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Prevalence and forms of violence against healthcare workers in the emergency department of a teaching hospital in Nigeria

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ABSTRACT

BACKGROUND: The incidence of workplace violence (WPV) is peculiar to both developing and developed countries, with more workers at risk in developing countries, especially in sub-Saharan Africa, due to poorly developed work environment. The objective of this study was to assess the prevalence and forms of violence against healthcare workers (HCWs) in the Emergency Department (ED) of the University of Benin Teaching Hospital (UBTH), Benin City, Nigeria.

METHODS: A cross-sectional study of all the 282 healthcare workers in the ED of the hospital. A standardized, interviewer-administered questionnaire was used for data collection. Data was analyzed using IBM SPSS version 25.0. Descriptive statistics were presented as frequencies and proportions.

RESULTS: The mean age of the HCWs was 36.1 ± 8.4 years, comprised of doctors 53 (18.8%), nurses 50 (17.7%), paramedics 36 (12.7%), porters 29 (10.3%), and laboratory scientist 19 (6.7%), among others. The prevalence of physical violence was 63 (22.3%) while that of psychological violence was 247 (87.6%). The predominant forms of violence were verbal abuse (99.5%), kicking (96.8%), slapping (60.3%), bullying (45.3%), threat (40.4%), and sexual harassment (32.4%). The perpetrators were mainly patient relatives, 93.6% and 96.7% for physical and psychological violence, respectively. The majority experienced post-traumatic stress disorder, and loss of job satisfaction following the violence.

CONCLUSION: This study showed a high prevalence of WPV among the healthcare workers. There is an urgent need for intervention programmes to be initiated to curb the menace of violence against healthcare workers. A surveillance system to monitor the mental health status of victims of WPV should be instituted.

Keywords: Violence, Workplace, Healthcare Workers, Emergency Department

INTRODUCTION

Globally, violence targeted at healthcare workers (HCWs) has reached an alarming level. The incidence of WPV is peculiar to both developing and developed countries with more workers at risk in developing countries, especially in sub-Saharan Africa due to poorly developed work environment. According to the World Health Organization (WHO), 8% to 38% of health workers suffer

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physical violence at some point in their careers [1]. A systematic review of studies on WPV published globally in PubMed, Embase and Web of Science from their inception to October 2018 showed that 61.7% of HCWs reported exposure to any form of WPV [2]. These reports lend credence to the widespread nature of WPV and the fact that it is assuming an epidemic nature across the globe.

The WHO defines WPV as, "incidents where staff 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"[3]. WHO considers both physical and psychological harm, including attacks, verbal abuse, bullying, and both sexual and racial harassment, to be WPV [3]. Violence against HCWs also entails the deliberate use of physical force or abusive words, either in verbal or written form directed against HCWs. This violence usually takes the form of intimidation, harassment, threats, beatings, stabbings, shootings, and other forms of assault with nurses and doctors among the most assaulted workers in the Nigeria workforce [4-8].

In healthcare settings, most violence is perpetrated by patients and patients' relatives [9-11]. Also, in disaster and conflict situations, health workers may become the targets of collective or political violence. However, in some instances, HCWs have been implicated in cases of WPV. Violence may occur anywhere in a hospital, but is most frequent in psychiatric units, emergency departments, waiting areas, wards, and geriatric and long-term care units [4,6].

The consequences of WPV are huge. Physical violence can result in life-threatening injuries and death [12]. The psychological consequences resulting from violence may include fear, anxiety, sadness, depression, frustration, mistrust, and nervousness. These consequences can have a negative impact on job satisfaction, income and the health status of HCWs. In addition to the effects on the individual health workers, violence against HCWs also has an impact on the organization through reduced output, absenteeism, payment of compensation, loss of experts, job dissatisfaction and worker turnover [13].

To the best of our knowledge, no study has focused solely on WPV in the ED of UBTH. Therefore, this study was conducted to determine the prevalence and forms of violence against HCWs in the ED of UBTH, Benin City, Nigeria. The study will also generate evidence on the magnitude of violence against HCWs in our setting and provide baseline data for future multi-centre studies in Nigeria.

METHODS

Study design and setting: This facility-based cross-sectional study was carried out in the ED of UBTH, a tertiary healthcare facility that serve as a referral centre in southern Nigeria, from 17th May to 10th June 2022.

