale), and 26 (25.8%) are concerned (marked 4 or 5 on the scale). 69 (68%) respondents claim that there are standard procedures for reporting workplace violence, and 38 (37.6%) are familiar with how to initiate the procedure. Regarding the method of reporting workplace violence, 23 (22.8%) respondents informed themselves, while 13 (12.9%) stated that they were informed by their superior. The majority of respondents who were exposed to workplace violence indicated that they were verbally abused (41.6%), followed by mobbing (21.8%), physically abused (5%) and sexually harassed (3%).

Three (3%) respondents stated that physical violence was committed by a patient or a patient's family member, and one respondent each stated that it was committed by a staff member or the supervisor. 21 (20.8%) respondents reported that verbal abuse was committed by a patient's family member, 16 (15.8%) indicated it was the patient, and 15 (14.9%) respondents reported that a staff member committed the abuse. Mobbing was mostly experienced by respondents from a staff member (12.9%). Sexual harassment was most frequently experienced from a staff member (2.0%) and from a patient (1.0%).

After the occurrence of physical violence, 3 (3.0%) respondents officially reported the incident, 2 (2.0%) asked the perpetrator to stop or confided in a colleague, and one attempted to physically defend themselves and initiated criminal proceedings against the perpetrator. After a verbal incident, only 3 (3.0%) respondents officially reported it, while the majority (19.8%) asked the perpetrator to stop, confided in their colleagues (17.8%) and close ones (14.9%). Following mobbing, 12 (11.9%) respondents stated that they asked the perpetrator to stop or confided in a colleague. No sexual harassment incidents were officially reported; the perpetrator was asked to stop (2.0%), and 1.0% of respondents did not react to the harassment. The psychological consequences of physical, verbal, sexual harassment, and mobbing are summarized in Table 1, and the actions of supervisors/employers after the incident are summarized in Table 2.

Table 1 Psychological consequences of violence

	Number of respondents (%)			
Mark how often the following occur with you:	**PHYSICAL**	**VERBAL**	**MOBBING**	**SEXUAL**
Repeated, disturbing memories, thoughts, or images of the attack?				
Never	**3 (3.0)**	**20 (19.8)**	**8 (7.9)**	**2 (2.0)**
Rarely	1 (1.0)	13 (12.9)	5 (5.0)	1 (1.0)
Sometimes	1 (1.0)	7 (6.9)	6 (5.9)	-
Often	-	2 (2.0)	3 (3.0)	-
Almost always	-	-	-	-
Avoiding thinking or talking about the attack or avoiding having feelings related to it?				
Never	**4 (4.0)**	**20 (19.8)**	**7 (6.9)**	**2 (2.0)**
Rarely	1 (1.0)	13 (12.9)	6 (5.9)	-
Sometimes	-	6 (5.9)	4 (4.0)	1 (1.0)
Often	-	2 (2.0)	5 (5.0)	-
Almost always	-	1 (1.0)	-	-
Being "super-alert" or watchful and on guard?				
Never	**3 (3.0)**	**15 (14.9)**	4 (4.0)	1 (1.0)
Rarely	-	14 (13.9)	3 (3.0)	1 (1.0)
Sometimes	1 (1.0)	10 (9.9)	**10 (9.9)**	1 (1.0)
Often	1 (1.0)	3 (3.0)	5 (5.0)	-
Almost always	-	-	-	-
Feeling like everything you did was an effort?				
Never	1 (1.0)	8 (7.9)	2 (2.0)	-
Rarely	1 (1.0)	10 (9.9)	3 (3.0)	**2 (2.0)**
Sometimes	1 (1.0)	**15 (14.9)**	**11 (10.9)**	-
Often	**2 (2.0)**	7 (6.9)	6 (5.9)	-
Almost always	-	2 (2.0)	-	1 (1.0)

Table 2. Superior'/Employer's approach

	Number of respondents (%)			
	PHYSICAL	VERBAL	MOBBING	SEXUAL
Did your superiors take certain measures against the perpetrator after suffering violence at the workplace?				
Yes	1 (1.0)	2 (2.0)	3 (3.0)	2 (2.0)
I don't know	1 (1.0)	24 (23.8)	14 (13.9)	-
No	**3 (3.0)**	**16 (15.8)**	**5 (5.0)**	**1 (1.0)**
Did your employer or supervisor offer to provide you with				
Opportunity of psychological counseling				
Yes	-	2 (2.0)	-	-
No	**5 (5.0)**	**40 (39.6)**	**22 (21.8)**	**3 (3.0)**
Opportunity to speak about/report it				
Yes	1 (1.0)	9 (8.9)	2 (2.0)	-
No	**4 (4.0)**	**33 (32.7)**	**20 (19.8)**	**3 (3.0)**
Other support?				
Yes	1 (1.0)	6 (5.9)	4 (4.0)	-
No	**4 (4.0)**	**36 (35.6)**	**18 (17.8)**	**3 (3.0)**

Doctors who decided not to report the incident mostly did not report it because they considered it useless (physical violence 3.0%, verbal 22.8%, mobbing 10.9%, and sexual 2.0%). Doctors did not report mobbing also due to fear of negative consequences (5.9%) or because they did not know whom to contact (5.0%).

