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DETERMINANTS OF VIOLENCE AGAINST HEALTH WORKERS IN PORTUGAL

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Summary

The focus of this article is on the determinants of workplace violence against health workers identified in two cross-sectional analytical studies. The prevalence of victims of the several types and of any-type of workplace violence was estimated in each study, as well as the relative frequency of the associated characteristics. Each dependent variable was also analyzed, in relation to the dichotomized independent variables using a stepwise logistic regression strategy. The Ministry of Health has adopted strategies, which include guidelines on what to do to prevent and correct violence against health workers and a workplace violence observatory. Workplace violence has societal, organizational and individual determinants that can be prevented and monitored.

Résumé

Cet article porte sur les déterminants de la violence sur les lieux de travail contre les travailleurs de santé tel qu'identifie par deux études transversales. La prévalence de victimes de plusieurs types ou de quelque type que ce soit de violence occupationnelle a été estimée ainsi que la fréquence relative des caractéristiques associées. Chaque variable dépendante a été analysée en relation avec les variables indépendantes dichotomisées en utilisant une stratégie de régression logistique. Le Ministère de la santé du Portugal a adopté des stratégies et des lignes directrices sur ce qu'il faut faire pour prévenir et corriger la violence contre les travailleurs de santé et a créé un observatoire de la violence occupationnelle. La violence sur les lieux de travail a des déterminants sociaux organisationnels et individuels qui peuvent être surveillés, ce qui peut aider à la prévention.

Introduction

This paper analyses the determinants of workplace violence in the health care sector found by several Portuguese studies on the subject. Workplace violence is defined; its types, consequences and the specificities of workplace violence in the health sector are analyzed using international evidence. Results from studies conducted among healthcare workers are reported and reanalyzed in order to identify the determinants of workplace violence in the health sector in the Portuguese context. Ministry of Health strategies to deal with workplace violence are presented and discussed in reference to literature on risk factors and on interventions as they apply to the health sector. Policy implications are also described.

Violence is a socially constructed concept, specific in the three dimensions - person, time and place. A violent act emerges and is defined as such in a certain social context and according to concrete values. In this paper, violence is defined as a destructive behavior against other person that can assume different forms: physical, mental and sexual (ICN, 2001).

Theoretical perspectives on violence vary among researchers, but most share a number of assumptions: violence results from the interaction between two or more people and therefore it is not an univocal behavior; it can be an intentional or involuntary act; it can or not be accomplished (e.g., it can occur or it might be only a threat); it is subjective (e.g., differently defined by victims and perpetrators); it varies according to temporal, contextual and ideological factors and it can take different forms (ICN, 2001; WHO, 2004).

Violence can be divided in sub-types, according to the context in which occurs: self-directed violence (when the perpetrator and the victim are the same person; includes self-abuse and suicide); interpersonal violence (occurs between different individuals; can be subdivided into family and intimate partner violence that

includes child maltreatment, intimate partner violence, and elderly abuse and community violence that is broken into acquaintance and stranger violence and includes youth violence, assault by strangers, violence related to property crimes, and violence in workplaces and other organizational settings); and collective violence (violence committed by larger groups of individuals and can be subdivided into social, political and economic violence) (WHO, 2004).

The concept of workplace violence can be defined as "any work or work environment related problem, which affects negatively the production and workers safety" (Fletcher, Brakel & Cavanaugh, 2000). It includes threats, verbal abuse, self-directed violence, physical violence and violence against property (Eisele, Watkins & Matthews, 1998).

Workplace violence, either physical or psychological, has become a global problem crossing borders, work settings and occupational groups (Eisele, Watkins & Matthews, 1998; AFSCME, nd; WHO, 2001; WHO, 2004). For long a "forgotten" issue, violence at work has gained recognition in recent years and is now a priority concern in most countries. Workplace violence affects the dignity of millions of people worldwide. It is a major source of inequality, discrimination, stigmatization and conflict at the workplace. Increasingly it is becoming a major human rights issue (ILO, 2002).