Study population, sample and sampling: This was a total population study of all the 282 HCWs in the emergency department of UBTH as at the time of the study. They include doctors, nurses, paramedics, laboratory scientists, pharmacists, radiographers, medical records officers, porters, plaster technicians, revenue clerks, housekeepers, and drivers. The census sampling strategy was used to recruit the HCWs for the study.

Data collection: Data for this study were collected using a structured interviewer-administered questionnaire which was adapted from International Labor Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI) workplace violence in the health sector country case studies research instruments joint program to measure workplace violence [14]. The questionnaire was divided into three sections as follows: personal and workplace data, physical workplace violence data and psychological workplace violence data. The questionnaire sought the following information from the HCWs: exposure to WPV, forms of violence, predisposing factors of violence, and consequences of violence.

Data analysis: Completed questionnaires were screened for completeness, coded, and analyzed using IBM SPSS version 25.0 software. Data were summarized using descriptive statistics such as mean and standard deviation for age, and proportions for categorical variables.

Ethical approval for this study was obtained from the Health Research Ethics Committee of UBTH (Protocol number: ADM/E22/A/VOL. VII/148312109). The information obtained in the study was treated with confidentially. The name of the HCWs were not written on the questionnaire to ensure anonymity. They were also allowed to withdraw at any time during the study. Permission was obtained from the management of UBTH, and

written informed consent was obtained from the HCWs before data collection.

RESULTS

A total of 282 HCWs with a mean age of 36.1 ± 8.4 years participated in this study. They were comprised of doctors 53 (18.8%), nurses 50 (17.7%), paramedics 36 (12.7%), revenue clerks 29 (10.3%), medical record officers 25 (8.9%), porters 23 (8.2%), and laboratory scientist 19 (6.7%).

Table 1: Socio-demographic characteristics

Variables	Frequency (n = 282)	Percent
Age group (years)		
20-29	82	29.1
30-39	99	35.1
40-49	86	30.5
50-59	15	5.3
Mean (SD)	31.6 (8.4)	
Sex		
Male	143	50.7
Female	139	49.3
Marital status		
Single	107	37.9
Married	175	62.1
Job category		
Doctors	53	18.8
Nurses	50	17.7
Paramedics	36	12.8
Revenue clerks	29	10.3
Medical records officers	25	8.9
Porters	23	8.2
Laboratory scientists	19	6.7
Housekeepers	14	4.9
Plaster technicians	10	3.5
Pharmacists	8	2.8
Radiographers	8	2.8
Drivers	7	2.5
Years of experience		
< 1	54	19.1
1-5	113	40.1
6-10	69	24.5
11-15	40	14.2
> 15	6	2.1

There were also housekeepers 14 (4.9%), plaster technicians 10 (3.5%), pharmacists 8 (2.8%), radiographers 8 (2.8%), and drivers 7 (2.5%). Half (50.7%) were males, 175 (62.1%) were married, and a higher proportion 113 (40.1%) had 1-5 years of work experience in the ED (Table 1).

Table 2 shows the prevalence and forms of violence against the HCWs. The prevalence of physical violence was 63 (22.3%) while that of psychological violence was 247 (87.6%).

Table 2: Prevalence and forms of violence experienced by the respondents

Variables	Frequency	Percent
Prevalence of violence*		
Physical	63	22.3
Psychological	247	87.6
Perpetrators of physical violence*		
Patient relatives	59	93.6
Patients	9	14.4
Perpetrators of psychological violence*		
Patient relatives	239	96.7
Patients	48	19.4
Hospital staff	6	2.4
Forms of physical violence*		
Pushing	61	96.8
Kicking	38	60.3
Slapping	36	57.1
Beating	8	12.6
Biting	2	3.1
Forms of psychological violence*		
Verbal abuse	246	99.5
Bullying	112	45.3
Threat	100	40.4
Sexual harassment	80	32.4

**Multiple responses*

The perpetrators were mainly patient relatives, 59 (93.6%), and 239 (96.7%) for physical and psychological violence, respectively. Hospital staff were also implicated in psychological violence, 6 (2.4%). The predominant forms of physical violence were pushing 61 (96.8%), kicking 38 (60.3%), and slapping 36 (57.1%), while for psychological violence, it was verbal abuse 246 (99.5%), bullying 112 (45.3%), threat 100 (40.4%), and sexual

