RESEARCH ARTİCLE

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KNOWLEDGE, ATTITUDE AND BEHAVIOR OF HEALTHCARE PROFESSIONALS FOR PHYSICAL VIOLENCE

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ABSTRACT

The aim of this study is to define the knowledge, attitude, and behavior of healthcare personnel working in a state hospital regarding physical violence in terms of several socio-demographic characteristics. The data was obtained by face-to-face interviews with participants voluntarily participating in the research (430 persons). The average age was 28.90±6.94 years. It was obtained that 81.6% of participants considered that violence against healthcare workers was increased. 20.4% of healthcare professionals stated that they experienced violence in the shift between 12:00 am and 08:00 am. The rate of healthcare professionals reporting violence was 44.0%. The rate of healthcare professionals who received psychological support against the violence they experienced was 12.8%, and 27.7% of the participants have been to considered to leave the profession. 77.9% of the participants reported that they thought that violence against healthcare professionals could be avoided. A safe and violence-free environment should be provided for healthcare professionals, and support for coping skills should be provided them.

Keywords: Healthcare professionals, physical violence, knowledge, attitude and behavior

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1. INTRODUCTION

The workplace violence is regarded as a substantial risk to be addressed and interested at international level by the World Health Organization (WHO), International Labor Organization (ILO) and International Council of Nurses (ICN). The Council also considers this to be a threatened to effective patient care service (Yesilbas, 2016). The violence at healthcare institutions is defined as a situation that poses a risk to healthcare professionals, involves threatening behavior performed by the patients/their family or other individuals, and may be in the form of physical/sexual assault and economic abuse (Saines, 1999). Physical violence is harsh and painful action that targets physical integrity and may be performed in the forms of beating, slapping, punching, kicking, pushing around and strangling (Buyukbayram and Okcay, 2013).

8-38% of healthcare professionals in the world are exposed to violence at some time of their professional life (WHO). It is reported that violence at the workplace is 16 times higher in the healthcare institutions where a wide range of employees work (Unsal Atan and Donmez, 2011; Camci and Kutlu, 2011). This is seen as a serious professional risk and increasingly growing in the world and in Turkey (Grand National Assembly of Turkey Report, 2013). The causes of violence against healthcare workers in Turkey include organizational causes (e.g., providing public with missing or inaccurate information on medical practices and labor rights, and characteristics of service providers and recipients); social factors (e.g., failure of individuals to properly communicate, broadcasting negative medial news by the media with a concern of low circulation and rating, and appearance of scenes on television series that would tarnish the image of healthcare workers); interaction and communication (e.g., negative communication of healthcare workers with their colleague due to competition, etc., long and demanding work hours, intensity of psychosocial situation in this field, insufficient training/education on communication techniques, uneven distribution of healthcare professionals over the country,

and not working in the area where they are a specialist); environmental factors (e.g., sound, ventilation, and noise-related problems); legal/judicial causes (lack of confidence in imposing sufficient punishment, long period for judicial judgement/conclusion, and legal actions that are taken without petition of the victim only in case of bodily injury, threats, and insult in the law) (Buyukbayram and Okcay, 2013; Keser Ozcan and Bilgin, 2011; Yigitbas and Deveci, 2011; Estryn-Behar et al., 2008; Gillespie et al., 2010; Doganay, 2014; Pinar and Pinar 2013; Serin et al., 2015). From the perspective of consequences, the violence causes physical-emotional and social damages, stress, difficulty in concentration, and increased medical faults (Cicek Durak et al., 2014). The aim of this study is to define the knowledge, attitude, and behavior of healthcare personnel working in a state hospital regarding physical violence in terms of several sociodemographic characteristics.

2. MATERIALS AND METHODS

This was a descriptive and cross-sectional study and the study universe was Healthcare Professionals of 112 Emergency Service and State Hospital located in a city center in the East Black Sea Region, Turkey. The sample of the research consist of 430 Healthcare Professionals. The data was collected by face-to-face interviews with participants voluntarily (between April 2015 and May 2015). Prior to the study, written permission of Provincial Directorate of Health and verbal consent of participants were obtained. The State Hospital where this study was carried out is a 208-bed hospital with 133 nurses and has a capacity for delivering inpatient treatment of approximately 10 thousand patients per year.

