ABUSE OF HEALTHCARE WORKERS

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For those among us who watch medical dramas on television, the premise is a familiar one – a patient in delirium or an aggrieved family member attacks a healthcare worker and we cringe as the scene unfolds. Unfortunately, there is very little warning or even sense of motive when such abuse occurs in reality. I have attended to hospital staff who were physically abused or assaulted, and a common reaction that they expressed is that they did not expect the assault to happen; it literally came out of nowhere and they had very little time to react sensibly. After the event, some are unable to return to work in the same ward or clinic, while others decide to leave clinical work altogether. Thus, the implications are significant.

Although data on abuse of healthcare workers is hard to come by and varies from institution to institution, visitors to hospitals over the last few years are much more likely to come across posters put up to deter abuse to its staff. From the Ministry of Health's website, we learnt that the number of staff abuse cases reported to the police doubled from 16 in 2010 to 33 in 2012.[1] Investigative reporting in our local newspapers highlighted the higher risk of abuse in the A&E departments and intensive care units where "emotions run high".[2]

An editorial in the *Annals of the Academy of Medicine*[3] suggested that potentially 70% of Singapore's hospital staff has experienced physical abuse, with older male patients with neuropsychiatric disorders or drug/alcohol intoxication being the most likely perpetrators of such abuse.

Occurrences of workplace violence

The World Health Organization (WHO) defines "workplace violence in the health sector" to include: physical assault, homicide, verbal abuse, bullying/mobbing, sexual and racial harassment, and psychological stress.[4] It also further adds that "violence does not only occur as one single incident, but also may be expressed in repeated small incidents which together create severe harm."

In some instances, the more severe abuse does not always happen when

the patient has already been identified as a high-risk patient. Even when they were identified, they had perhaps been calm throughout the admission, or they had been essentially confined to bed and confused, and so assumed to be harmless. It is usually only after the abuse or assault has occurred that there is some indication, somewhere in the history, that the patient had been aggressive in the past. In other occasions, it could be a patient suffering from dementia who, in a moment of responding angrily to his limbs, which suffer from contracture, being stretched to allow a diaper change, ends up kicking the nurse severely enough to cause a rib fracture. According to WHO, while psychological abuse has the element of intention, physical violence reports only the aspects of the behaviour without mention of intention.

If there is one common thread to staff assaults and abuse, it is that they are opportunistic. The single unrestrained arm of a psychotic patient, because someone had forgotten to reapply the restraints after blood taking, can be dangerous. The incoming nurse who arrived five minutes late as she was helping the previous shift nurse with a procedure and missed being informed about the patient in her care who had molested staff repeatedly in a previous admission, and who then goes on be molested by said patient, becomes a victim. The patient with severe dementia, who assumes that an open ward door led back to his home and punches the attendant, who happened to be in his way, then becomes an assailant.

In that sense, abuse is very much like an infection. We all know what we need to do to prevent it. However, if we assume that it will not happen and when it does, it causes much harm to those who come into contact with it. Abuse can take many forms – verbal, physical, sexual, intimidation, harassment, etc. Unfortunately, the message that is sometimes perpetuated is that since the practice of medicine or nursing is a calling, it is somehow not appropriate to report incidents where the healthcare worker is subjected to abuse.[2] Thus, many events go unreported, either by explaining away that the patient or their family had not meant to hurt, or that it was somehow the fault of the healthcare worker to have done something to elicit such a response.

Despite the under-reporting, we do know that hospital staff abuse rates are "on the rise".[1] Partly, I ascribe this subtly shifting tide to increased awareness that something can be done about the abuse and more people are willing to come forward to seek help. The old ways of doing things – appearing to be stoic and to deny any complications from the abuse – are now slowly being replaced by processes designed to pick up the abuse, and an increased awareness that it is not part of anyone's job description to be abused in the course of their work. Reporting is key; it allows not only the workplace to address possible gaps in safety, but also enables the patient to be helped earlier, before the next abuse escalates. And hopefully, with better data, we can intervene more effectively by targeting the crucial times and situations during which abuse happens more frequently.

The potential causes

So why do patients or their relatives abuse the people they know they are dependent on to get better? The reasons are numerous, but we are able to quickly discern two groups who are "abusers" – those who maintain their mental faculties and those who don't. For the latter group especially, the abuse can be quick, unexpected and frightening when they are not able to judge the consequences of their actions and behaviours. In several instances, the patient feels threatened or is responding to internal stimuli beyond what the environment presents to him or her. In such cases, a prudent approach to the static and dynamic risk factors will enable healthcare workers to firstly identify that there is risk, then to approach with caution, and always be mindful that one instance of a pleasant encounter is no guarantee that future encounters will be just as pleasant. Therapeutic relationships are built on an accurate assessment of risk (historical and current) and present a level of engagement with a view to future collaboration, without complacency or assumptions.

For patients and families who are, to external appearances at least, able to discern right from wrong, the situation is trickier. A sense of righteous anger can sometimes pervade a rational mind to the point that there is little sense left to reason with. Usually, there is some instance of perceived mismanagement or being misunderstood that snowballs into a matter of "principle", where the patient or family insists that they are "right" to expect a certain outcome. Unfortunately, to maintain that one is "right", one must prove the other "wrong" and the situation soon spirals into a string of accusations, culminating in verbal or physical abuse. Such abuse can be painful or, if spread over time, exhausting for the healthcare worker and can lead to burnout – another common endpoint of working in an abusive environment.

So what can we do about abuse at the workplace? The first step is undoubtedly to be prepared for it, and to install the necessary environmental changes, work processes and human interactions that will hopefully minimise the risk. Specific recommendations are beyond the scope of this review. Secondly, in the event that abuse does occur, we should expect to react instinctively as an organised group rather than individually and piecemeal. Thirdly, we should seek to protect our staff, patients and workplace, and report abuse when it does occur. Lastly, having suffered abuse, we can always offer compassion and a commitment to change instead of seeking to ascribe blame; in so doing, we can hopefully prevent secondary trauma to staff recovering from a workplace event they had not counted on happening. After all, limiting opportunities mindfully, rather than turning a blind eye, is the best way to defeat this phenomenon. ◆

References

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