Original article

Legal response of physicians towards Workplace Violence during COVID-19 pandemic in Egypt: A cross sectional study

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ABSTRACT

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Workplace violence (WPV) is defined by World Medical Association as "an international emergency that undermines the very foundations of health systems and impacts critically on patient's health". The physicians are specifically vulnerable for such these acts from patients or even their relatives. WPV has detrimental effects on both health professionals and the quality of health care services administered. **Aim:** to highlight the problem of assault against doctors and their legal response towards it, generally in medical practice and specifically during COVID 19 pandemic. **Subjects and methods:** A cross sectional study was done through anonymous self-structured internet-based questionnaire survey on 300 physicians. It included different data as regards sociodemographic data, occurrence of bullying, type of assault and response of the physician towards such assault. **Results:** About 55% of responders claimed previous exposure to verbal or physical violence, nearly 19% faced verbal violence and 14% faced physical violence, about 15% notified head of the department while only 9.7% notified police. Almost 80% of the responders were not satisfied by actions taken after notification, and 23% were exposed to bullying due to working during COVID era. All responders (100%) believe that media affect how people deal with physicians. **Conclusion:** Workplace violence against doctors is escalating vigorously. Under-reporting and lack of security support are the main issues in solving this catastrophic health system problem.

Key words: workplace violence, legal response, physicians, COVID-19, Egypt

I-INTRODUCTION:

Workplace violence against doctors is an increasing problem worldwide, It is defined 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'. It includes physical and verbal assault, aggression, sexual harassment, bullying, and even threats (Liu et al., 2019). Many countries reported cases of violence for example, at China in 2014, nearly 70% of healthcare workers suffered verbal or physical assaults. In United Kingdom nearly 57,000 cases of physical assault against medical professionals were recorded in years 2016 and 2017 (Vento et al., 2020).

The international committee of Red Cross (ICRC) raised an initiative named 'Healthcare in danger" which aimed at improving protection of medical personnel and facilities through law implementation and practical interventions (Shaikh et al., 2020).

Egypt had the second highest prevalence of WPV (59.7%–86.1%) across studies following South Africa (nearly 100%) (Njaka et al., 2020). Assaults included verbal violence (76.5%) followed by physical (30.6%) in a study done in Tanta University emergency hospitals (Kabbash and El-Sallamy,2019). Hospital safety measures aren't available and there is neither successful reporting system nor victim support to any kind of assault (Bakr et al., 2019).

The problem with such violent acts is that the physician might face serious consequences as life threatening injuries or even death together with negative work environment causing burnout, undermining physician capabilities leading to decreased work interests and defective professional efficiency (Vento et al., 2020).

More studies are needed to explore the magnitude of the problem and tackle the issue of legal responsive position together with obstacles facing the reporting of workplace violence.

The aim of the current study is to highlight the problem of assault against doctors and their legal response towards it, generally in medical practice and specifically during COVID 19 pandemic.

II-SUBJECTS and METHODS:

The current study is a descriptive cross-sectional study, it included a sample of physicians in Egypt.

An anonymous self-designed questionnaire was used to collect data; it was sent out to 300 doctors with job grades from house officer to senior registrar, randomly selected from Egyptian universities, educational hospitals, and heath governmental sectors. Only 171 doctors answered our questionnaire. The questionnaire collected information about the participant's age, sex, job grade, specialty, place of work, previous exposure to verbal or physical violence before and after COVID, if they previously forced to prescribe medicine or write false data, if they experienced breaking their or their place of work property, they were asked to mention the type and the site of injuries they had before due to bullying whether pre or post COVID, whether they notify or not and to whom, whether the people became more aggressive during COVID, reason for that in their opinion, did they were bullied outside hospital due to their job, by whom, they were asked about their opinion regarding the media in general (TV shows, Facebook, etc…).

Questionnaire was chosen as a data collecting tool for this research as it consists of a series of questions that help gather information from participants and data could be collected in a short time, also it's an easy method that doesn't put pressure on respondents. And data can be analyzed more scientifically and objectively than other forms of research (Muhammad & Kabir, 2016).