A form developed by the researchers in accordance with literature was used as a tool for acquiring data. The first section of the form (Personal Information Form) addresses to the socio-demographic history of participants and includes 12 questions. The second section of the form questions the knowledge, attitude and behavior of participants regarding physical violence and includes 24 questions.

The independent variable of this study included the data from personal information form, and the dependent variable included the knowledge, attitude, and behavior of participants regarding violence.

2.1. Statistics

SPSS (Statistical Package for the Social Sciences) 15.0 have been used in the analysis of the data obtained within the scope of the study. The descriptive data was distributed in percentage and number, and the data were analyzed by chi-square and Fisher's exact test-2-sided. The mean values were provided with standard deviations and the significance level (p) in the statistical tests has been accepted as 0.05.

3. RESULTS

The mean age of nurses included in this study was 28.90±6.94 years (min: 18 years, max: 58 years), and the mean of the term of office in nursing was 6.50±5.77 months (min: 1 year, max: 33 years). 31.9% of participants were male, and 51.9% were married (Table 1).

Table 1.Distribution of Participants by their Characteristics (N=430)

Characteristics	Number	%
Age		
18-25	163	37.9
26-35	222	46.5
36 and over	67	15.6
Gender		
Female	137	31.9
Male	293	68.1
Education (n=402)		
Vocational School of Health (SML)	197	66.5
Associate degree	76	28.8
Bachelor degree	120	4.2
Postgraduate degree	9	0.5
Place where most of their life was spent		
City	286	66.5
District	123	28.6
Village	21	4.9
Marital Status		
Married	224	52.1
Single	206	47.9
Smoker		
Yes	171	39.8
No	259	60.2

Alcohol Intake		
Yes	28	6.5
No	402	93.5
Occupation		
Doctor	55	12.8
Nurse/midwife	246	57.2
Emergency Medical Technician (ATT)- Paramedic	129	30.0
Total term of office in profession		
Less than 5 years	251	58.4
6 to 10 years	97	22.5
11 years and over	82	19.1
Income		
Sufficient	261	60.7
Insufficient	61	14.2
Partially sufficient	108	25.1
Like their profession?		
Yes	356	82.8
No	74	17.2

The participants in this study, 26.3% felt safe where they worked, 36.9% were exposed to physical violence minimum once throughout their professional life, 17.2% were subjected to physical violence by the patient and 42.3% were subjected to physical violence by the patient's family, 44% reported the violence they suffered, 16.3% found themselves negligent for violence they were exposed to, 37% wished to be trained on violence, 61.6% were aware of laws and regulations on violence, 8.1% found sufficient of such laws and regulations (Table 2).

Table 2. Knowledge, attitude and behavioral characteristics of participants for violence (N=430)

Characteristics	Number	%
Dou you feel safe where you work?		
Yes	113	26.3
No	148	34.5
Partially	169	39.2
Do you think that there is an increase in violence against healthcare professionals?	347	81.6
Yes	83	18.4
No		
What would you do if you experienced violence?*		
To avoid eye contact with the attacker	208	48.4
To keep a safe distance of minimum length of an arm to the attacker	235	54.7
Not to escape and fight if considered it would be a failure	136	31.6
No to be insistent if the patient keeps moving away, and stand where the patient wants you to stand	142	33.0
	106	24.7

To look like being afraid of the patient if needed	315	73.3
To ask for help in case of tendency to aggressiveness	204	47.4
To stand close to the door to escape in case of any threats		
Have you ever been exposed to any violence during your term of office? (n=425)		
Yes	157	36.9
No	268	63.1
When were you exposed to violence (n=245)		
Between 08:00 am and 4:00 pm	115	46.9
Between 4:00 pm and 12:00 am	77	31.4
Between 12:00 am and 08:00 am	50	20.4
It depends	3	1.3
Who was the last person that used violence against you?*		
Patient	74	17.2
Patient's family	182	42.3
Senior person	12	2.8
Similar senior person	5	1.2
Other healthcare professionals	12	2.8
Did you report the violence you experienced? (n=216)		
Yes	95	44.0
No	121	56.0
Where did you report the violence you experienced?*		
Ministry of Health	27	6.3
Provincial Directorate of Health	31	7.2
A manager of institution	56	13.0
Police/security	76	17.7
Prosecution office	26	6.0
Did you find yourself negligent in violence you experienced?(n=215)		
Yes	35	16.3
No	180	83.7
Have you considered to leave this occupation because of violence you experienced? (n=224)	62	27.7
Yes	162	72.3
No		
What do you think the cause of violence against healthcare professionals?*	105	24.4
Insufficient treatment	155	36.0
Delay in response	135	31.4
Lack of care for the patient	239	55.6
Inadequate laws and regulations on violence	231	53.7
Insufficient security services in institutions	198	46.0
Lack of support from hospital officers for employees	307	71.4
Low cultural level of society		
Do you think that violence against healthcare professionals can be prevented?	328	76.3
Yes	92	21.4
No	10	2.3
I don't know		
Which of the followings could be used to prevent violence against healthcare?*	212	49.3

