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THE SMOKLER CENTER FOR HEALTH POLICY RESEARCH

Violence against Staff at Primary Health Clinics in the Community and Comparison with Specialist Clinics

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The study was commissioned and funded by Clalit,
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Clalit Physicians and the Organization of Clalit Employees

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Executive Summary

Background

Incidents of violent behavior of patients and their escorts against medical staff are recognized to be among the most challenging problems currently facing hospitals and clinics in the community. The problem is becoming more severe with the increase of violence throughout Western society as a whole, and specifically in Israel. In health organizations, the risk of violence in the workplace is among the highest in any professional field.

In Israel, apart from two studies focusing on violence against medical staff in emergency rooms, there has been little research into violence in the health system as a whole or, specifically, in clinics in the community. Following a wave of violence in the health system in 2008, which culminated in the stabbing of hospital surgeon Dr. Guy Marius by one of his patients, an amendment to the penal law (initiated by the Israel Medical Association [IMA]) was passed in February 2010. The amendment stipulated that a person who assaults an "emergency worker" (i.e., physician, nurse, midwife, etc.) when the latter is treating a patient who is at risk or in an emergency room may be sentenced to five years imprisonment (Penal Law [Amendment 105] 5770-2010 clause 2229, February 16, 2010, p. 385). This amendment does not apply in the case of violence against workers in the public sector who are not emergency workers, e.g., medical staff at clinics. The sentence for assaulting a non-emergency worker is up to three years.[1]

At meetings of the national committee appointed by the Ministry of Health to examine ways of coping with violence in the health system, security officials at the Ministry of Health presented data on violent incidents in 2008. The data revealed that violence occurred in all the health plans and in other community health settings such as district health offices and ambulances. Participants at the meetings emphasized that there was a lack of information about the extent and characteristics of the violence and that this was vital for formulating informed policy to deal with the issue. Subsequently, in 2009, Clalit, the Israel Medical Association, the Organization of Clalit Physicians and the Organization of Clalit Employees commissioned the Myers-JDC-Brookdale Institute to conduct a comprehensive survey of violence against medical staff (physicians, nurses, pharmacists and administrative staff) at Clalit community clinics.

Concurrently, for the past two years, Clalit and the IMA have been endeavoring to prevent and contend with violence against medical staff at the managerial level and in the field. For example, Clalit's efforts to cope with violence have included the development of workshops to equip staff members with knowledge, skills and patient-caregiver communication tools, security budgets have been increased, and some 200 security guards working in healthcare settings have been granted powers by the Israel police to search and detain people. In addition, the IMA has proposed 3 legislative bills regarding violence against staff, there have been advances in

[1] Nevertheless, the sentence may be increased to five years in the following circumstances: 1. The assailant intended to prevent the worker from doing his job; 2. The assailant was armed. 3. The assault was carried out by more than two people.

cooperative efforts between the Ministry of Health and the Israel Police, press releases have been issued, protest meetings have been held, and steps have been taken to encourage staff members to report all violent incidents.

This report presents the findings of a survey conducted among staff at primary care and specialist clinics of Clalit on the subject of violence they have witnessed and violence perpetrated against them by patients and their escorts – verbal violence, spatial/physical violence (physical violence and refusal to leave the room) and violence against property in primary care or specialist clinics. The report presents the findings from primary care clinics and compares them with the findings from the specialist clinics.

Study Goals

1. To examine the extent and nature of violence against members of staff at Clalit community clinics
2. To identify risk factors for violence
3 To examine the way in which caregivers and the system in which they work strive to prevent violence and the way that they cope with violent incidents
4. To examine how exposure to violence affects the wellbeing of the staff members themselves and the treatment that they provide
5. To identify directions for preventing violence and coping with it more effectively.

Study Method

The study population included all staff members (physicians, nurses, pharmacists and administrative staff) working over 12 hours a week in large urban clinics belonging to Clalit. The clinics were sampled from a list of all Clalit clinics in order to obtain a regionally representative sample.

The survey included primary care and specialist clinics in 8 out of Clalit's 9 districts, for which a stratified sampling was conducted by district; in each district, a simple random sample was conducted and 6 or 7 clinics were sampled.

From the 159 primary care clinics employing at least four physicians, 51 clinics were sampled. Among the specialist clinics, 15 of the 91 medium and large clinics (500–2,000 appointments per month and over 2,000 appointments per month, respectively) were sampled.