A pilot study was done on 10 physicians who were excluded from the study samples; based on their opinion; vague and confusing questions were excluded and some modifications was were done to improve the final form of the questionnaire.

Validity of the questionnaire was assessed through face validity. Face

validity involves an expert looking at the items in the questionnaire and agreeing that the test is a valid measure of the concept which is being measured. The expert involved was a prestigious professor of Forensic medicine and Clinical Toxicology in Cairo university (Bolarinwa, 2015).

Ethical considerations:

This study was done after the consent of all the participants to answer the included questions in the questionnaire and taking their approval that the collected information could be used in research.

Statistical methods:

Data were coded and entered using the statistical package for the Social Sciences (SPSS) version 28 (IBM Corp., Armonk, NY, USA). Data was summarized using frequency (count) and relative frequency (percentage) for categorical data. Only Chi square ($\chi 2$) test was performed. Exact test was used instead when the expected frequency is less than 5. For comparison between categorical data measured before and after McNemar and Marginal Homogeneity tests were used (Chan, 2003). $P < 0.05$ was considered as statistically significant.

III-RESULTS:

As regards sociodemographic data; most of the responders were females (69.9%), the age range was 36 to 45 years old in about (88.5%), nearly 55% of the participants had an educational level as specialists, GP or house officers, clinical speciality constituted (90.9%), most participants were from urban areas (93.8%), nearly (89.8%) of participants worked in governmental and educational hospitals (Table 1).

Looking in depth at the details of history of workplace violence and its different forms; about (59.7%) of participants had contact with COVID cases with (55.1%) of them claiming previous exposure to verbal or physical violence, while (18.8%) of them were subjected to verbal violence before and after COVID era (Table 2).

As response to whether they were subjected to breakage of personal property; most of them negated such

act (96.9%), about (14%) were subjected to physical violence. In pre COVID era ; types of injuries were abrasions and bruises in (4.5%) of participants, cut lacerated wound was found in one case only, but in post COVID period; types of injuries for sufferers of physical violence were : abrasions and bruises which were found in 3 cases (1.7%) and cut-lacerated wounds were demonstrated in 3 cases (1.7%) (Table 2). There was no statistical significant difference between types of injuries pre and post COVID (Table 3).

Sites of injury were mostly limbs (4%) followed by head (2.8%). Nearly (34.7%) and (18.2 %) reported that the patients or his relatives broke some hospital properties in both periods before and after COVID respectively (Table 2). There was a statistical significance between the incidents of breaking the hospital property by the patient or his relatives pre and post COVID (p <0.001) (Table 9).

Around (60%) of responders believe that people became more aggressive during COVID they claimed that the reason for assaults were mostly due to lack of enough beds or medications (43%), followed by the deterioration of patient's condition or death (29.5%), lastly due to lack of patient's cooperation (26.7%). For Example, refusal to give blood samples (Table 2).

As regards the legal response of participants as shown in table (4); most of them (75%) didn't notify the incidence and those who notified; (14.8%) notified head of the department or hospital management system while only (9.7%) notified police. The response to notification was none in (46.9%), apology of the assaulter in (46.9%) and legal suit in only (6%). Most of the respondents (80.4%) weren't satisfied by the action taken after their notification. Asking non notifiers about their reasons; (57.57%) confessed lack of trust in procedures taken, (in 49%) of situations the assaulter apologised, in (44.4%) the participant dealt with the situation themselves as they were able to control the violent situation through efficient communication with the patient and his relatives, about (55%) feared from future problems or detrimental effects on their own reputation, lastly (8.9%) stated that they feared from threats.

There was a statistical significance between the incidence of non-notifying and clinical specialty (Table 8).

Table (5) demonstrates the respondents' exposure to bullying; (23.3%) of cases were exposed to bullying outside hospital due to their job during COVID, (11.4%) of cases were bullied by their neighbours or strangers, while nearly 5% of cases were bullied by their relatives and friends.

As regards the effects of assaults and bullying on participants; about (39%) thought of immigration, (36.5%) wanted to take a long vacation,
(27%) wished to make a career shift and (20.6%) thought of resigning (Table 6).