Stress management of healthcare professionals, training them on communication Improving quality of service in healthcare institution Strengthening laws and regulations Using security systems (e.g., cameras, detectors)	240 346 281	55.8 80.5 65.3
Would you like to receive consultancy on violence? (n=411) Yes No	 152 259	 37.0 63.0
Are you aware of laws and regulations on violence? Yes No	 265 165	 61.6 38.4
Do you find sufficient laws and regulations on violence? Yes No	 35 395	 8.1 91.9

**Multiple answers are provided.*

The following conditions appeared to make differences:

- Being exposed to any violence during the term of office in those who were between the ages of 26 and 35 years, married, graduated from Vocational School of Health, and had a term of office less than 5 years,
- Failure to report the violence to any authority by women, nurses and those who had a term of office less than 5 years,
- Personally finding oneself negligent for violence by those who did not smoke and who spent most of their lives in the city,
- Being aware of applicable laws and regulations on violence in those with sufficient income ($p>0.05$), (Table 3).

Table 3. Distribution of several characteristics of participants relating to physical violence by several sociodemographic characteristics of participants (N=430).

	Being exposed to physical violence during term of office*		**Reporting physical violence to any authority***		**Finding oneself negligent in experienced physical violence***		**Perception of whether physical violence can be prevented***		**Being aware of laws and regulations on physical violence***	
	p	**Description**	**p**	**Description**	**p**	**Description**	**p**	**Description**	**p**	**Description**
Age	**0.001**	26 to 35 years ↑	0.339	-	0.346	-	0.132	-	0.272	-
Gender	0.705	-	**0.021**	Not reporting by women ↑	0.063	-	0.979	-	0.346	-
Education	**0.050**	SML ↑	0.415	-	0.692		0.253	-	0.849	-
Place where most of life is spent	0.719	-	0.787	-	**0.001**	City ↑	**0.040**	City ↑	0.190	-
Marital status	**0.001**	Married ↑	0.934	-	0.951	-	0.532	-	0.993	-
Smoking	0.708	-	0.075	-	**0.008**	Non-smokers ↑	0.742	-	**0.003**	Smokers ↑
Alcohol intake	0.889	-	0.747	-	0.296	-	0.470	-	0.918	-
Occupation	0.422	-	0.006	Not reporting by nurses ↑	0.941	-	0.415	-	0.263	-
Total term of office	**0.003**	Not being exposed violence by those with term of office less than 5 years ↑	**0.050**	Not reporting by those with term of office less than 5 years ↑	0,623	-	**0.045**	Perception of whether violence is prevented in those with term of office less than 5 years ↑	0.398	-
Income	0.278	-	0.910	-	0.326	-	**0.021**	Those reported sufficient ↑	**0.029**	Those reported insufficient ↑
Whether they like their occupation	0.783	-	0.181	-	0.123	-	0.763	-	0.494	-