Table 3: Factors predisposing to violence against HCWs

Factors*	Physical	Psychological
	n = 63 (%)	n = 247 (%)
Non-availability of doctors/nurses on call duty	53 (84.1)	107 (43.3)
Aggressive personality of the perpetrators	52 (82.5)	156 (63.1)
Loss of patient	41 (65.1)	66 (26.7)
Non-availability of bed space	23 (36.5)	71 (28.7)
Talking with patient	6 (9.5)	33 (13.4)
Unprovoked	6 (9.5)	8 (3.2)
Attempting to calm patient	5 (7.9)	45 (18.4)
Restraining aggressive patient	4 (6.3)	40 (16.1)
Giving instruction to patient	3 (4.8)	87 (35.2)

**Multiple responses*

Table 4: Consequences of violence against HCWs

Consequences*	Physical	Psychological
	n = 63 (%)	n = 247 (%)
Post-traumatic stress disorder	58 (92.1)	185 (74.8)
Loss of job satisfaction	49 (77.8)	121 (48.9)
Loss of confidence in themselves	17 (27.0)	48 (19.4)
Decline in productivity	6 (9.5)	14 (5.7)
Absence from work	1 (1.6)	5 (2.0)

**Multiple responses*

harassment 80 (32.4%). The factors predisposing to violence against HCWs are shown in Table 3.

Non-availability of doctors/nurses on call duty 53 (84.1%) and aggressive personality of the perpetrators 156 (63.1%) were the most predominant factors that predisposed to physical and psychological violence, respectively. Other predisposing factors were loss of patient, 41 (65.1%) for physical violence, and 66 (26.7%) for psychological violence, and non-availability of bed space, 23 (36.5%) for physical violence, and 71 (28.7%) for psychological violence. In some cases, violence was unprovoked, 6 (9.5%) for physical violence and 8 (3.2%) for psychological violence.
Table 4 shows the consequences of violence against the HCWS. The majority of the HCWs experienced post-traumatic stress disorder following the violence, 58 (92.1%) for physical violence, and 185 (74.8%) for psychological violence. Other consequences of violence among the HCWs were loss of job satisfaction, 49 (77.8%) for physical violence, and 121 (48.9%) for psychological violence, and loss of confidence in themselves, 17 (27.0%) for physical violence, and 48 (19.4%) for psychological violence.

DISCUSSION

The rising prevalence of violence against healthcare in Nigeria has serious implications for the effective healthcare delivery system of a country that is already overburdened with economic challenges and a drastic reduction of the health workforce occasioned by brain drain. Many HCWs have emigrated in drones from the shores of Nigeria for greener pastures abroad, over the past couple of years. This study revealed a high prevalence of WPV especially psychological violence mainly in the form of verbal abuse, bullying, and threats among

the HCWs studied. In this study, a good proportion of HCWs who had experienced WPV attested to the fact that the non-availability of doctors and aggressive personality of the perpetrators were the prevailing predisposing factors. Shortage of manpower in the ED of a tertiary healthcare facility is a precursor to WPV because few HCWs attending to the teeming population of patients will result in long waiting times which in turn will provoke aggression of patients and patient relatives. On the part of the HCWs, depletion of the health workforce will imply more work for the remaining few, thereby triggering the vicious cycle of long waiting time, reduced quality of services rendered, aggression, and then WPV. Good service delivery and a well performing health workforce are important components of the WHO six building blocks for an effective health system [15]. A defect in these two components will result in a crack that will weaken the entire health system, and this has serious implication for universal health coverage and the achievement of sustainable development goal (SDG) target 3 in Nigeria. Several studies in Nigeria and other parts of the world have reported high prevalence and similar associated factors of WPV against HCWs [16-20]. This calls for a global action to curtail the rising incidence of WPV.

The death of a patient is predisposed to almost two-thirds of physical violence and slightly more than a quarter of psychological violence in this study. This may be attributed to the nature of cases that present at the ED. Apart from delay in presentation and the seriousness of cases, such as victims of fatal road traffic accidents that are handled at the ED, patient relatives often expect instant recovery for the patients once they arrive at the ED, and when this expectation fails to happen, they vent their anger on HCWs and this results in WPV. A previous study in southwest Nigeria that reported a high mortality rate at the ED of a tertiary hospital linked its finding with late presentation, as most patients presented when the chances of salvaging the situation looked very bleak [21]. This underscores the need for community-based public enlightenment campaigns on early presentation and expectation management for patient relatives and community members to forestall the menace of WPV following the loss of patients.

