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Violence: Recognition, Management and Prevention

VIOLENCE AGAINST HEALTH CARE PROVIDERS: A MIXED-METHODS STUDY FROM KARACHI, PAKISTAN

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☐ **Abstract—Background: Violence against health care providers (HCPs) remains a significant public health problem in developing countries, affecting their performance and motivation. Objectives: To report the quantity and perceived causes of violence committed upon HCPs and identify strategies intended to prevent and de-escalate it. Methods: This was a mixed-methods concurrent study design (QUAN-QUAL). A structured questionnaire was filled in on-site by trained data collectors for quantitative study. Sites were tertiary care hospitals, local nongovernmental organizations (NGOs) providing health services, and ambulance services. Qualitative data were collected through in-depth interviews and focus group discussions at these same sites, as well as with other stakeholders including media and law enforcement agencies. Results: One-third of the participants had experienced some form of violence in the last 12 months. Verbal violence was experienced more frequently (30.5%) than physical violence (14.6%). Persons who accompanied patients (58.1%) were found to be the chief perpetrators. Security staff and ambulance staff were significantly more likely to report physical violence (p = 0.001). Private hospitals and local NGOs providing health services were significantly less likely to report physical violence (p = 0.002). HCPs complained about poor facilities, heavy workload, and lack of preparedness to deal with violence. The deficiencies highlighted predominantly included inadequate security and lack of training to respond effectively to violence. Most stakeholders thought that poor quality of services and low capacity of HCPs contributed significantly to violent incidents. Conclusion: There is a great need to design interventions that can help in addressing the behavioral, institutional, and sociopolitical factors promoting violence against HCPs. Future projects should focus on designing interventions to prevent and mitigate violence at multiple levels.**

☐ **Keywords—violence; health care providers; preventive strategies**

INTRODUCTION

The World Health Organization defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (1). Violence was declared a major public health problem in the Forty-Ninth World Health Assembly in 1996 (2). The Assembly recommended that Member States give urgent consideration to the problem of violence and set up public health activities to prevent and mitigate it. Almost one-fourth of workplace violence occurs within the health care sector. Within health care, emergency care is the sub-sector

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most impacted by violence that occurs in the workplace (3). Fear of violence affects the performance of health care providers and decreases their responsiveness to patients' health care needs, especially in emergency situations (2). Moreover, ineffective security also decreases the confidence of the patient that they will be able to obtain health care services safely, without experiencing violence perpetrated by other patients or those who accompany those patients (4). As effective security services are an important contributor to a hospital's reputation, hospitals with the means to do so, and hospital leadership motivated to do so, will allocate sufficient resources to enable a safe environment in hospitals (5). Violence against health care providers (HCPs) at the workplace is an alarming problem in both developed and developing countries. Although developed countries have made significant progress in providing a safe work environment for their HCPs, it remains a significant public health challenge in developing countries (6–10).

In Pakistan, violence against health care staff such as sectarian killings of doctors, extortion threats, execution of patients, and targeting of HCPs due to possession of sensitive information have been widely reported by the print and electronic media (11). This study aimed to report the quantity and perceived causes of violence committed upon HCPs and identify strategies intended to prevent and de-escalate it. It was conducted in Karachi, which is one of the world's top 10 most populous cities, with an estimated population of 18 million (12). Although reported events of violence like terrorism, militant attacks, target killings, and security operations have declined, the city still remains the most violent place in the country (13). More importantly, it is widely believed that many low-level incidents of verbal and physical violence remain hidden and unreported. The city's health care system comprises a mix of 134 public and private hospitals providing health care services to the locals, with a significant number of referred patients from other parts of the country (14). Previous studies in the health care settings in the city have also shown frequent experience of physical and verbal abuse of varying intensity by HCPs (15,16).

MATERIALS AND METHODS

This was a mixed-methods concurrent triangulation design (QUAN-QUAL).

Quantitative Methods

Quantitative data were collected from HCPs at hospitals, nongovernmental organizations (NGOs), and ambulance services. We interviewed all cadres of HCPs, including doctors, nurses, technical staff, support staff, administrative/clerical staff, security staff, and ambulance staff. As data were being collected from multiple stakeholders without an accurate estimate of the target population, we decided to collect data from at least 50% of the staff present in the institutions. Data were collected from all consenting respondents using nonprobability convenient sampling.