4. DISCUSSION

The healthcare sector requires direct contact with persons in a difficult condition and the employees of the healthcare sector may be the most important target of violence at the workplace or may occasionally be a victim (Celebi, 2016). Therefore, violence in the medical area is considered a serious occupational hazard (Lipscomb et al., 2012). The individuals must feel safe at the workplace for a proper working environment. However, the cases of violence due to insufficient security measures, gaps in the legal arrangements, etc., may cause employees to feel unsafe (Yigitbas and Deveci, 2011). In this study, one of approximately every four employees (26.3%) reported that they felt unsafe. This percentage was 38.3% in the study performed by Yakut et al. (2012). In this study, if they encountered violence, 73.3% of participants reported that they would ask for help if they felt a tendency to aggressiveness; and 54.7% stated that they would keep a safe distance of the minimum length of an arm between themselves and the attacker. The results were consistent with the literature. Annagur (2010) advised to avoid eye contact with the attacker in case of violence, keep a safe distance of the minimum length of an arm to the attacker, avoid being insistent if the patient keeps moving away, stand where the patient wants, look like being afraid of the patient if needed, ask for help in case of tendency to aggressiveness, and stay close to the door to escape in case of any threat. The report by WHO, ILO and ICN on "Violence at Workplace in Healthcare Sector" reports that more than half of the healthcare professionals are exposed to violence when they perform their job (Nau et al., 2009), and that 3-17% of this violence is physical (Chen et al., 2008). The violence in the healthcare sector is not a problem only specific to Turkey but also a significant problem in world countries. For example, the rate for violence against healthcare professionals is 27% in the UK (Winstanley and Whittington, 2004), 56% in Germany (Schablon et al., 2012), 11% in Spain (Gascón et al., 2009), 13% in the USA (Hodgson et al., 2004), 32.3% in Australia (Hills et al., 2012), 15.9% in Japan (Fujita et al., 2012), 9.3% in Egypt (Abbas et al., 2010),

6% in Brazil, 7% in Bulgaria, 6% in Lebanon, 17% in South Africa, and 10% in Thailand (Picakciefe, 2014), and the higher rates are significant in several countries. As provided in Table 2, the rate for being exposed to violence during the term of office was reported to be 36.9%. The same rate in the literature is reported to be 15.8% (Camci and Kutlu, 2011), 82.7% (Atik, 2013), 24.2% (Akca et al., 2014), 64.1% (Gunaydin and Kutlu, 2012), and 64.5% (Akbas et al., 2016). Likewise, the rate for being exposed to physical violence reported in other Turkish studies was 4.8% (Vural et al., 2013), 7.7% (Bickici, 2013), 8.3% (Elmas et al., 2013), 11% (Kahriman, 2014), 11.2% (Celebi, 2016), 12.5% (Bahar et al., 2015), 13% (Cicek Durak et al., 2014), 14.1% (Nart, 2014), 17% (Yakut et al., 2012), 22.7% (Atan and Donmez, 2011) and 60.6% (Durmaz et al., 2016). For both of the cases, the reason for differences might be explained by the differences in the profession of participants, work conditions, social-cultural factors, sample size, and sampling method.

The period of time when being subjected to violence at highest level was reported to be between 08:00 am and 4:00 pm with 46.9%, and similarly Bilisli and Hizay (2016) (75%), Bahar et al. (2015) (32%) and Vural et al. (2013) (66%) found that more violence was used between 08:00 am and 4:00 pm The reason for this might be attributed to congestion and increased circulation. As indicated in Table 2, the person who used violence was the patient's family with 42.3% on top, which was followed by the patient (17.2%) and senior personnel or another healthcare professional, respectively (the rate was 2.8% for both) in this study. Those who used violence against healthcare professionals were mostly the patients and their family (Buyukbayram and Okcay, 2013). The reason for this is that the patient's family see their patient as more urgent and have higher expectations. In the literature, there are several studies that placed the patient's family using violence on top, which is consistent with this study, and those studies include Kahriman (2014) (24.2%), Nart et al. (2014) (45.1%), Akca et al. (2014) (45,5%), Akbas et al. (2016) (57.5%) and Bahar et al. (2015) (60.2%).

