Politics of Violence in Healthcare in Times of Peace

Lessons from Protests by Health Professionals

EDITORIAL

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Abstract

Violence against healthcare workers (HCWs) has surged globally, extending beyond conflict zones into areas of relative peace. This editorial examines the epidemic of such violence, which has been exacerbated by recent pandemics. Historical and contemporary instances, such as the 1830s cholera riots, the 2013/14 Ebola outbreak, and recent attacks in Kolkata, highlight how political instability, public mistrust, and socio-economic inequalities fuel aggression against HCWs. A comprehensive analysis reveals that 50-75% of HCWs experience workplace violence, with a significant portion facing sexual abuse. Contributing factors include inadequate security, poor governance, and societal intolerance of HCWs. Possible solutions offer hope, including workplace safety, legal protections, and public awareness of the problem. The editorial calls for a multi-faceted approach involving legislation, better reporting, and global cooperation to address the root causes of violence and improve the safety of HCWs.

Keywords: violence, healthcare professionals

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Background

Attacks on healthcare staff and facilities are common in conflict zones, representing serious violations of human rights. [1] There is extensive conversation around this topic given the number of conflicts raging across the world today. However, this editorial explores violence against HCWs in areas of relative peace. There appears to be a rising epidemic of such violence, especially in the recent pandemic. As a global society, we need to explore the reasons for this problem.

Popular aggression towards healthcare workers (HCWs) during emergencies is not a new phenomenon; it has been observed during previous epidemics in response to restrictive healthcare interventions and forced quarantine. The best-documented cases are the European cholera outbreak of the 1830s and the 2013/14 West African Ebola epidemic. During Europe's first cholera epidemic in the 1830s, riots raged across the continent, destroying entire cities and torching healthcare facilities. Doctors and nurses were required to implement strict government health measures, such as isolating the sick and quarantining people. In 2019 attacks on healthcare coincided with the first-ever Ebola outbreak in an active conflict zone. Many of the attacks on the Ebola response were perpetrated by civilians who intended to disrupt the response, which in turn contributed to the spread of the virus. Why would communities attack the very people trying to protect them from disease? [2]

An analysis of such events reveals that they are not merely precipitated by the 'distrust' of healthcare professionals, perpetrated by miscreants with 'ulterior' motives. The political landscape such as exclusion of affected regions, cancellation of democratic processes i.e. elections, restricting freedom of movement, forcible interventions such as vaccinations, combined with a general mistrust of the privileged political or economic classes, heavy-handed authoritarian regimes, and many such factors may lead to spiralling of violence, often egged on by political groups. Such analyses also demonstrate that healthcare responders have a limited ability to build trust when counter-political dynamics are at work.

The learning that healthcare is not divorced from socio-economic and ethno-cultural dynamics in any population, was seen in the variable response to the most recent pandemic- the fear of vaccinations and the influence of misinformation on social media. Hence, like healthcare provision, which is determined by societal inequalities and established socio-economic or deprivation fractions, so is the epidemic of violence in healthcare. This is often fuelled by socio-political players who may have little or no primary involvement in healthcare provision.

What is more alarming is that not only armed groups or mercenaries, but also 'innocent' civilians can be caught up in mob psyche and become perpetrators. Healthcare professionals are often dragged into the socio-political crossfire.

The brutal rape and murder of a postgraduate trainee doctor in RG Kar Medical College Hospital in Kolkata on 9 August 2024 was perhaps the straw that broke the camel's back. Many in the profession hold that this is not the first time this has occurred, nor the last. Indeed, in 2019, a young doctor suffered a head injury in another Kolkata Medical College when around 200 people attacked the hospital following the death of a patient. (https://www.opindia.com/2019/06/mrs-hospital-junior-doctor-paribaha-mukhopadhyay-released-after-skull-surgery/). In 2012, the rape and murder of a physiotherapy student in Delhi sparked national outrage.[ref] Almost a decade later the national crime statistics show no reduction in

the daily record of violence against women in India. However, India is not an outlier in violence against women across the world.

Why is this incident capturing the imagination not only of HCWs, but people from all walks of life? Even if one were to ignore the claims and counterclaims of institutional corruption, of organised crime, of the ineptitude from those in positions of political power, of unholy nexuses, of coverups and expositions, of the pervasive underbelly of shielded criminals in society - there still remains at the core a blatant act of sexual violence and murder of a medical colleague who had dedicated her life to the service of her people, of her community. That is a symptom of the gross insecurity that HCWs, particularly women, face in a so called civilised society.

This article aims to explore the epidemiology of violence against HCWs, explore the causes and search for meaningful solutions.

