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Violence in the health care workplace: a theme for international cooperation in human resources in the health sector

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Abstract

Among the themes in concerning human resources in the health sector, major attention is being given to working conditions and health risks to workers, including, according to the 2006 World Health Report, violence in the workplace. Based on a study of the literature and official documents, this article seeks to show the problem's relevance and identify elements for creating international cooperation strategies on this theme. Studies show that aggression can affect more than 50% of workers. The World Health Organization argues that violence is the result of the complex interaction of various factors, among which working conditions and organization and worker-aggressor interaction stand out. Health care units situated in more vulnerable locations may present a greater risk of violence for its workers, affecting professionals from those areas. Limited knowledge about the theme and regional differences are the reasons for the strategy of establishing networks among workers, users, managers, communities and academy in order to confront the problem. In Brazil, there are various initiatives of this type. Internationalizing these experiences create opportunities to strengthen these networks and also the horizontal cooperation in human resources in the health sector.

Keywords

human resources; health sector; health care workers; violence in the workplace; networks on the culture of peace and non-violence

In recent years, a consensus has been built about the crisis facing human resources in the health sector and the urgency of a joint effort to confront it. Mainly involving a shortage of professionals, their distribution in the territory, their skills mix and qualification, the negative effects of this crisis are detected in the quality of care, the capacity to prevent diseases, the performance of health care systems, finally, the achievement of desired health care results (PAHO/OMS, 2007). The World Health Report 2006 – Working Together for Health (WHO, 2007) brought the theme to a central place, describing the setting of the crisis and proposing a plan to confront it. Health care workers' health is characterized as one of the factors that may contribute to workers' absence, causing significant losses in the workforce and compromising the accumulation of knowledge, memory and the systems' culture.

Out of the strategies outlined in the plan proposed by the report, the following can be mentioned in relation to the health workers' health: ensuring the health and safety of health care workers with respect to diseases and accidents; protecting what works, regarding work in conflict environments and dangerous areas; and developing and implementing tactics against violence, dealing with the occupational risks of health care workers.

In its 2007-2015 Plan of Action for Human Resources for Health (OPAS/OMS, 2007), the Pan American Health Organization focuses its attention on the work environment, establishing as a goal for the period that 80% of the region's countries should implement health and safety policies for health care professionals, including the support to programs

to reduce workplace-related diseases and injuries.

This article aims to contribute to the discussion on how to confront violence in the workplace as a relevant issue for the professionals', health, as part of the health sector care human resources agenda and to tackle elements for strengthening strategies which include research networks, sharing experiences and intervention in the national, regional and international scope.

At first, a non-exhaustive review of the scientific production on violence in the workplace is presented, with emphasis on the health care sector since the 1980s, seeking to outline the problem and tackle its conditions and causes. Then, some models developed to understand the issues are also presented. Finally, considerations on the opportunities to produce information and actions to confront the problem are discussed.

Violence in the workplace in the health sector

From the end of 1980s on, violence in the workplace became a relevant question for workers' health. Between 12 and 17% of the deaths ocurred in the workplace were homicides (JENKINS et al., 1992; TOSCANO & WINDAU, 1994; TOSCANO & WEBER, 1995; BRASIL/MTB, 1998; 2000).

According to the workplace accident reports in the Campinas region, between 1979 and 1989, analyzed by Lucca and Mendes (1993), homicides and injuries caused by other people were the third cause of death totalling 9.2% of the cases. Oliveira and Mendes (1997) observe that homicides were the main cause of deaths, accounting for 58% of the cases. Carneiro (2000), analyzing incident reports recorded in São Paulo's north zone in 1998, confirms that homicides and armed robberies were the main cause of workplace-related deaths, representing 34% of the total.

Although violence may affect practically all productive sectors, specific patterns and degrees of seriousness can be detected. Toscano and Weber (1995) show that violence in the workplace differs in its fatal and non-fatal forms. The main victims of violent death in the workplace are men, workers in retail sales, urban transport, bars and restaurants and are related to robberies and theft. On the other hand, non-fatal violence affects primarily women, professionals in health care services and the aggressor is usually a patient.