A structured questionnaire was adapted from previous studies and finalized after discussions with stakeholders after 10 iterations. It included questions on the quantity of the problem, classification/types of violence, perceived reason or triggering of event, and consequences of the event. It was translated into the local language (Urdu) by a certified translator and was piloted prior to the formal start of the survey. A broad definition of violence was adopted for the study to capture all types of violence affecting the health care system, ranging from low-intensity verbal violence to armed attacks. Violence was defined as any act of verbal abuse (speaking in loud voice, threatening, abusing), physical abuse (pushing, beating, throwing things), and other acts, including use of weapons or damage to facility. The questionnaire was completed by trained data collectors. The field teams were accompanied by the supervisors, who checked the completeness of every form prior to submission to the project office for data entry. The data were entered in SPSS version 19 (IBM, Armonk, NY) on the same day.

Statistical analysis. Descriptive statistics are reported as frequencies and percentages. The relationship between predictor variables (age, gender, language, workplace, job position, and job experience) and two major types of violence (verbal and physical) was calculated using the chi-squared test. A p-value of < 0.05 was considered significant.

Qualitative Methods

The qualitative data were collected through 42 in-depth interviews (IDIs) and 17 focus group discussions (FGDs) conducted by researchers, which included senior faculty of the Institute of Public Health who had training in qualitative research and had previous experience of conducting IDIs and FGDs. Qualitative data were collected from hospitals, local NGOs providing health services, ambulance service providers (ASPs), and other stakeholders including media, law enforcement agencies (LEAs), and the Pakistan Medical Association. All the stakeholders were formally approached, official permission was taken, and face-to-face interviews were conducted. All participants were informed about the aims and objectives of the interview and the process of the interview. Purposive sampling was done to identify participants for IDIs and FGDs, which included service

providers and management staff of the organizations mentioned above.

The semi-structured interview guide developed by engaging all stakeholders was tested during the training of the data collectors. All the IDIs and FGDs were video- and audio-taped. The researcher guided the discussion, one data collector recorded the interview on paper, and the other recorded the nuances of the discussion and managed the recording. Each IDI/FGD time ranged from half an hour to 1 h. Details on distribution of organizations and participants are attached as Appendix 1.

Coding of the transcripts was done manually by three independent experts and consensus was reached after discussion on major themes and subthemes. Thematic content analysis was done and five broad themes were derived from data including description of violence, acceptance of violence, causes of violence, sequelae of violent events, and recommendations. The final analysis was shared with all the stakeholders. The study was approved by the National Bioethics Committee, which has a mandate to approve multicenter research on health issues.

RESULTS

A total of 861 structured questionnaires were initiated, and data from them were collected. However, those with missing information (n = 39) were not included, so the 822 fully completed questionnaires were utilized. The mean age of the participants was 34.51 years, with 59.7% males and 40.3% females. Of all HCPs, 21.2% were nurses, 15.8% were physicians, and 15.1% were technicians. Other participants included security, administrative, support, and ambulance staff.

Frequency, Nature, and Characteristics of Violence Experienced or Witnessed

Almost two-thirds of the participants (65.6%) had experienced or witnessed some kind of violence, and one-third reported having experienced some form of violence in the last 12 months (Table 1). Figure 1 shows the predominant nature of violence experienced or witnessed by the participants. More commonly experienced or witnessed forms included abusive language (82.8%), pushing and pulling (40.6%), and threats (34.7%). Persons who accompanied patients, including family members or friends (58.1%) and the general public (26%), were found to be the chief perpetrator in the events of violence, whereas 10.1% of events were initiated by HCPs themselves. The emergency department (ED; 56.4%) was the most common site of violence in the hospitals.

Table 1. Nature of Violence Experienced or Witnessed (n = 822)

	Violence Experienced or Witnessed	Violence Experienced
Verbal	58.5% (481)	30.5% (251)
Physical	28.6% (235)	14.6% (120)
Facility damage	11.1% (91)	6.2% (51)
Overall (any form of violence)	65.9% (542)	33.5% (275)

Causes of Violence

The top five reasons for violence reported were failure to meet the expectations of patients and persons accompanying them (56.1%), communication failure (55%), human error (53.7%), unexpected outcome (42.6%), and substandard care (35%) (Figure 2).