In the primary care clinics, an interviewer from the research team attended a staff meeting at each clinic and handed out a closed self-report questionnaire to all staff members. Questionnaires with stamped addressed envelopes were left for those who were absent. In these clinics, a total of 738 questionnaires were completed. The response rate was 86%. In the specialist clinics, the director of the clinic handed out the questionnaires for the staff to complete. He was also in charge of

collecting them (in sealed envelopes) and returning them to the research team office. A total of 855 questionnaires were completed. The response rate was 77%.

The findings were weighted by sampling probability and analyzed using the SPSS program for complex sampling, which takes into account the dependence between incidents at the same clinic. The differences between primary care clinics and specialist clinics are presented only when statistically significant ($p<0.05$) unless noted otherwise.

Findings

The findings indicate extensive reports of violence by staff members. In most cases, the assailant was the patient him/herself.

Frequency of Violence

- 75% of the staff members reported that they had experienced verbal violence (including shouts, curses and threats) at least once in the previous year and 40% reported such violence at least three times in the previous year.
- We defined physical/spatial violence broadly, to include throwing objects at the caregiver and refusal to leave the room. Using this definition, 36% of the respondents reported physical/spatial violence at least once in the previous year (and 10% of these reported such violence at least three times in the previous year).
- Approximately 85% of the staff members reported they had witnessed some form of violence in the previous year. This is known as "secondary violence" and according to the literature, it too has considerable implications for the wellbeing of staff members and the quality of care they provide.

Perception of the Severity of Different Types of Violence

We examined two aspects of severity of types of violence: 1) The way that staff members perceived the severity of hypothetical violent incidents; and 2) The way they perceived events that they had actually experienced.

Perception of the Severity of Violent Incidents

- The staff members were asked to grade on a scale of 1–5 ("not at all severe" to "very severe indeed") the degree of severity of various hypothetical violent incidents. The highest percentage of reports for an incident graded "very severe indeed" was for "the patient hits or shoves a staff member" (89%). Incidents graded as severe by a lower percentage of respondents were: "the patient threatens to complain about a staff member" (25%), "refuses to leave the room" (37%), and "bursts in or slams the door" (39%).
- However, when we combined the categories "very severe" with "very severe indeed," we found that over 75% of the staff members included all the incidents that were presented to them in these categories, with the exception of "threatens to complain about a staff member" (66%).

Most Severe Incident of Violence in the Previous Year

- The most prevalent types of incidents reported by staff members as the most severe in the year prior to completion of the questionnaires were: Experiencing verbal violence (48%), witnessing verbal violence (43%) and experiencing a patient's refusal to leave the room (23%). Only 6% reported physical assault.
- In two-thirds of the cases, the staff members (excluding those who had witnessed violence) reported that in the most severe case of violence they had experienced in the previous year, the assailant was the patient him/herself. Similarly, in two-thirds of the incidents, the assailant was a man. They also reported that, in their estimation, about half of the assailants were over age 46.

Fear of Violence among Staff Members

- About a quarter of the staff members reported that there was a high risk of being a victim of violence at their clinic.
- On a personal level, about a third of the staff members feared that their patients would use verbal violence against them and about a quarter were afraid of physical or spatial violence (as noted, hitting, throwing objects at the caregiver and refusing to leave the room).

Risk Factors for Exposure to Violence

- All types of employees were found to be exposed to violence.
- At the same time, the rate of exposure to violence was highest among staff members who worked over 20 hours a week and those who had less than 26 years of work experience. Staff members in managerial positions were at greater risk of physical/spatial violence. Several additional personal and professional characteristics were also associated with elevated risk.
- Greater risk of exposure to violence was found in certain districts.
- The two main factors noted by staff members as contributing to violence among patients were "overload of work at the clinic" and "the health plan directives on referrals and refunds."
- Other factors that scored relatively highly were: "attitudes of the staff to patients," "communication with the patient," "staff availability" and "waiting times at the clinic."

Response of the Victim during and after the Violent Incident

We asked the staff members how they responded during and after a violent incident.

- The most common reaction during the incident was to "try to calm down the assailant" (57%). Fourteen percent reported that they called the police while the incident was taking place.
- 40% reported that after the incident they "did nothing." Eleven percent off the incidents were reported to the police after they occurred.
- In the case of physical/spatial violence, about a third of the cases were reported to the police.

- 13% of the respondents who had experienced physical/spatial violence had thought about leaving their jobs at the clinic as a result of the incident.