Epidemiology

The proportion of WPV exposure differed greatly across countries, study location, practice settings, work schedules and occupation. In systematic reviews, (with n > 300,000), 62% reported exposure to any form of workplace violence, 43% to non-physical violence, and 24% reported experiencing physical violence in the past year. Verbal abuse was the most common form of non-physical violence, followed by threats and sexual harassment. [ref] From meta analysis, the most robust estimates of reported prevalence of WPV from studies across the world, is between 50% and 75%. The highest prevalence of generic WPV was reported in a Chinese meta-analysis performed on 5926 psychiatric ward nurses, which highlighted a 79% prevalence.[REF] Amongst HCWs workplace violence mostly occurs in psychiatric departments, emergency services, polyclinics/waiting rooms, and geriatric units.

Healthcare workers regularly face the risk of violent physical, sexual, and verbal assault from their patients. Major forms of physical violence included beating, throwing things, abusive language, threats, harassment, damage to buildings, furniture, vehicles and equipment. Intolerance and grouse against doctors is a global phenomenon but India seems to lead the world in violence against doctors. According to the World Health Organization, about 8–38% healthcare workers suffer physical violence at some point in their careers. Many more are verbally abused or threatened. Since women account for about 75% of HCWs in most countries, the gender-based violence dimensions are particularly relevant. Furthermore, insufficient data hamper effective prevention, and lack of attention may threaten women, the nursing profession, and migrant/minority groups the most.[ref] A 3-year analysis released in August 2021 by the WHO indicated that more than 700 healthcare workers and patients have died (2,000 injured) as a result of attacks against health facilities since 2017, which is likely a gross underestimate due to under-reporting and lack of appropriate collation.

Factors Contributing to WPV

Violence against HCWs has been described by World Health Organisation as a complex problem “rooted in social, economic, organisational and cultural factors” (International Labour Office [ILO], International Council of Nurses [ICN], World Health Organisation [WHO], Public Services International [PSI] 2002: 9). Factors such as lack of information, insufficient personnel and equipment, and communication breakdowns increase the risk of violent behaviour in healthcare services. Most violence in health institutions is perpetrated by patients and their relatives.[ref] From a healthcare provision simplified perspective studies indicate that opposition against public health

measures (28.5%), fears of infection (22.3%), and supposed lack of care (20.6%) were the most common reasons for attacks. Most attacks occurred in facilities (often related to a supposed lack of care) or while health workers were on duty in a public place (often due to opposition to public health measures). [ref] [ref]

The public appears to be increasingly intolerant to a large number of social issues because of poor governance, influenced in many countries by disruptive political influence or 'vote bank politics'.[1] Often violence during the provision of health care, is an expression of frustration due to unbalanced power relationships between patients and HCWs. This may be worsened by an unequal system based on patients' purchasing power, caste, race or religion.[ref] In South Asian countries, violent incidents against HCWs often involve mobs— groups of persons who organise violence based on community, caste, religion, or political affiliations.[ref] The mob acts at the behest of its "leader," often having no direct relationship with the healthcare transaction of HCW. It is usually premeditated and systematic vandalism, often associated with financial gain through extortion and blackmail.

At an institutional level, contributors to violence include complicated internal processes, a stressful workload, and risks in the physical environment. Cultural contributors include an lack of consequences for low-level patient aggression against healthcare workers and the need for stronger teamwork.[ref] HCWs often shift the responsibility for violence from individuals to societal structures shaping health inequities. [ref] Many HCWs feel that the broader political context, including disparaging news or social media coverage and the myth that the health system is deliberately failing, amplifies their vulnerability to abuse.
HCWs can make it more difficult to tackle workplace violence. Men were more likely to think that violence is normal in their workplace, while those from ethnic minorities are less likely to order perpetrators to stop or to report it when faced with psychological violence.

Sexual Violence Against HCW

Reducing non-partner sexual violence, including rape, sexual assault and other forms of non-contact sexual abuse, is one of the main indicators of the sustainable development goals for the World Health Organisation (WHO). The WHO estimates, based on data from 137 countries between 2000 and 2018, that 6% of women aged 15–49 years reported experiencing sexual violence in their lifetime from someone other than an intimate partner. [ref] Nearly one out of every three (29%) women around the world has been a victim of sexual violence [ref] with 14% for attempted rape, 8% for rape, and 33% for sexual harassment. Women and girls are much more likely to be the victims and men the perpetrators and, in most instances, the perpetrator is known to the victim. HCWs who are deployed in geographically remote locations, and in the community are at higher risk.[ref] Nurses are three times more likely to be exposed to sexual violence than any other medical personnel.[ref]

What was particularly concerning in the RG Kar Hospital case from August 2024, was that the doctor appeared to have been assaulted in her own place of work, which had its usual degree of activity, and by someone who appeared to have had access to the facilities, as

[1] Group of electors who vote *en masse* for a particular party or candidate. The term is often used in South Asian politics, where a feudal and caste-based social structure is seen to constrain individual choice when voting. Evidence suggests that vote banks are more a product of crude generalisation amongst political commentators than an accurate description of voting behaviour.

a civic volunteer. This suggests that security, rest places for those on night shifts, and systems for vetting may have been grossly inadequate.