Appendix 2 shows a comparison of causes of violence among different stakeholders. Whereas the HCPs and ambulance staff complained of unreasonable behavior and expectations of persons who accompany patients, media and representatives of LEAs pointed to negligence in the behavior of HCPs. One of the doctors said, "Violence occurs when people get over demanding without communicating their concerns to the doctor." An ambulance driver noted, "Persons who accompany patients (family members or friends) want 4–5 of them to come with the patient in the ambulance. We tell them to take 1–2 but they don't listen." A policeman commenting on his perception of negligence on the part of doctors said, "Violent issues arise when doctors do not give proper attention to patients. They have become earning machines."

Among institutional causes, HCPs mentioned poor facilities and heavy workload. A postgraduate trainee of a government hospital said, "You know this is a government hospital and everything is not available here, but attendants don't realize this." The deficiencies highlighted predominantly included inadequate security and lack of training to prevent, mitigate, or respond to violence. One of the respondents said, "It is our bad luck that we are not given any training for these situations, we judge and manage these situations according to our experience."

In the field, delays in rescuing patients due to traffic and negligence of vehicle drivers in giving space to ambulances were raised by ambulance staff. Media respondents said that delays were due to competition among ASPs to take the patients; representatives of LEAS mentioned poor quality of services and low competency of HCPs as a cause of violence.

Predictors of Physical and Verbal Violence Among Different Categories

Table 2 shows the comparison of experiencing physical and verbal violence among different groups of HCPs.

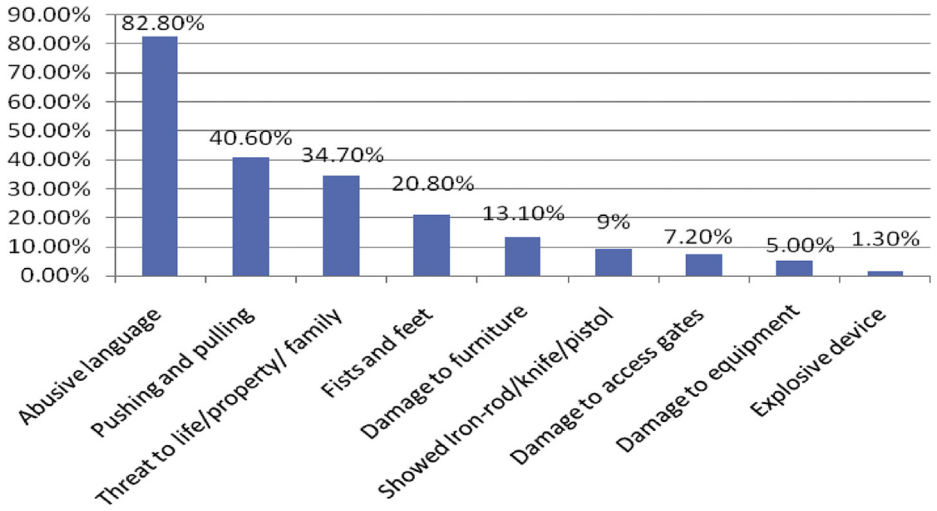

Figure 1. Predominant nature of violence experienced or witnessed (n = 542).

Physicians, security staff, and especially ambulance staff reported significantly higher frequencies of verbal violence as compared with other job positions ($p = 0.004$). Women were significantly less likely to experience physical violence ($p \leq 0.001$). Security and ambulance staff experienced significantly more physical violence ($p = 0.001$) compared with all others. Public sector hospitals and ambulance services reported significantly more violence compared with private hospitals and local NGOs providing health services ($p = 0.002$).

