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EDITORIAL

Workplace Violence: Consequences and Solutions in Healthcare Institutions

KHALIL AHMED SHAIKH[1], NUSRAT NISAR[2], DUA BUKHARI[3], MUQADAS FATIMA[4], SYED ZULFIQUAR ALI SHAH[4], SYED JAHANGHIR[4], FARHEEN QADEER[4]
[1]Department of Cardiothoracic Surgery, Liaquat University of Medical and Health Sciences (LUMHS) Jamshoro
[2]Department of Gynecology & Obstetrics, Bilawal Medical College for Boys, LUMHS Jamshoro
[3]Department of Surgery, Liaquat University of Medical and Health Sciences (LUMHS) Jamshoro
[4]Department of Medicine, Liaquat University of Medical and Health Sciences (LUMHS) Jamshoro
Correspondence to: Dr. Syed Zulfiquar Ali Shah. Email: zulfikar229@hotmail.com

Violence may appear in a variety of contexts, such as private homes, public places, commercial spaces, colleges and universities, and other facilities[1]. It has a profound effect on people from all social classes. Because there was no standard term for violence, which made it a complicated and pervasive issue, it was not previously seen as a public health concern[2].

There is more to understanding violence than just tying it to empirical data. Instead, it entails making decisions about what constitutes proper and acceptable behaviour, which are influenced by societal norms, beliefs, and practices[3]. The deliberate use of force, real or threatened, towards themselves, another individual, an organisation or society, or oneself is what the World Health Organization, or WHO, defines as violence. This conduct has the risk of causing injury, death, psychological suffering, stunted growth, or impoverishment[4]. Although professional violence, including punching, kicking, shoving, hitting, shooting, and harming, has been acknowledged, until recently, little has been done to combat intellectual assault[5]. The intentional use of harm towards a person or group, including the threat or application of blunt force, is referred to as psychological abuse. The victim of this kind of assault may have detrimental effects on their psychological, ethical, moral, physical, and cognitive well-being[6].

Violence at work in the healthcare industry is roughly estimated to make up approximately 25% of all incidents of workplace violence[7,8]. The incidence of workplace violence in the health profession is increasing due to factors such as increasing workloads, stressful job challenges, excessive job stress, interpersonal conflicts, uncertainty in society, and economic restrictions[9].

According to the World Health Organization (WHO), between 8% and 38% of healthcare workers are thought to have been physically abused at some point in their careers[10,11]. At the same time, more people are experiencing verbal abuse or are at danger of experiencing it. The majority of violent cases are perpetrated by individuals who are either relatives or acquaintances of the individuals and are subsequently followed by the victims themselves. The occurrence of violence in healthcare institutions intensifies during times of trouble, emergency, or tragedy, particularly when there is a big gathering of individuals who are already highly distressed due to anxiety attacks, shock, unpredictability, anxieties, and concerns about their own or family members' illnesses[12].

A comprehensive analysis of 47 surveys revealed that 62.4% of workplace assaults against healthcare personnel occurred in general. At 61.2%, verbal abuse was the most frequent type of violence, followed by threats (39.5%), assault with weapons (13.7%), mental assault (50.8%), and sexual abuse (6.3%)[13]. Because of the settings in which healthcare is provided at hospitals, healthcare workers are particularly vulnerable to harassing at work. The risk variables or associated factors that have led to the increased frequency of assault against medical professionals over the past decade involve (i) patient, relatives, companion, or visitor mindsets and behaviors, as these groups are frequently under a lot of psychological stress; (ii) medical care employees and work-related factors, such as staff shortages, untrained or anxious staff, poor methods of coping, and a lack of education; and (iii) system or surroundings, such as crowded fields, long wait times, rigid visiting hours, absence of knowledge, and cultural differences[14,15]. Erroneously, a lot of medical professionals believe that work-related violence is just a part of what they do and that they were simply just unfortunate sufficient to be in the wrong environment at the wrong moment. Many employees refuse to put up with the stigma and trouble of reporting violations and followed through on legal actions, believing that no action will ever be taken on the offenders[16]. Usually, people are afraid that if they talk about what has happened to them, their supervisors won't support them and they'll be embarrassed or called inept.In a crisis, the focus is mostly on protecting the physical security of hospitals, whereas measures to avoid attacks on healthcare professionals in non-emergency scenarios focus on techniques for more successfully handling violent persons and high-risk visitors[17,18]. The following are some examples of preventative and control tactics found in the structure of efficacy: The first method is substitution, which entails relocating a patient or someone with a history of violent conduct to a more suitable secure area; the second is technical supervision measures, like installing sensors, alarms for safety precautions, useful the hospital or visitor fields, and clearly marked escape paths; the third is executive and work environment control systems, such as the adoption of regulations against abuse and intolerance in workplaces, the ability to settle disputes amicably, the creation of a system that must be followed for prompt reporting, the guarantee that employees are not working alone, and flowcharts for the assessment and handling of emergency situations; the fourth is protocols and services provided after a tragic event, including trauma-crisis therapy, employee assistance programs, and critical-incident stress evaluations; the fifth is health and safety training to ensure that all workers are aware of potential hazards and know how to use current policies and procedures to safeguard themselves and others at job.

Furthermore, the involvement and financial and technical assistance provided by commercial firms, non-governmental organizations (NGOs), and community organizations are crucial in reducing and avoiding workplace violence in healthcare environments.

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