Workplace violence is responsible for incapacities and its consequences include long-term disruption of interpersonal relationships, lower quality of work organization and of the working environment. Workplace violence generates productivity losses and turnover increase (Fletcher, Brakel & Cavanaugh, 2000). Every country, sector and profession are affected.

The health sector is especially at risk: violence in this sector might represent a quarter of all violence at work (ILO, ICN,

WHO & PSI, 2002). Violence against health workers in their workplace has become a prevalent problem around the world, and Portugal is no exception. ILO estimates that 50% of health workers suffer at least one physical or psychological violence episode each year (ILO, ICN, WHO & PSI, 2002). In the United Kingdom, in 2003, violence against health workers had an estimated cost of 99 millions euros (National Audit Office, 2003).

The main consequences of workplace violence in the health sector are: changes in delivery of health care services (deterioration in the quality of care and increased intention to leave the profession; reduction in health services available to the population and increase in health costs (ILO, ICN, WHO & PSI, 2002).

According to the International Labor Organization (ILO 2002) interventions are urgently needed. More evidence is needed to increase awareness of the importance of the problem and to make it a priority target in the health sector.

According to Portuguese research (Ferrinho, Biscaia, Fronteira, Craveiro, Antunes, Conceição et al, 2001), carried out in 2001 aimed at understanding the problem of violence against health workers in their workplace and at identifying strategies to control this type of violence, 37% of health workers of a Hospital had suffered at least one violent episode on the previous 12 months. The prevalence of workplace violence in a HC ranged from 49% (2004) to 60% (2001). In a Community Mental Health Centre workplace violence prevalence was 78% (2001). The most frequent victims in the Hospital and in the HC were women. Workplace violence was more prevalent among male workers in the hospital and female workers in the health centre. The majority of victims had suffered repeated episodes and the problem was similar for sexes, professional groups and services. The most frequent perpetrators were adult patients and relatives. In the case of bullying/mobbing and discrimination, the most

frequent perpetrator was a co-worker. Women were the main perpetrators of verbal abuse and moral pressure, and men for all the other types.

The majority of victims had suffered repeated episodes and the problem was similar for sexes, professional group and services (and there was no distinction between sexes, professional group and services). All violence types were reported: verbal abuse, moral pressure, violence against property, discrimination, physical violence and sexual harassment. The most frequent perpetrator was an adult patient and their relatives. Nevertheless, in the case of moral pressure and discrimination, the most frequent perpetrator was a work colleague. Women were the main perpetrators of verbal abuse and moral pressure, and men were of the other types of violence.

In another Portuguese study, that took place in 2003, 75% of NHS and private institutions with inpatient care had reported cases of violence against health workers on the three previous years (Neto, Biscaia & Meirinho, 2003).

We reanalyzed the two studies (Ferrinho, Biscaia, Fronteira, Craveiro, Antunes, Conceição et al, 2001) described above in order to identify determinants of the patterns of violence observed in Portugal.

Populations and Methods

Two cross-sectional, analytical studies were reanalyzed to identify determinants of the patterns of violence observed in Portugal: one conducted among district hospital workers (total of 277 health workers; response rate of 80%) and another among health centre complex workers (total of 221 health workers, response rate of 86%). The hospital was in a fast growing residential village within one of the two metropolitan areas of Portugal, but serving also a rural population. The health centre was an urban complex in the same metropolitan area. It included

four primary health care units one dedicated to the treatment of drug addicts, a unit for the treatment of tuberculosis and a community based extension of the psychiatric hospital services for the ambulatory treatment of psychiatric patients.