Acceptance of Violence

Acceptance of verbal abuse was reported more as compared with acceptance of physical violence, as stated by the ED director of a government tertiary care hospital: "Now people do not consider verbal violence as violence at all. They are so acclimatized to verbal abuse that they do not even consider that it is any sort of violence." The main reasons for acceptance of violence included considering it the patient's right or part of the profession, and fear of the adverse consequences of reporting. Policemen reported tolerance

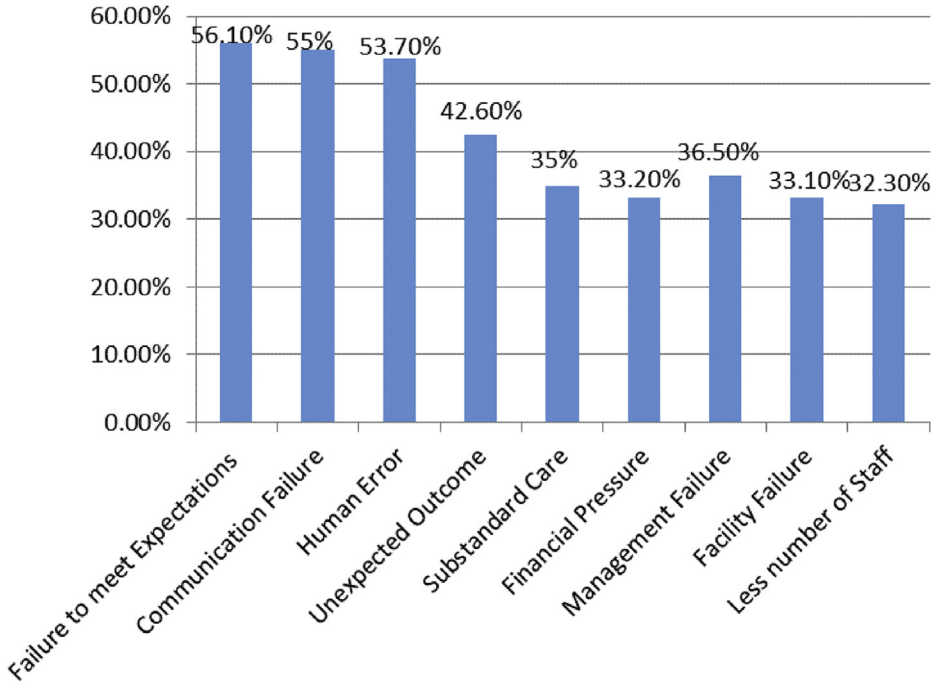

Figure 2. Predominant factors that were perceived to play a role in the development of the incident (n = 542).

Table 2. Predictors of Verbal and Physical Violence Among Different Categories (n = 822)

	Verbal Violence		Physical Violence	
	% (f)	*p*-Value	% (f)	*p*-Value
Age, years				
18–39 (n = 581)	32.2% (187)		14.1% (82)	
40 and above (241)	26.6% (64)	0.111	15.8% (38)	0.541
Gender				
Male (n = 491)	31.6% (155)		18.5% (91)	
Female (n = 331)	29% (96)	0.434	8.8% (29)	< 0.001
Major language				
Urdu (496)	29.2% (145)		13.5% (67)	
Sindhi (72)	31.9% (23)		16.7% (12)	
Punjabi (111)	32.4% (36)		15.3% (17)	
Pushtu (69)	40.6% (28)		17.4% (12)	
Baluchi (27)	18.5% (5)		18.5% (5)	
Others (47)	29.8% (14)	0.328	14.9% (7)	0.909
Nature of job				
Support staff (132)	22% (29)		11.4% (15)	
Physician (124)	38.7% (48)		15.3% (19)	
Nurse (174)	27.6% (48)		12.1% (21)	
Administration/clerical (71)	31% (22)		11.3% (8)	
Technical staff (128)	22.7% (29)		5.5% (7)	
Security staff (78)	38.5% (30)		24.4% (19)	
Ambulance staff (115)	39.1% (45)	0.004	27% (31)	
Work experience				
Under 1 year (96)	22.9% (22)		4.2% (4)	
1–5 years (349)	30.9% (108)		12.9% (45)	
6–10 years (176)	35.8% (63)		20.5% (36)	
11 and above (201)	28.9% (58)	0.157	17.4% (35)	0.002
Worksite				
Public hospital (n = 403)	30% (121)		15.4% (63)	
Private hospital (n = 176)	27.8% (49)		9.1% (16)	
NGO (n = 92)	28.3% (26)		8.7% (8)	
Ambulance service (n = 151)	36.4% (55)	0.341	22.5% (34)	0.002

NGO = nongovernmental organization.

among doctors for paying extortion money and said, "Doctors are soft targets, their time is money, therefore to get rid of the issue, they prefer to give money."