In this last case, Toscano and Windal (1995) show that health care workers are among those most affected by aggression, with this sector accounting for approximately one quarter of all workplace violence. According to the *National Crime Victimization Survey*, among the health professionals, excluding those linked to mental health, nursing presented the highest average rate of victimization in the period from 1993 to 1998: 22/1000. Physicians, technicians and other professionals in the health sector presented, respectively, 16, 13 and 9 out of 1000 workers. Victimization rates for nurses and physicians were not significantly different, however, the former presented a rate 72% higher than that of technicians and twice as high as that of other health professionals.

The risk of violence for health care workers is significantly linked to contact with the public (LAVOIE et al., 1988; LIPSCOMB & LOVE, 1992). According to Conn and Lion (1983), patient aggression against workers occurs in differents locations: psychiatric units (41%); emergency rooms (18%); clinical units (13%); surgical units (8%), and even in pediatric units (7%). Ambulance, emergency and nursing staff are the most exposed to the risk of violence, amongst the health care workers (MCKAY, 1994, *apud* NOLAN et al., 2001).

According to Madden et al. (1976), Lanza (1983), and Poster and Ryan (1989), between 46 and 100% of nurses, psychiatrists and therapists in mental health services experienced at least one aggression during their careers. Lavoie et al. (1988), investigating 127 emergency departments in university hospitals, verified that 43% of these had at least one physical aggression against some member of the medical staff every month. Seven percent of violent acts in the five previous years had resulted in death.

The research performed jointly by the International Labor Organization (ILO), the World Health Organization (WHO), and Public Services International (PSI) (OIT et al., 2002) indicates that violence in health care services is a global phenomenon. In developing countries, where data used to be rare or nonexistent, more than half of the interviewees reported at least one incident of physical or psychological violence in the previous year.

Data from this research referring to the various types of health care services in the city of Rio de Janeiro (PALÁCIOS et al., 2003) indicates that 19.5% of the workers consulted reported having suffered some kind of verbal aggression at work during the previous year. Moral harassment was reported by 15.2%, physical aggression by 6.4%, sexual harassment by 5.7%, and racial discrimination by 5.3%. The questionnaires sent by Health Care Centers (UBS) reveal that 70% of the workers reported some kind of episode. The most frequently-reported forms of violence are: verbal aggression (65.5%), bullying (20%), physical

aggression (7.3%), and sexual and racial harassment (3.6% each).

Research performed in a sanitary district of Belo Horizonte (CAMPOS, 2004; CAMPOS & DIAS, 2007) aimed at studying the violence issue in the workplace in Basic Health Care Units. The most frequent aggression reported by workers, present in 73.7% of cases, was verbal aggression, in the form of an offense or insult. Second were threats of physical aggression (23.4%). Sexual harassment or undesired sexual behavior was reported in 18.8% of the cases. Physical aggressions and threats with firearms or knives were both reported by 4.3% of workers. Finally, in 1.6% of cases, firearms or knives were used in the aggressions. The previous data refers to events involving service users; aggressions or threats by someone previousily involved in crimes were reported by 33.3% of workers.

Santos Junior and Dias (2004), studying episodes of violence in the workplace against physicians in the Primary Care Units (UPA) of the city of Belo Horizonte, observe a prevalence of 1.9% for physical aggressions, 45% of threats of physical aggression against the professional, his family or damage to his property, and 82% of other forms of violence (aggressive or hostile posture, offenses, intimidation, sexual harassment, racial discrimination, etc.).