The population served by this complex was mostly urban, including some of the wealthiest neighborhoods of the country, but it also served both rural and poor urban neighborhoods. Both studies aimed at characterizing social, demographically and professionally the working population, calculate the prevalence of physical and psychological violence among healthcare workers (in the health centre violence against property was also studied), characterize the place where the violent incident took place, the perpetrator, the factors that contribute to workplace violence, the victim, the behavior of victims towards a violent incident and identify the consequences of workplace violence. Both studies considered as health workers all those working part-time or full-time, with a permanent or temporary work contract with the hospital or HC or even with firms providing services on the premises of the hospital or the HC. The measurement instrument was an international questionnaire translated to Portuguese. The dependent variables studied were "victim of workplace violence physical violence, verbal aggression, sexual harassment, bullying/ mobbing and discrimination for both hospital and HC and violence against property only in the HC study) in the last twelve months". The independent variables included socio-demographic data (age, sex, marital status, having dependent children, race) and professional (profession, service, working hours, work schedule, contact with patients, type of patients, work contract, dual practice) were collected. The prevalence of victims of the several types and of any type of workplace violence were estimated in each study as well as the relative frequency of the associated characteristics. Each dependent variable was also analyzed, using SPSS 10.0 in relation to the dichotomized independent variables using a stepwise logistic regression strategy.

Results

For the Hospital study, the simultaneous effect of profession (p=0,02), shift work (p<0,01), working between 18 p.m. and 7 a.m. (p<0,01), contact with patients (p<0,01), physical contact with patients (p<0,01), number of working hours per week (p=0,02) and dual practice (p<0,01) in the dependent variable "victim of any type of violence" was analyzed. A first logistic regression model was obtained with a predictive value of 63% (p=0,02) but not every independent variables were statistically related with the dependent variable. Thus, all variables with a p-value inferior to 0.25 were chosen and a new model containing the independent variables working between 18 p.m. and 7 a.m. (p=0,206), physical contact with patients (p=0,109) and dual practice (p=0,249) was built. The predictive value of this model was 64% (p<0,01) but the p-value for the independent variables was not statistically significant. The variable with a larger p-value was then excluded from the model (dual practice). A new model was achieved where working between 18 p.m. and 7 a.m. and physical contact with patients explained 64% of workplace violence that took place at the Hospital (p<0.01). It was also possible to conclude that working between 18 p.m. and 7 a.m. (OR=2,1; IC=[1,0;4,2]) and physical contact with patients (OR=2,2; IC=[1,0;4,8]) doubled the risk of suffering any type of violence when all other variables were controlled.

For the HC study, the simultaneous effect of sex (p=0.02), working in the community (p=0.01), physical contact with patients (p<0.01) and type of schedule (part-time of full-time) (p<0.02) in the dependent variable "victim of any type of violence" was analyzed. A logistic regression model was obtained with a predictive value of 68% (p<0.01) where every independent variables entered were related with the dependent variable (p=0.05). It was also possible to conclude that being a women (OR=3.3; IC=[1.6; 7.0]) tripled the risk of suffering any type of violence when all other variables were controlled and

working part-time was a protective factor for not suffering workplace violence (OR=0.2; IC=[0.1;0.6]).

Discussion

The prevalence of violence against health workers in their workplace in the Portuguese studies seem to indicate that this is a serious problem (the prevalence is greater than those reported in international studies) (Eisele, Watkins & Matthew, 1998) that affects all workers. Recent studies confirm that workplace violence in the health sector is universal, although local characteristics may vary, and that it affects the health of both women and men, though some are more at risk than others (ILO, 2002).

Portuguese health workers are suffering from several types of violence, which might enhance the already serious consequences at individual, institutional and social levels of workplace violence (Di Martino, Hoel & Cooper C, 2003; Arnetz, 2001; Hoel & Sparks, 2000; National Audit Office, 2003). Workplace violence in the health sector affects the physical and mental health of directly and indirectly involved workers; represents a threat to the functioning of health sector, increases absenteeism and staff turnover, decreases professional satisfaction, and the number of professionals willing to work overtime.