Answers to questions about the role of media towards physician public picture showed that all health care providers admit that the media affect people against them (100%) and more than half (75.6%) of them saw that the media has a clear role in such bullying behavior (Table 7).

Respondents were asked to propose suggestions to protect doctors against workplace violence; 68 responses most of them included confirming the arising need for application of the laws that protect healthcare workers with strict dissuasive penalties against assaulters also increasing the protective measures needed in the Emergency department of hospital to prevent chaos and violence, they highlighted the importance of increasing awareness of people as regards the crucial role of medical sectors and the expensiveness of medical appliances together with the efforts made by doctors to improve the whole health system (Table 10).

Table 1: Number and percentage of participant's' sociodemographic data

		Count	%
Age	less than 25 years and from 25-35	68	38.6%
	36-45 years	88	50.0%
	46-55 years	16	9.1%
	more than 56 years	4	2.3%
Gender	Male	53	30.1%
	Female	123	69.9%
Educational level	Consultant	79	44.9%
	specialist, GP , House officer	97	55.1%
Specialty	Clinical	160	90.9%
	Academic, Laboratory	16	9.1%
Place of work	Rural	11	6.3%
	Urban	165	93.8%
Hospital	Governmental: institute, educational hospital, EFMA	158	89.8%
	Private hospital or clinic	14	8.0%
	Isolation hospital	4	2.3%

EFMA=Egyptian forensic medical authority

Table 2: Number and percentage of detailed history of workplace violence and reasons for different forms of violence as proposed by the participants

		Count	%
Contact with COVID cases	yes	105	59.7%
	no	71	40.3%
Previous exposure to verbal or physical violence	yes	97	55.1%
	no	79	44.9%
Verbal violence	before COVID	31	17.6%
	after COVID	7	4.0%
	no exposure	105	59.7%
	before and after COVID	33	18.8%
Previously forced to prescribe medicine or write false data	before COVID	29	16.5%
	after COVID	6	3.4%
	no exposure	126	71.6%
	before and after COVID	15	8.5%
Breakage of personal property like mobile phones, car	yes	6	3.4%
	no	170	96.6%
Physical violence	yes	25	14.2%
	no	151	85.8%
Type of injuries post COVID	Abrasions, bruises	3	1.7%
	cut-lacerated wound	3	1.7%
	no injuries	170	96.6%
Type of injuries pre COVID	Abrasions, bruises	8	4.5%
	cut-lacerated wound	1	0.6%
	no injuries	167	94.9%
Site of injuries	head injuries	5	2.8%
	limb injuries, chest	7	4.0%
	no injuries	164	93.2%
The patient or his relatives break hospital property before COVID	yes	61	34.7%
	no	115	65.3%
The patient or his relatives break hospital property after COVID	yes	32	18.2%
	no	144	81.8%
During COVID people became more aggressive	yes	105	59.7%
	no	71	40.3%
The reason for this assault in the participant's opinion	no enough beds -no medications	77	43.8%
	patient refuses to cooperate	47	26.7%
	deterioration of patient's condition or death	52	29.5%

Table 3: Chi square statistical analysis of relation between type of injuries pre & post COVID

		Pre COVID		Post COVID		*P* value
		Count	%	Count	%	
Type of injuries	Abrasions, bruises	8	4.5%	3	1.7%	0.131
	cut-lacerated wound	1	0.6%	3	1.7%	
	no injuries	167	94.9%	170	96.6%	

P value < 0.001

Table 4: Notifications' history and causes of not notifying as proposed by the participants

		Count	%
Notification	yes	44	25.0%
	No	132	75.0%
To whom	police	17	9.7%
	head of department, hospital management	26	14.8%
Response to notification	None	23	46.9%
	Apology of assaulter	23	46.9%
	Legal suit against assaulter	3	6.1%
Satisfaction against response to notification	yes	9	19.6%
	no	36	80.4%
Causes of not notifying (Multiple responses were allowed)	Lack of trust in the procedures taken	26	57.8%
	The assaulter apologized	22	48.9%
	The participant dealt with the situation himself	20	44.4%
	Fear from future problems or fear over his reputation	25	55.%
	Fear of threat	4	8.9%
	No reason mentioned	3	2.2%