Sequelae of Violence

More than half of the participants (Figure 3) felt hopeless (50.3%), wanted to avoid talking about the incident (50.4%), and had repeated disturbing memories about the incident (58.7%). A doctor said, "You are giving care to a patient on one hand and you have to listen to bad language from persons accompanying the patient on the other hand. This really makes me feel bad about my job." An ambulance driver said, "We feel scared when someone is shot. We try to take the victim to hospital as soon as possible." A crime reporter said that violence not only affected HCPs but also terrified the patients.

Reporting to management or seniors and counseling the perpetrators were the two predominant immediate responses to violence. A few interviewees pointed to calling the available security or law enforcement agencies and warning the perpetrators if they did not de-escalate their violent behavior, they risked discontinuation of their care. Some of them mentioned escaping in such situations. Short-term responses included recovering damages and provision of incentives to victims in a few cases. In the long run, increase in security measures and pursuance of inquiry was reported in a few instances, whereas some participants complained of no response at all.

Recommendations

In the qualitative data, the responders' recommendations were categorized as institutional and societal. Institutional recommendations included improvement in availability of facilities (equipment, medicines, and personnel), training of HCPs in communication and violence de-escalation skills, and enhanced security facilities. An emergency physician at a public-sector hospital emphasized the importance of training in de-escalating violence: "A training module should be developed in which you teach HCPs how to deal with violent individuals." Some of them also drew attention to improved professional skills of HCPs, job conditions, and incentives for HCPs and staff coordination and teamwork. Improvements suggested were: formulation of rules and

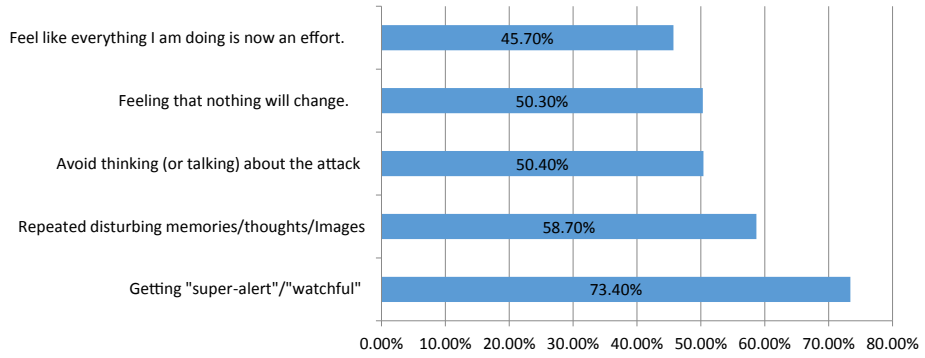

Figure 3. Predominant effect of violence on the victim (n = 549).

regulations, restricted access of attendants inside the hospital, training on "triage," and strict regulation for HCPs. A weapon-free policy in institutions was also mentioned.

At a societal level, need to increase awareness of respecting HCPs in emergency situations was widely highlighted. General awareness of the need to respect the law and the benefits of polio vaccines was also recommended. Major social reforms recommended included improvement in performance of LEAs, literacy rate, judicial system, and reduction of political interference in institutions. Great emphasis was placed on the need for the media to play a positive role in raising awareness and telling people the truth.

DISCUSSION

Our results are in conformity with three previous studies in Pakistan that reported prevalence of verbal violence from 72.5–93.2%, and physical violence from 11.9–16.5% (15–17). Relatively higher proportions of verbal and physical violence among HCPs have been reported in studies from developed and developing countries (16–19). One possible reason for such high proportions of verbal violence in the other studies could be that only health care physicians who generally deal with patients in EDs of the hospitals were interviewed, whereas the present study included multiple cadres of HCPs.