In the UK, most hospitals have reduced or eliminated facilities for rest for doctors on night shifts. Returning home from hospitals at night is also a risk for HCWs. Data from the UK Women's Network showed that more than 6500 sexual assaults - some against children under 13 - have been committed in hospitals in England and Wales over nearly four years during the COVID-19 pandemic. Only 265 people (4.1 per cent) have been charged for these offences. At least 2088 rapes and 4451 sexual assaults (total: 6539) in hospitals were recorded by police forces in the UK since January 2019. One in 7 of the crimes - or 266 a year - occurred on hospital wards. [REF] UK NHS trusts recorded more than 35 000 cases of rape, sexual assault, harassment, stalking, and abusive remarks between 2017 and 2022, but only one in 10 trusts appeared to have a dedicated policy to manage the problem.[ref] Most incidents (58%) involved patients abusing staff, with patients abusing other patients the next most common type of incident (20%). Analysis by the Care Quality Commission found that of nearly 60,000 reports, at least 1,120 were of sexual incidents. It also found that more than a third of the incidents (457) were directed at patients or staff. [ref]

Solutions

Good working conditions and support for the physical and mental wellbeing of HCWs are an obligation for both employers and governments. Governments must develop policies to tackle the individual and systemic risk factors HCWs face. HCWs often suggest policies such as increased staffing, enhanced security such as personal alarms and body cameras, building design changes, simplified reporting, using the criminal justice system, and better training.

The barriers that need to be eliminated include the normalisation of violence; underreporting; lack of respect from patients, visitors, higher status professionals, and supervisors; poor communication; and the threat of reprisal for speaking publicly. Inadequate post-incident psychological and financial support compound their distress.[ref] Trivialization was also positively associated with witnessing violent acts, not with being a direct victim of workplace violence.[ref]

In the late 1990s the UK government introduced a policy of 'zero tolerance' to minimise such violence. [ref] In July 2022 NHS England established a Domestic Abuse and Sexual Violence (DASV) Programme to increase safeguarding processes for protecting patients, improve victim support, and focus on early intervention and prevention. [ref] The measures include data collection and reporting systems, dedicated leadership and investment in training and support.

Often the violence recorded in healthcare facilities is a manifestation of societal risks and may need a wider response. An example of this is the *'Cure Violence'* (CV) scheme to reduce sexual violence, which was launched in 2000 and now operates in 23 US cities and many countries. [ref] Laws to prevent violence against doctors do exist but they need to be made firmer and implemented properly.[ref] Institutions, healthcare policymakers, media organisations, and law enforcement agencies must work together to improve public awareness. False reporting of unverified data such as during the RG Kar incident only drives mob frenzy and may prevent the robust investigation of such incidents. Media coverage of violence can be overwhelmingly negative and reductionist, and this needs to be stopped. [ref]

At a national level we need legislation to provide speedy justice. In Algeria, the penal code was amended to increase protection for healthcare workers against attacks. In the United Kingdom, the police, crime, sentencing, and courts bill proposed to increase the maximum penalty from 12 months to 2 years in prison for anyone who assaults an emergency worker. India amended its emergency epidemic law to make attacks on healthcare workers punishable by up to 7 years in prison while Sudan created a dedicated police force to protect healthcare workers during the pandemic.[ref]

Conclusions

The well-being of health workers is seriously disrupted by workplace violence. This not only weakens doctor-patient relationships, but also feeds a general environment of insecurity.[ref] The 'Framework guidelines for addressing workplace violence in the health sector', was recently developed by WHO, International Labour Organization, International Council of Nurses and Public Services International to develop policies to document and prevent such violence.[ref] It recommends that we:

- Prepare HCWs. Integrate violence prevention in education and training, e.g. training in self-protection against violent attacks; coping strategies for mental health; communication strategies to de-escalate violence; multi-professional training models to improve teamwork—*micro-level, actor-centred*.
- Protect HCWs. Improve the scope and enforcement of existing laws and define violence prevention as a goal for management; implement zero tolerance guidelines; establish information, helplines and mental health support—*organisation level*.
- Establish reporting systems, improve research evidence—*health policy level*.
- Engage the media, police and public. Launch a coordinated campaign to raise awareness—*local public policy level*.
- Encourage international public health organisations to respond with coordinated action—*global/EU public health policy level*.
- Take action against violence on HCWs on all levels of governance, including its gender-based and racialized forms.

However, as WHO observes, the interventions prioritise physical over mental security and more research is needed to evaluate the effectiveness of such measures in lower- and middle-income countries. (https://www.who.int/activities/preventing-violence-against-health-workers)

The central issue of how such violence is driven by socio-political factors remains a challenge to address. Social research is needed to delve into the labyrinth of events leading to the final eruption of violence. However, the immediate physical security of healthcare professionals is starting point for change.