Table 5: Exposure to bullying and people involved in such act according to the response of the participants

		Count	%
Exposure to bullying outside hospital due to participant's job during COVID era	yes	41	23.3%
	no	135	76.7%
Persons involved in bullying	neighbors, strangers	20	11.4%
	relatives and friends	9	5.1%
	no answer to the question	147	83.5%

Table 6: Effect of assaults and bullying on participants

		Count	%
Assaults and bullying made the participant think of (Multiple responses were allowed)	Resigning	13	20.6%
	Taking long vacation	23	36.5%
	Career shift	17	27%
	Immigration	31	49.2%
	None	5	8%

Table 7: Role of media towards physicians' public picture according to the participants response

		Count	%
Media has a role in such bullying behavior	yes	133	75.6%
	no	43	24.4%
Media affect people behavior against healthcare providers	yes	176	100.0%

Table 8: Chi square statistical analysis of relation between notification of assault and specialty among participants

		specialty				
		clinical		Academic, Laboratory		*P* value
		Count	%	Count	%	
Notification	yes	44	27.5%	0	0.0%	0.013
	No	116	72.5%	16	100.0%	
To whom	police	17	10.6%	0	0.0%	0.283
	head of department, hospital management	25	15.6%	1	6.3%	
	no notify	118	73.8%	15	93.8%	

P value < 0.001

Table 9: Chi square statistical analysis of relation between breakage hospital property pre and post COVID among participants

		Pre		Post		*P* value
		Count	%	Count	%	
The patient or his relatives break hospital property	yes	61	34.7%	32	18.2%	< 0.001
	no	115	65.3%	144	81.8%	

P value < 0.001

Table 10: Number and percentage of suggested solution for work place violence proposed by the responders

Solution	Count	%
Application of laws protecting health care workers	34	50%
Increasing security personnel	24	35.3%
Increasing awareness of importance of medical facilitates	10	14.7%

IV-DISCUSSION:

The current study is one of the few studies that dealt with the workplace violence in Egypt and highlighted the notification response of different physician towards such problem.

Verbal violence represented nearly19%, it's more common than physical violence 14.2%. This agrees with the study done in Pakistan where verbal violence was leading physical assaults, this could be attributed to the fact that most of our participants were females (nearly 70%) and they mostly won't engage in physical violence and won't escalate the stressed patients or relatives' response up to exploding physical assault. On the other hand, higher frequency of verbal violence against females could be explained by the lack of acceptance and respect for women to do field work (Shaikh et al., 2020).

Fortunately, minority of respondents suffered injuries (Abrasions, contusions, cut lacerated wounds), this agrees with a study done in Saudi Arabia (Alshahrani et al., 2021),but the current study showed that severity of injuries was increased in post COVID era as three participants suffered cut lacerated wounds when only one suffered this injury in pre COVID era, also 60% of the participants believed that people became more aggressive during COVID. The notable increase of aggression during COVID-19 pandemic was explained by killgore et al.,(2021) that people were subjected to fear of the unknown, frustrated goals and decreased autonomy due to lockdown and self-isolation.

According to the classification of injuries proposed by kumari et al,(2020) respondents who suffered from abrasions, contusions and lacerated wounds belong to grade III

severity of work place violence, which is defined as : "Physical assault (pushing, kicking/beating, using objects such as knives or guns, slapping, strangling, pulling hair, etc) causing moral and psychological distress but no physical disability." This raises flags concerning the seriousness of work place problem in Egypt. It needs drastic measures to eradicate it.

There was a statistically significant difference between the incidence of breaking hospital property before (34.7%) and after (18.2%) COVID era, this was generally explained by Bhatti et al., (2021) as relatives almost always blame the doctors for harming their patients but the notable decrease in post COVID era could be attributed to the strict governmental regulations of limiting number of relatives accompanying COVID patients.