In the majority of incidents, persons accompanying the patients were the main perpetrators, and more than one perpetrator was involved. This reflects the easy access of multiple persons accompanying patients, leading to overcrowding and resulting in violence inside hospitals, especially in emergency units. Access restriction of persons accompanying the patients was the primary recommendation made by HCPs in this regard. Easy access of people without screening also increases the chance of weapons being brought into the hospital, although most hospitals do have a no-weapon policy. This is contrary to developed countries, where screening the person coming to the hospital is a routine procedure. Moreover, in case any person is found to have a weapon, security personnel are called immediately to secure the scene, and HCPs are allowed to enter only if the scene is deemed secure.

There was no significant correlation of verbal violence with age, gender, ethnicity, worksite, and work experience. This is suggestive of the endemic nature of verbal violence across all sections of society. Women were significantly less likely to experience physical violence, which is consistent with previous studies (6,7,17). Security and ambulance staff reported a significantly higher proportion of physical violence, as they are usually the first point of contact in emergency situations. In comparison with public-sector hospitals and ambulance services, private hospitals and local NGOs providing health services reported a significantly lower proportion of physical violence. This is indicative of better institutional rules and security facilities in the private sector. The other reason could be that patients and persons accompanying them at private health care institutions are slightly more educated.

A high threshold for acceptance of violence was observed in both public and private health care facilities. Two-thirds of all respondents considered incidents of violence as "typical" in the study. Some of the respondents considered workplace violence in the medical profession as part of their job and the patient's right. More than half of the respondents did not report an incident due to previous experience of no action or because they did not consider the incident important enough to be reported. A lack of response and no action in the majority of incidents have also been reported in a previous study (15). A few respondents showed reluctance to report due to possible adverse consequences on their job or in their family life. A lack of reporting due to adverse consequences of reporting was also reported in studies conducted in hospitals in Palestine and Saudi Arabia (7,18). There was also reluctance to report due to lack of encouragement by the hospital and low confidence in lengthy prosecution processes. None of the respondents mentioned any policy of the institutions that suggests zero tolerance for violence. An interventional study in the past showed an improvement in reporting ability to