Differences in the distribution of exposure to violence in relation to gender, age, and whether the respondent is a resident or a specialist were statistically analyzed using Fisher's exact test, and for all characteristics, the P value was above 0.05, indicating no statistically significant differences between the mentioned characteristics.

The participants were asked which measures used for dealing with workplace violence exist in their work environment and 57 (56.4%) respondents mentioned security measures, 18 (17.8%) protocols for patients, 14 (13.9%) advanced controls at the hospital entrance, and 37 (36.6%) stated that they have none of the above. The most useful measure in the work environment for 62 (61%) respondents is an increase in the staff number, and for 59 (58%) respondents, it is security measures, while changes in shift work or schedules or reduced periods of working alone are not useful at all. Changes that have occurred in the workplace and their impact on daily work are summarized in Table 3.

Table 3 The changes that took place in the workplace and their impact on daily work

	Number of respondents (%)
Which of the following changes, if any, have occurred in the workplace/health care setting in the last 2 years?	
None	**35 (34.7)**
Restructuring / reorganization	8 (7.9)
Decreased staff numbers	**13 (12.9)**
Increased staff numbers	5 (5.0)
Restriction of resources	**18 (17.8)**
Additional resources	1 (1.0)
I don't know	21 (20.8)
In your opinion, what impact have the above changes had on your daily work?	
None	**26 (25.7)**
Work situation for staff worsened	**24 (23.8)**
Work situation for staff improved	9 (8.9)
Situation for patients worsened	9 (8.9)
Situation for patients improved	2 (2.0)
I don't know	26 (25.7)
Other	5 (5.0)

Discussion

This study questioned whether the physicians employed at the Clinical Medical Center Osijek were exposed to violence during their working hours and their perception of the safety in the workplace. Previous research shows that young, female physicians are more likely to experience workplace violence (21). This is confirmed by data from countries like the USA, where 30% of women in the healthcare sector have experienced sexual harassment in the workplace compared to only 4% of men, and data from South Korea, where 64% of female healthcare workers experienced verbal abuse and 42% experienced threats of physical violence in 2019 (22). Although female doctors at Clinical Medical Center Osijek have more frequently experienced physical, verbal, and sexual harassment at work compared to their male counterparts, due to the small sample size, these data are not statistically significant. Women are likely more often exposed to violence due to gender stereotypes that portray them as more passive and less prone to conflict, making them more vulnerable targets and weaker authorities, thus less likely to report violence. The underreporting of violence can be a consequence of economic risks, as women often work under more insecure conditions with lower compensation and fewer benefits (22). The most frequent perpetrators of violence were consistently reported to be the patient and/or the patient's family across all forms of violence. This data aligns with a study from India, which found that in 97% of cases, the attacker was a family member of the patient, and in five cases, it was the patient themselves (8). These findings also correspond with data from the 2016 Croatian Medical Chamber survey, where the most common perpetrators of violence were patients (76%) and their family members (74%) (18). The underlying cause of their attitude and behavior is most often emotional stress and a sense of vulnerability arising from illness or injury (2). The psychological consequences of violence are often not immediately noticeable. Most participants stated that they often feel strained and exhausted but rarely have recurring distressing memories of the attack. The severity of the consequences depends on the individual, the frequency, and the intensity of the incidents (9). A stressful work environment can cause

sleep disorders, depression, anxiety, and deterioration of physical health. A small number of respondents reported using medications like alprazolam due to work-related stress. In 2016, 62% of Croatian physicians reported that they occasionally or constantly feel fear of becoming victims of violence at work. Many respondents also indicated increased stress, decreased motivation, and feelings of insecurity in their daily work, accompanied by emotional exhaustion. Such consequences lead physicians to adopt a more distant approach toward patients in an effort to protect themselves from potential conflicts, which negatively affects the quality of care. In some cases, physicians even consider leaving their jobs (18). Employers should provide support such as psychological counseling, but according to the survey, not a single doctor was offered counseling after an incident. Workplace violence has many causes, so there is no simple solution. The role of the employer is important in reducing the risk of abuse and improving the handling of violent incidents. The employer should inform doctors about standard procedures for reporting violence, but most respondents obtained this information on their own. The employer must take action against the perpetrators, but most respondents stated that this was not done. This lack of standard procedures discourages victims and encourages abuse (9). Many hospitals do not have procedures to prevent violence, making the safety of doctors a lower priority. This is confirmed by survey data where most respondents expressed dissatisfaction with how any incident was resolved, as in most cases, there were no consequences for the attacker. Doctors who decided not to report the incident mostly did not report it because they considered it useless, feared negative consequences, or did not know whom to contact. This correlates with the data from 2016, where as many as 72% of physicians who experienced some form of violence did not file an official report for the same reasons (18). The employer must ensure an environment where employees feel safe to report violence, as fear of reporting increases the risk of errors, results in poorer care, and decreases individual performance, teamwork, and communication (23, 24). Mobbing is common amongst the physicians, particularly directed towards younger residents by their older colleagues, and this behavior is often normalized, leading to underreporting (1). Underreporting poses challenges in identifying and addressing violence and hinders research efforts on the topic (25). Physicians often downplay violence, considering it part of the job, especially those who work with psychiatric patients, despite the psychiatrists being the most often exposed to workplace violence (26, 11).