Violence explanatory models show that no single factor can explain why some people or groups are at greater risk of interpersonal violence. WHO (2004) ecological model for understanding the causes, consequences and prevention of violence, assumes that violence is the outcome of the interaction of many factors at four levels: 1) the individual – personal history and biological factors influence individuals' behavior and their likelihood of becoming a victim or a perpetrator of violence; 2) the personal relationships – with family, friends, intimate partners and peers; 3) the community contexts in which relationships occur – level of unemployment, population density,

etc.; 4) the societal factors – influence whether violence is encouraged or inhibited and can include economic and social policies that maintain socioeconomic inequalities or social and cultural norms for instance related with male dominance over females.

The models constructed from data from two studies analyzed demonstrated that there is not one single risk factor that can explain per si violence against healthcare workers in their work place. The model found for the Hospital showed that the combination of physically contacting with patients and working between 18 p.m. and 7 a.m. enhances the risk of suffering some type of violence in the workplace. This is consistent with the current knowledge on the issue (Cembrowicz, Ritter & Wright, 2001). Working in the community was a risk factor for HC workers. Some authors refer that in a society or in a group there is always a legitimate portion of violence, recognized and accepted by a group (Fisher, 1992). The findings from HC study can be explained if, for example the HC served a community where violence against healthcare professional is socially accepted.

Workplace violence policies in the health sector

The results of the studies carried out in 2001 raised the awareness of the Health Ministry of violence against healthcare workers. In 2006 a Newsletter (Circular Informativa nº 15/DSPCS de 07/04/2006 "Melhorar o Ambiente Organizacional em prol da Saúde dos Profissionais") was issued, by the Department of Health (General Health Directorate), proposing a prevention and "how to handle" approach to curb violence. Violence in the health sector observatory was created to monitor and study the phenomenon and to allow healthcare workers to report a workplace violent incidents.

According to observatory's registration system the most frequent perpetrator was a patient (49%) followed by a patient's relative

(26%), and 20% by a co-worker. Men were the main perpetrators in 71% of the incidents. The types of violence reported were: physical violence (33%), discrimination (48%), insults (56%), defamation (40%), moral pressure (23%), sexual harassment (9%), slander (30%) and violence against property (6%). Seventy-six percent of all reports were made by nurses made 76% of total reports and female workers represented 66% of the victims. There were more incidents occurring in hospitals (44%) than in health centers (37%), 10% of the incidents occurred in unspecified central services of the Health Ministry. For 9% of cases it was not possible to know the place where they had occur. In the majority of cases (76%) victims considered the incident could have been prevented. The findings from the violence observatory reporting system are very similar to those from the hospital and HC study. Being a national reporting system the possible doubts raised by two studies very context specific can be overlooked and probably we have already a well defined scenario for workplace violence in the health sector in Portugal.

Employers have the responsibility of implementing policies, procedures and practices that promote safety and the well-being of their workers. On the other hand, Governments have the responsibility of funding and supporting work environments that promote safety and well-being. In order to do so the Department of Health plans to publish an annual report, summarizing the most significantly results and also prioritize projects, with Hospitals, HC and other health services, develop a humanized workplace culture based on dignity, non-discrimination, equal opportunity and cooperation, a clear policy statement on workplace violence from the top management and awareness raising initiatives at all levels.

Conclusion

Workplace place violence is a predictable, economically heavy and serious hazard, which has solution. The health sector has particularities (e.g. staff interaction with public) that have to be

contemplated, but the knowledge of the problem allows accurate interventions and adequate public policies.

In order to prevent violent acts in the workplace it is critical to analyze the underlying factors and their consequences. Prevention and risk management are the indicated approach to violence. When determinants of violence are known, it is easier to face the problem of violence against health workers, both at individual and organizational level.

Data from the Portuguese studies carried out in Portugal as well from the violence observatory have contributed to build a consistent scenario for the determinants of workplace violence in the health sector. This scenario can gave evidence for policy but research in this area must continue especially to monitor policy implementation and evaluate changes in workplace violence reality.

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