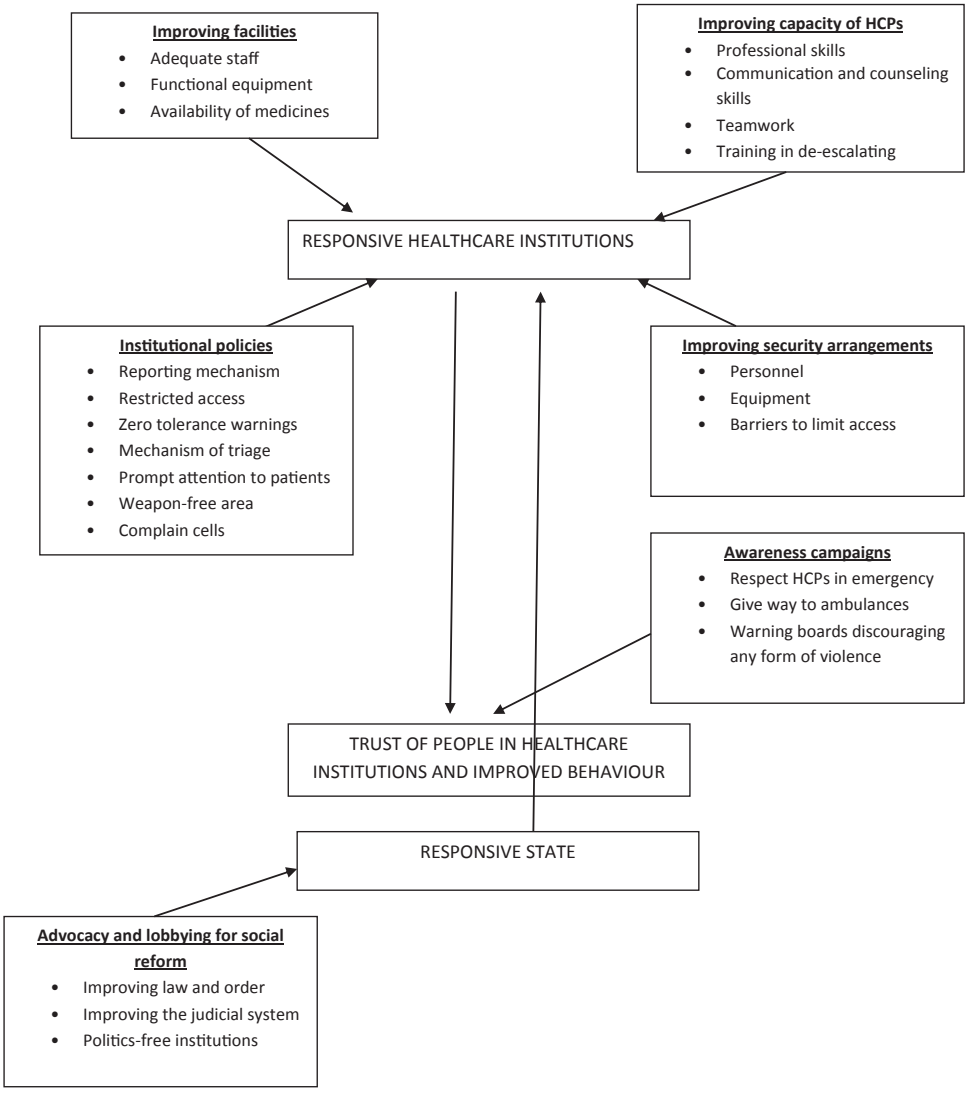

Figure 4. Proposed framework of interventions for preventing violence. HCP = health care provider.

deal with violence after the management recorded the violent events and provided structured feedback (20).

Most respondents said that violence erupts as a consequence of emotional reactions by attendants (less frequently by patients themselves) due to patients' serious conditions or adverse outcomes. Another more frequently mentioned reason was failure to meet the expectations of the patients and persons accompanying them. Training aimed at preventing or mitigating violence on the part of the patient's family members or friends, through effective violence mitigation techniques, especially in life-threatening emergencies (or in situations where the patient might incorrectly believe they have a life-threatening emergency), can help reduce the intensity of the anger and frustration of those affected. A communication gap between HCPs and persons accompanying the patients was also reported as one of the major causes. Therefore, HCPs should be trained in keeping the patients and persons accompanying them informed about the patient's health status. Low competence of HCPs for the provision of high-quality care leads to mismanagement of patients and could be a major factor contributing to violence. Poor quality of services was also reported as a major cause of violence among HCPs in a prior study conducted in Karachi (16). This can be resolved through merit-based appointment and continuous capacity-building of HCPs. Poor availability of essential equipment, lack of medicines, and inadequate staff were also mentioned as a cause of violence by many respondents. Two-thirds of the participants also pointed to the lack of security personnel and equipment. Resource-related issues were also reflected in previous studies (8,18,19). Here, the way forward is to conduct cost-estimation exercises for resources required to deliver

a minimum standard of services and maintain adequate security levels.

More than half of the victims felt scared and threatened at their workplace, which negatively affected their motivation at the workplace. A study in Karachi also reported that violence reduces job satisfaction and affects the performance of victims (17). A study in Lebanon has also reported a high tendency to quit one's job as a consequence of violence (19).

Although this is not the first study that has investigated violence against health care professionals in Pakistan, it is unique in the fact that it involved multiple members of the health care team, and was not limited to including physicians. Also, it involved a more detailed level of questioning than prior studies.

LIMITATIONS

Limitations of this study include convenience sampling, which reduces the overall generalizability; however, the main focus of the study was on gaining an in-depth understanding of the problem. Second, involvement of an international organization in the project and video-taping the interviews meant that people possibly held back the most sensitive political or organizational information. This was, however, mitigated by the lack of involvement of any international staff in the data-gathering process. Moreover, participants were fully assured of anonymity and confidentiality of their respective identities.

CONCLUSION

Violence faced by HCPs is a multifactorial complex issue. There is a great need to design interventions that can help in addressing the behavioral, institutional, and sociopolitical factors promoting violence perpetrated against HCPs. Future projects should focus on designing interventions to contain violence at multiple levels. Based on our findings, we propose a framework for interventions to contain violence (Figure 4).

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The study was approved by National Bioethics Committee.

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ARTICLE SUMMARY

1. Why is this topic important?

Violence against health care providers (HCPs) has emerged as major threat to provision of quality care, especially in developing countries where safety and security measures are minimal. All cadres of HCPs are vulnerable to different forms of violence, ranging from minor verbal abuse to life-threatening physical violence.