To be physically or verbally attacked while carrying out lifesaving professional duties could seriously affect the psyche of HCWs especially if their thought processes are not properly organised. Therefore, it is not surprising that the predominant consequences of WPV reported by the HCWs were post-traumatic stress disorder, followed by loss of job satisfaction and loss of self-confidence. This finding could negatively influence the delivery of efficient healthcare services, quality of care, relationship with patients, and the mental health status of the HCWs. A study in the Volta region of Ghana reported that WPV was statistically significantly associated with a decline in all the facets of quality of care by nurses in government hospitals [22]. Similarly, psychological problems were found to be the first consequence of WPV among nurses at the University Teaching Hospital of Kigali, Rwanda [23]. A review conducted by Lim et al. showed that the negative physical and psychological well-being of HCWs resulting from WPV includes: demoralization, depression, loss of self-esteem, ineptitude, and post-traumatic stress disorders. Our findings corroborated the results of these studies [24].

The psychological effects of WPV can have dire consequences on the quality of care provided in healthcare facilities. The high proportion of HCWs who reported post-traumatic stress disorder following WPV in this study, is a pointer to the fact that their mental health status may be in jeopardy. Violence, harassment, or bullying are among the documented risks to mental health at work [24]. A study in a teaching hospital in southwest Nigeria reported that WPV was common in the hospital, and a significant proportion of workers were at risk of developing psychiatric morbidity [4]. If not nipped in the bud, WPV could become a major contributor to the rising burden of mental disorders among HCWs in Nigeria. However, the limited number of mental health professionals and clinical psychologists to deal with these cases, and lack of institutionalized structures that handles the after-effects of WPV in many healthcare facilities in Nigeria, is a cause for concern. Several studies have shown that HCWs do not report cases of WPV but rather bottle them up in their subconscious because of reasons ranging from lack of incident reporting policy/procedure and management support, previous experience of no action taken by relevant authorities, and fear of consequences [11,15,17,26,27].

In this study, almost a third of the HCWs had experienced sexual harassment. This can be a demoralising experience and may probably explain the loss of both job satisfaction and self-confidence

(low self-esteem) reported by the HCWs. Without adequate intervention, these conditions could lead to a decline in productivity and absenteeism and be complicated further by mental health issues. Living with low self-esteem can harm the mental health of HCWs and lead to problems such as depression and anxiety [28]. A study in Pakistan reported that sexual harassment was the significant predictor of low self-esteem and low job satisfaction among in-training female nurses of four teaching hospitals/ medical institutes [29], while in a Malaysian study, a significant proportion of HCWs had been bullied, and bullying exposure was shown to be associated with depression and low self-esteem [30]. The myriad of mental health issues associated with WPV, especially psychological violence, is capable of affecting the work output, and general health status of HCWs, as they may somatize in psychic distress. Therefore, the findings of this study necessitate a surveillance mechanism to regularly monitor the mental health status of HCWs in the ED of healthcare facilities, especially those who have experienced any form of WPV.

This study has some limitations. The information provided by the HCWs may have been prone to both recall and information bias. However, this was minimized during the interview as the interviewers took time to explain the thematic areas to the HCWs.

CONCLUSION

This study showed a high prevalence of both physical and psychological violence among the HCWs of the ED of UBTH. The predominant forms of physical violence were pushing, kicking, and slapping, while for psychological violence, they are verbal abuse, bullying, and threats. The major consequences of these WPV were post-traumatic stress disorder, loss of job satisfaction, and low self-esteem. There is an urgent need for intervention programmes directed at patients, patient relatives, HCWs, and the community, to be initiated to curb the menace of violence against HCWs. These will include policy guidelines aimed at preventing and handling the incidence of WPV in healthcare facilities. The management of UBTH should deploy more staff to the ED to reduce the waiting time of patients. There should be regular monitoring and evaluation of the mental health status of HCWs in the ED of healthcare facilities, especially those who are victims of WPV.

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