According to Leather (2001), reviewing researches on this issue, although health care workers are exposed to all kinds of violence, several studies point out that up to 69% of the aggressions in the health care workplace are indeed linked to episodes involving patients. Generally, the following are considered characteristics of the patient prone to violent acts: prior record of aggressiveness, history of alcohol and drug abuse, mental disturbances, emotional instability, and socioeconomic problems. Analizing volence risks, there are inconsistent results concerning the influence of the gender. The evidence indicates that these risks are not related to gender, but to the different distribution of men and women in the occupations. Little work experience and a reduced number of workers are also related to high levels of violence. These elements tend to generate problems in care, resulting in increased dissatisfaction in users, who may in some situations, respond aggressively. According to the author, there is thus an increasing consensus that the role of the characteristics is being over-estimated to the detriment of situational factors in the production of episodes of violence in the workplace.

Models for the understanding of violence in the workplace

Despite the various attempts to identify risk factors for violence in the workplace, Di Martino e al. (2003) point out the difficulties of drawing a clear and comprehensive risk profile. LeBlanc and Kelloway (2002) observe that lists of risk factors for violence in the workplace frequently point out factors related to the characteristics of those involved, aggressors or victims, or focus on the activity or productive sector.

Seeking to overcome the difficulties resulting from the diversity of violence and their multiple determinants, some models propose different levels of causes of violence patterns in the workplace. In its World Report on Violence and Health (KRUG et al., 2002), the WHO argues that violence is the result of a complex interaction of factors, which are individual, relational, social, cultural, and environmental (Figure 1).

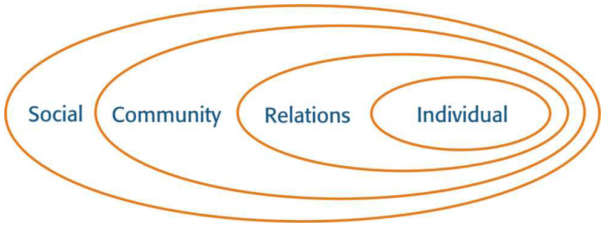

Figure 1 - Ecological model presented by Krug et al. (2002)

Other authors distinguish between different types of violence. Di Martino et al. (2003) organize risk factors into groups concerning each type of violence in the workplace according to the way it is manifested (physical, sexual, psychological violence, etc.). The Washington State Department of Labor and Industries (2000) opts for differentiating risk factors with emphasis on the situation, considering the type of relationship between aggressor and victim – related to crime, involving the user, between work colleagues, and involving a personal relationship.

Beyond identifying vulnerable activities or sectors, the importance of situational factors in producing violence episodes becomes clearer with approaches that focus on interaction. In this line, violence and aggression in the workplace are seen as a possible consequence of interpersonal interactions which, for their turn, are immersed in a broader organizational and social context, influenced by, among others, behavioral norms, customs, task characteristics and, especially, working conditions and organization.

In the case of health sector, where episodes between workers and users are more frequent, the rules and the way the service functions, for example, may generate dissatisfaction, frustration and a feeling of injustice in users. Thus the workers, become vulnerable to aggressive reactions (LEATHER, 2001).

To Bulatao and VandenBos (1996), the occurrence of such an episode is the result of a course of interactions situated within a context. As it is an interaction in a work situation, emphasis is given to its organization. Leather (2001) argues that this is a possible, but not necessary, result. Its occurrence points not only to the various levels of its causes, but also to a failure in the attempt to regulate the interaction, considering the interests and the possibilities of the affected parties.

Curbow's model (2001; Figure 2), focuses on the interaction between the worker and the aggressor. This, for its turn, is represented as connected to multiple determination levels, with emphasis on the organizational level. The model is proposed for the health sector and represents the most frequently the type of interaction related to violence in this context, involving worker or user. However, the author highlights that it can also be applied to events involving colleagues.

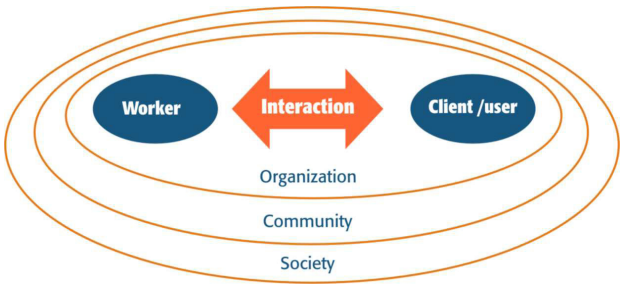

Figure 2 - Conceptual model for violence in the workplace (CURBOW, 2001).