2. What does this study attempt to show?

This study attempts to investigate the issue of violence against HCPs in detail with key stakeholders to generate an in-depth understanding on different determinants of this issue and identify priority interventions to resolve it.

3. What are the key findings?

A significant proportion of HCPs face violence of varying intensity. HCPs involved in provision of emergency care are more prone to more severe forms of violence. Different behavioral and institutional factors influence the incidence of violence among HCPs, which can be addressed through simple interventions.

4. How is patient care impacted?

A safer interaction between HCPs and patients ensures better quality of care.

Appendix 1. Distribution of Organizations and Participants for Qualitative In-Depth Interviews (IDIs) and Focus Group Discussions (FGDs)

	In-Depth Interviews		Focus Group Discussions	
Organization	Participants	n	Participants	n
Local NGOs providing Health Services	Community Health Supervisors	3	Community Health Workers	3
	Administrators	2	Polio Workers	1
	Doctors	2	Doctors	1
	Nurse	2	Nurses	1
	Technicians 1	1		
Law Enforcement Agencies	Policemen	2	Policemen	2
	Chief Central Police Liaison Committee	1	Administrative Staff	1
Hospitals	Doctors	7	Doctors	2
	Lady Health Supervisor	1	Lady Health Workers	1
	Nurses	2	Nurses	2
	Dispenser	1	Technicians/Dispensers	1
	Director ED	1		
	Ward Master	1		
	Vaccinator	2		
Ambulance Services	Drivers	5	Drivers	2
	Administrators	2		
Media Groups	Crime Reporter	3		
	Photographer	2		
	Camera Man	2		
	TOTAL IDIs	42	TOTAL FGDs	17

NGO = nongovernmental organization; ED = emergency department.

Appendix 2. Comparison of Causes of Violence Among Different Stakeholders

Causes of Violence	Healthcare Providers	Ambulance Workers	Media	Law Enforcement Agencies
Behavioral	Reaction to adverse outcomes & serious conditions*** Lack of culture of respect** High expectations from hospital** Communication gap b/w patient and HCP** ''Violence occurs when people get over demanding without communicating their concerns to doctor'' Doctor	Reaction to adverse outcomes & serious conditions** High expectations of people* Communication gap b/w patient and HCP** ''Persons accompanying patients want 4–5 of them to come with the patient in the ambulance. We tell them to take 1–2 but they don't listen'' Ambulance driver	Reaction to adverse outcomes & serious conditions*** Negligence of HCPs** ''Attendants tell us that deaths happen due to negligence of doctors.'' ARY crime reporter	Reaction to adverse outcomes & serious conditions** Negligence of HCPs*** ''Violent issues arise when doctors do not give proper attention to patients. They have become earning machines.'' Police officer
Institutional	Overcrowding** Lack of staff/Heavy workload* Lack of facilities*** Lack of security* ''It becomes difficult to provide care to a patient with 10–12 persons accompanying the patient.'' Staff nurse ''You know this is a government hospital and everything is not available here, but attendants don't realize this.'' PG Trainee	Overcrowding* Low capacity to provide quality services*** Lack of facilities* Delay in treatment** Competition among ambulance service* Low incentives for HCPs* ''Sometimes it is not possible to reach the victim on time, especially in traffic hours. Then people fight with us.'' Ambulance driver	Overcrowding** Low capacity to provide quality services*** Lack of staff/high workload* Lack of facilities** Delay in treatment* Competition among ambulance services** ''I don't know what they want but they fight over one dead body, three organizations fight to place their sheet on a dead body.'' Photographer Ambulance drivers drive so fast. Ambulances do not have any facility to save life, they are just carriers.'' Crime reporter ''In our hospitals, proper treatment is not available, as a result people get frustrated.'' Crime reporter	Overcrowding** Low capacity to provide quality services** Lack of staff/high workload* Lack of facilities*** Delay in treatment** Competition among ambulance services* ''Most of the hospitals and clinics do not meet the standard that they should.'' Policeman ''Doctors do not give attention according to what patients want and expect.'' Policeman

HCP = health care provider; PG = postgraduate.
*,**,***Denotes the number of times the point was repeated.