Although most respondents mention the presence of security measures such as alarms and phones, some emphasize that their workplaces lack adequate protective measures. This can leave physicians feeling unprotected. Respondents believe that increasing the number of staff would reduce the workload and improve individual patient care. However, the majority state that no changes have occurred in their workplaces, and in fact, the number of staff has decreased and resources have been limited. Most respondents react to violence by asking the perpetrator to stop, confiding in loved ones, or not reacting at all. It is possible that for this reason, most respondents suggest that useful measures would include training for medical staff to alert and prepare them for workplace violence, familiarizing them with useful coping strategies and communication skills. Skills used to calm situations and patient tension can be both verbal and non-verbal, aimed at building trust with the patient and mitigating violent actions (27, 28). Investing in communities that aid addicts can also reduce the risk of violence (5, 6). Protecting healthcare workers also requires engagement from governmental bodies, as seen in Italy where monetary fines and imprisonment are introduced for violence against healthcare workers, while India imposes prison sentences of up to seven years, especially for incidents related to COVID-19 patients (15, 17). In Croatia, a physician does not have the status of a public official, and therefore violence against a physician is not prosecuted as such under criminal law. It wasn't until January 2019 that a new criminal offense called "Coercion against a healthcare worker" was

introduced into the Croatian Penal Code. This offense criminalizes the behavior of perpetrators who, by force or threat of immediate use of force, prevent a medical doctor, dental doctor, or other healthcare worker performing their duties as a public service from carrying out their healthcare activities. The penalty for this offense can be imprisonment of up to three years. In more severe cases, such as causing injury or endangering the life of the healthcare worker, the sentence can be up to five years of imprisonment (29). The Croatian Medical Chamber records all cases of violence against physicians to monitor its frequency and provide legal assistance. Physicians can report attacks or violence in writing, either by mail or email, to the Croatian Medical Chamber (30).

Conclusion

Based on the conducted research and the obtained results, we can conclude that physicians at the Clinical Hospital Center Osijek are exposed to violence during working hours, with verbal violence being the most frequently experienced, followed by workplace bullying (mobbing), physical, and sexual abuse. There are no significant differences in the distribution of respondents based on exposure to any form of violence concerning gender, age, or whether they are residents or specialists. Physicians at the Clinical Hospital Center Osijek are moderately concerned about any form of violence in the workplace, with only 37.6% of physicians being familiar with how to initiate the violence reporting process. Physicians consider increasing the number of staff to be the most useful security measure. This study acknowledges the limitation of its small sample size, which restricts the generalizability of the findings. Due to the low statistical power, the results should be interpreted with caution. Further research with larger sample sizes is necessary to validate these preliminary findings. Additionally, the study may not have had sufficient power to detect statistically significant effects, indicating the need for more robust studies to confirm the observed trends. Furthermore, the lack of recent national data on the topic limits the contextualization of our findings.

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Guarantor of the study: MM, APE
Provision of study materials or patients: MM, APE
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Izloženost liječnika nasilju na radnom mjestu

Sažetak

Cilj: Glavni je cilj istraživanja bio odrediti jesu li liječnici Kliničkog bolničkog centra Osijek izloženi nasilju na radnome mjestu, kojem obliku nasilja, postoje li razlike u izloženosti između liječnika prema dobi, spolu te ovisno o tome jesu li specijalist ili specijalizant.

Ispitanici i metode: Istraživanje je ustrojeno kao presječno istraživanje. U istraživanju je sudjelovao 101 liječnik zaposlen u KBC-u Osijek. Podaci su prikupljeni rješavanjem anonimnog online upitnika.

Rezultati: Većina ispitanika koji su bili izloženi nasilju na radnome mjestu je označilo da su doživjeli verbalno zlostavljanje (41,6 %), zatim zlostavljanje na radnome mjestu (mobbing) (21,8 %), fizičko (5 %) pa spolno zlostavljanje (3 %).

Zaključak: Zbog malog uzorka studije nema značajne razlike u raspodjeli ispitanika prema izloženosti bilo kojem obliku nasilja u odnosu na spol, dob ili po tome jesu li specijalizanti ili specijalisti.