Regarding causes of assaults, 43% of responders claimed that the main cause was the lack of enough beds or medications which was explained by Shaikh et al.,(2020) that all public hospitals are overcrowded and under resourced and actually 90% of our responders worked in governmental hospitals which confirms the fact of resource rarity. About 29.5% saw that the main reason was patients' deterioration or death and lastly 26.7% believed that the causes of assault were due to lack of patient's cooperation. This coincides with a study done in Pakistan where the main reason was patient worsened condition or death.

The legal response of participants showed that most of them didn't notify the assault and nearly 15% notified head of the department or hospital management, only 10% notified police, this coincides with a study done in Saudi Arabia where most of participants didn't notify their incidence But findings disagree with a study done in Egypt which showed that half of the study population notified police and one third of them reported to senior staff (Bakr et al., 2019).

The causes of non-notifications were mostly (58%) lack of trust in procedures taken and about 55% feared about their reputation especially in clinical speciality, this differed from a study by Bakr et al., (2019) who found that most of non-reporters were due to the fact that they didn't know who they could report to or they believe the incident itself is not important.

Unfortunately, most of notifiers around 80% weren't satisfied by the actions taken after their notification, in 47% there was no response taken and in another 47% the perpetrator

apologised. The causes of dissatisfaction might be that they believe that it was just a slap on the hand of the assaulter. This disagrees with another study done in Egypt where about 4th of the participants were satisfied as regards the actions done towards their notification (Bakr et al., 2019).

Bullying was an issue to 23.3% of participants, it occurred outside hospitals by neighbours and strangers (11.4%) during the COVID era. This was explained by a study done in Iraq; as doctors during COVID are the new movable source of infection, these misconceptions were amplified by fears, rumours, and ignorance about the nature of COVID 19 spread (Lafta et al., 2021).

Assaults and bullying have detrimental effects on physicians; about 39% thought of immigration, 36.5% wanted to take long vacations and around 20% thought of resigning. A study done in Tanta agreed with these findings, it confirmed that assaults could affect the physicians mental and psychological welfare (Kabbash and El-Sallamy,2019).

The role of media is crucial as regards the public response towards physicians, this was approved by 100% of responders and 75.6% believe that media play a role in bullying and assault against doctors. This agrees with a study done in India which proposed that medicine is not a black and white issue as showed by media. Diagnosis and treatment of patients is a complicated ongoing process that needs patience and dedication (Ghosh, 2018).

Respondents proposed suggestions to help solve the increasing problem of workplace violence, most of them mainly flagged the importance of application of laws and strict penalties against the assaulters. Some studies proposed a 'zero tolerance policy' with explicit statements and warning signs stating that violence will not be tolerated. (Raveel and Schoenmakers ,2019).

This agrees with a study done in Saudi Arabia by Alshahrani and his colleagues, they addressed the importance of encouragement of authorities to facilitate reporting procedures of different violent incidents in order to help the implementation of strict penalties against perpetrators of violence towards healthcare professionals (Alshahrani et al., 2021). Other participants confirmed the importance of abundance of security personnel to help protect healthcare workers from chaos and violence, these suggestions agree with a study done in Bangladesh hoping to

decrease workplace violence (Shahjalal et al., 2021).

This also agrees with Ghosh (2018) who highlighted the importance of presence of nearby police stations and prevention of entrance of relatives of patients with any kinds of weapons or heavy tools, also transparency in addressing the fees of the administered services could help in overcoming patients' or relatives' anticipation and misunderstanding.

Bakr et al. also confirmed the importance of rapid access to trained security personnel. Security systems should be improved, presence of live cameras could help improving incidents that might occur in different occasions (Bakr et al.,2019).

A study in Pakistan showed that patient education has a significant reduction in the events of violence. Education of patients as regards the importance of one attendant policy and waiting for his return together with adherence to access restriction policies of the hospital (Shaikh et al., 2020).

In India a study showed that the long waiting periods of patients for their turn could contribute to patients' aggression, and they proposed that the use of digital technology and mobile applications can substantially help in this problem (Ghosh, 2018).