Finally, the model by Minayo and Souza (1997/1998), highlights that no matter how it is approached, violence – with its causes, its manifestations and the possibilities for preventing and controlling it – is a historical and social phenomenon that, while it is almost universally present in the most diverse eras and societies, takes on in each of these characteristics that distinguish it and connect it to that time and place.

The authors propose the category Structural Violence, to which other forms of violence are connected to. The introduction of the Structural Violence category is attributed to the article *Violence and Peace Research* by Johan Galtung (1969) and refers to iniquities perpetuated in social structures that profoundly influence the practices of socialization, leading individuals to accept or inflict suffering according to the role that corresponds to them, in a "naturalized" manner. According to Minayo and Souza (1997/1998):

> *[Structural violence] is understood as that which offers a reference for behavioral violence and applies both to the organized and institutionalized structures of family and to the economic, cultural and political systems that lead to the oppression of groups, classes, nations and individuals to which society's conquests are denied, making them more vulnerable than others to suffering and death.*

Final considerations

This article aims to link the view of violence as a health risk and an object of public health with a focus on human resources in the health sector. Concerning the latter, the objective is to highlight its importance for workers' health and as a factor which threatens the efficiency and efficacy of services and creates obstacles for placing professionals in highly-vulnerable urban areas.

In recent years, violence has become widely recognized as a public health problem (DAHLBERG & KRUG, 2009; MINAYO 2009), occupying a prominent place in the work of international institutions. Worthy of note are UNESCO'S (PAGE, 2001) proposal for the International Year of the Culture of Peace; the work group created by the ILO and the WHO about violence in the health care workplace and discussions conducted at the International Committee of Occupational Health (ICOH).

In Brazil, several initiatives for tackling violence are being developed, based on the National Policy for Reduction of Morbimortality by Accidents and Violence (BRAZIL, 2001) and stimulated, for example, by the UNESCO strategy for building networks on the culture of peace and non-violence (PAGE, 2001). Some works (CONCHA-EASTMAN & MALO, 2009; DESLANDES, 2009; NJAINE et al., 2009; GOMES et al., 2009) are dedicated to describing and analyzing projects such as these.

As for the health care human resources agenda, expressed on an international level in the 2006 World Health Report and on a regional level in the 2007 Pan American Sanitary Conference Report, the question of health care workers' health is emphasized and includes a concern with violence in the workplace.

Campos (2009) argues that violence is especially

relevant to the difficulty of making health care professionals stay in highly-vulnerable urban areas which are frequently marked by tense situations between service users and health care professionals and afflicted with high levels of crime and insecurity. In these cases, where the population's health conditions are more fragile and public policies have a lower reach in general, the loss of professionals and their efficiency has important consequences, both for the work load of the area's professionals and for the health of the local population.

Considering both the causes and the implications of workplace violence in health care services and its probable relationship with violence and vulnerability in communities and social groups, the need to confront workplace violence in the health care sector overlaps with other initiatives already in place on a national and international level. Building this connection should include:

- identifying groups and actors involved in the theme of violence and violence in the workplace;
- disseminating experiences and knowledge about violence in the workplace;
- supporting the production of knowledge and information about the theme of violence in the workplace;
- stimulating the development of new initiatives and including the theme of violence in the workplace in actions for confronting social violence that already exists.

Violence is still a complex and difficult theme. The phenomenon's many forms, the theoretical and methodological limitations to gaining knowledge about it, its territorial variations and, in many cases, its naturalization, all contribute to this difficulty. Thus, the opportunity must be taken to strengthen actions for confronting violence. Strategies supported by projects already underway, using successful network mechanisms and establishing cooperation, as well as encouraging the tackling of violence in the health care workplace should strengthen the capillarity of actions and intensify their effects.

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