Although many studies have found that the highest rate for using violence is observed in the healthcare sector, it is interesting that reporting violence has the lowest level. What those studies have in common is that only severe events such as bodily injury are regarded as violence, and other events are neglected, or even perceived as a requirement of the profession. In addition, lack of managerial support or problems with reporting procedures is also emphasized (Buyukbayram and Okcay, 2013; Estryn-Behar et al., 2008; Sahin et al., 2011; Elbek and Uslu, 2013). 44.0% of participants in this study stated that they reported the violence they were subjected to. In their study, Gunaydin and Kutlu (2012) indicated that only 3.4% of nurses reported the event after violence. The studies suggest that healthcare professionals are usually hesitant to report the violence used against them with a concern whether or not to receive support. However, the rate for reporting after a physical assault was reported to be higher than that of verbal assault (Al et al., 2012). A study concluded that no administrative or judicial actions are taken for the victims of violence (Akca et al., 2014). The study performed by Akbas et al. (2016) reported that the rate for those who did not react and continued what they were doing after violence was 80.9%, the rate for those who resorted to a remedy was 10.0%, the rate for those who reported to the police force was 16.1%, and the rate for those who reported to management was 28.1%. Bahar et al. (2015) reported a number of rates including the rate for taking a statement down with 42.2% and the rate for not reporting with 47.8%. In the study by Vural et al. (2013), the rate for reporting to judicial authorities was 19.5% while 85.6% of participants did not resort to any judicial units after being exposed to violence in the study by Cicek Durak et al. (2014). To prevent violence against healthcare professionals in Turkey, the important steps include White Code and Hello 113 that are implemented by the Ministry of Health, establishment of Employees' Security Units, and the "Regulation on Principles and Procedures for Legal Assistance for Crimes against Personnel of Ministry of Health" (Attar, 2017).

As provided in Table 2, the cause for violence reported by the participants included low cultural level of society (71.4%), insufficient laws and regulation on violence (55.6%), inadequate security services in institution (53.7%), lack of support from hospital officers (46.0%), delay in response (36.0%), inadequate care for the patient (31.4%), and insufficient treatment (24.4%). The studies reported that assaults rather occurred when the service was insufficient, the patient was admitted unwillingly, or an attempt was made by the healthcare worker to restrict eating, drinking, smoking or alcohol intake (Picakciefe, 2014). In his study, Celebi (2016) stated that 61.6% of participants reported aggressiveness-assaultiveness of society and %42.4 reported low education level of family and society as the cause of violence. Ozturk and Babacan (2014) identified impatience (85%) and lack of care for the patient (43%) as the cause of violence.

In the present study, a difference was made by being exposed to any type of violence during the term of office in those who were between the ages of 26 and 35 years, married, graduated from Health Vocational High School, and had a term of office less than 5 years. Incapability of healthcare professionals with a low term of office and low education level to coop with aggressive actions, communicate or manage crisis increase the rate for being subjected to violence (Buyukbayram and Okcay, 2013; Gillespie et al., 2010). Cicek Durak et al. (2014) found that under 25 years of age and the emergency service workers were found to have higher rates of exposed violence. It is detected that women and non-workers of the emergency room are exposed to less physical violence. Kahriman (2014) found that the nurses (81.8%) being exposed to physical violence by patients were mostly in the 30-39 age group, and reported a statistically significant difference between the age groups and being exposed to physical violence. From the perspective of gender variable for using violence against healthcare professional, several studies reported that male healthcare workers (Eker et al., 2011; Franzet et al., 2010; Dursun, 2012) were exposed to violence more frequently, and the others reported that female healthcare workers were exposed to violence more frequently (Abbas et al., 2010;

Akca et al., 2014; Bilisli and Hizay, 2016). Among the studies investigating the relationship between the education level and the occupational violence, the studies (Gunaydın &Kutlu, 2012; Sahin et al., 2011; Estryn-Behar et al., 2008) indicated that those with lower education level were highly likely to be exposed to violence, and several studies showed that education level was not important (Camci and Kutlu, 2011).

According to the results of the chi-square test, the difference between the gender of participants and the rate for reporting the violence to the competent authority was statistically significant. Atik (2013) concluded that 28.6% of women reported the violence to a competent authority after being exposed to violence but 71.4% did not report, 10.1% of men reported and 89.9% did not report to any competent authority.

5. IMPLICATIONS FOR PRACTICE

This study suggests that only one of every four healthcare professionals felt safe in the workplace. It was reported that violence rather occurred during the day shift. The rate for reporting/not reporting the violence is half and half. Approximately, one of every 8 healthcare professionals finds themselves to play a role in the violence. Four of every 5 healthcare professionals consider that violence cannot be prevented.

A safe and violence-free environment should be provided for healthcare professionals, and support for coping skills should be provided them.

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