A study in Bangladesh confirmed that effective organisation of night shifts is crucial to decrease the stress and fatigue caused by long working hours, which is an escalating burden over physicians' shoulders. Also, victims of workplace violence should be supported by comprehensive medical and psychological services (Shahjalal et al., 2021).

The fore mentioned study highlighted the importance of increasing awareness about the impact of violence on health sector which was a solution also proposed by the participants in the current study(Shahjalal et al., 2021).

V-CONCLUSION:

Workplace violence against doctors is escalating vigorously. Under-reporting and lack of security support are the main issues in solving this catastrophic health system problem.

VI-RECOMMENDATIONS:

- Strict governmental policies and penalties are needed to face workplace violence against the physicians

-Availability of enough security personnel should be considered.

-Medicolegal documentation of cases in special forms together with proper data collection concerning the legal response of physicians are needed to

help in proper evaluation and solving of this problem.

- Media should be directed to raise the awareness about difficulties facing the health system in general (rarity of hospital beds or defective medications) and doctors in specific (long shift hours and stressful job).

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الاستجابة القانونية للأطباء تجاه العنف في مكان العمل أثناء جائحة الكورونا في مصر: دراسة مقطعية

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1 قسم الطب الشرعي والسموم الاكلينيكية – كلية الطب -جامعة عين شمس

2 قسم الطب الشرعي والسموم الاكلينيكية – كلية الطب -جامعة القاهرة

الملخص:

تم تعريف العنف في مكان العمل من قبل الجمعية الطبية العالمية بأنه "حالة طوارئ دولية تقوض أسس النظم الصحية وتؤثر بشكل خطير على صحة المريض". الأطباء معرضون بشكل خاص لمثل هذه الأعمال من قبل المرضى أو حتى أقاربهم. العنف في مكان العمل له آثار ضارة على كل من المهنيين الصحيين وجودة خدمات الرعاية الصحية المقدمة. الهدف: تسليط الضوء على مشكلة الاعتداء على الأطباء واستجابتهم القانونية لها ، بشكل عام في الممارسة الطبية وتحديداً أثناء جائحة كورونا .المنهجية: أجريت دراسة مقطعية من خلال استبيان مجهول الهوية قائم على الإنترنت على 300 طبيب. تضمنت بيانات مختلفة فيما يتعلق بالبيانات الاجتماعية والديموغرافية ، وحدوث التنمر ، ونوع الاعتداء واستجابة الطبيب لمثل هذا الاعتداء. النتائج: ادعى حوالي 55٪ من المستجيبين تعرضهم السابق للعنف اللفظي أو الجسدي ، وتعرض ما يقرب من 19٪ للعنف اللفظي و 14٪ تعرضوا للعنف الجسدي ، وحوالي 15٪ أبلغوا رئيس القسم بينما أبلغ 9.7٪ فقط الشرطة. ما يقرب من 80٪ من المستجيبين لم يكونوا راضين عن الإجراءات التي تم اتخاذها بعد الإخطار ، وتعرض 23٪ للتنمر بسبب العمل خلال فترة كوفيد. يعتقد جميع المستجيبين (100٪) أن وسائل الإعلام تؤثر في كيفية تعامل الناس مع الأطباء. الخلاصة: العنف في مكان العمل ضد الأطباء يتصاعد بقوة. يعد نقص الإبلاغ ونقص الدعم الأمني القضيتين الرئيسيتين في حل هذه المشكلة الكارثية الخاصة بالنظام الصحي.التوصيات: هناك حاجة لسياسات حكومية صارمة لمواجهة العنف في مكان العمل ضد الأطباء .يجب مراعاة توفر عدد كافٍ من أفراد الأمن.- يجب توجيه وسائل الإعلام للتوعية بالصعوبات التي تواجه النظام الصحي بشكل عام (ندرة أسرة المستشفيات أو الأدوية المعيبة) والأطباء بشكل خاص. هناك حاجة إلى التوثيق الطبي القانوني للحالات في أشكال خاصة مع جمع البيانات المناسبة بشأن الاستجابة القانونية للأطباء للمساعدة في التقييم المناسب وحل هذه المشكلة.