Victim's Need for Counseling or Medical Care

- About 14% of the staff members who had experienced any form of violence reported that they had needed professional counseling or medical care following the incident, but only a third of them had actually received the treatment and/or counseling they needed.

Ability of the Staff Members to Cope with Violence

- Staff members believed that violence could have been prevented in about 30% of the cases.
- About 30% of the staff members graded their ability to calm down an angry or tense patient as moderate, or less than moderate
- About half of the staff members reported that they had no tools (even to a small extent) to cope with physical/spatial violence or damage to property.

Steps Taken to Prevent Violence

- Many staff members (75%) reported that they had participated in in-service training provided by Clalit dealing with communication with patients or coping with violence.
- About 40% of those who had participated in a training program reported that it had helped them to a great or very great extent.
- About 60% of all the respondents reported that in-service training of this kind was essential to a great or very great extent.
- About half of the respondents noted that the district management did "little" or "nothing at all" to prevent violence.
- Accordingly, about half of the staff members noted that Clalit could do more to help them cope with violent incidents.
- Staff members singled out the need for security measures such as a security guard, emergency button and closed-circuit TV cameras (CCTV).
- About half of the respondents reported that there were currently no such measures at their clinics.
- About a third of the staff members were not conversant with the reporting procedures at Clalit in the event of violence.
- A high percentage of staff members supported the introduction of rules and procedures at Clalit that would prevent assailants from receiving medical care at the setting in which the attack took place for a specified duration (e.g., 3 months).

The Effect of Exposure to Violence on Staff Members

We examined the impact of violence on staff members who had experienced or witnessed violence in two ways – directly and indirectly. In the first case, we asked them how the violence had affected their attitude to patients and the quality of their lives. In the second, we examined a

number of variables related to wellbeing that were liable to be affected by exposure to violence: burnout, job satisfaction, quality of care, mental distress and post-traumatic stress disorder.

The Effect of Exposure to Violence on Perceived Quality of Life and on Attitudes to Patients

- About 20% of the staff members who had experienced violence in the previous year reported that it had affected their personal lives and their quality of life adversely to a great or very great extent.
- 40% of the staff members reported that since the violent incident, they had feared more for their safety, were more vigilant and were quicker to call security.
- Experiencing a violent incident also affects the attitude of staff members towards their patients. Among those who had experienced violence in the previous year, 30% reported that since the incident, they tried harder to respond to the demands of their patients and 40% reported that they listened to them more patiently.

The Correlation between Exposure to Violence and Variables Relating to the Wellbeing of Staff Members

- In a multivariate analysis, a strong correlation was found between the extent of exposure to violence and a relatively high level of burnout at work and low job satisfaction.
- No correlation was found in a multivariate analysis between the extent of exposure to violence and reports of mental distress.
- In screening questions to assess the need for PTSD diagnosis, 30% of the staff members reported symptoms that required further investigation.
- A multivariate analysis revealed no correlation between a staff member being exposed to violence and his/her perception of low quality of care at the clinic.

Comparison of Findings from Specialist Clinics and Primary Care Clinics

The survey reveals that the findings from the specialist clinics were in most cases similar to those found at primary care clinics. The following are some of the differences:

At the specialist clinics, as opposed to the primary care clinics:

- Fewer instances of verbal violence, physical/special violence and damage to property were reported.
- More respondents noted factors that had to do with interpersonal and professional aspects of care ("communication with the patient" and "attitudes of the staff to patients") contributed to violence and noted "physical conditions at the clinic" among the administrative factors contributing to violence.
- There were fewer reports of a sense of high "self-efficacy" to prevent violent incidents and coping with violence.
- There were fewer reports of contacting the police both during and after incidents.

- The staff members perceived violence to be lower on the agenda at Clalit than did those at primary care clinics.
- There were fewer reports of burnout at work and greater satisfaction at the workplace was reported.
- More staff members noted that they had "not changed their attitude to patients" after experiencing violence.
- Fewer reported that they considered the quality of care to be "very good."

In order to assess the independent effect of the type of clinic (primary care or specialist) on several key variables, we conducted a multivariate analysis controlling for differences in the background characteristics of staff members. The following variables were found to be associated with work in primary care clinics: Damage to property; self-efficacy to prevent and deal with violence; burnout; and some of the items relating to the perceived quality of care at the clinic.

Exposure to Violence among Staff in Various Professions

We compared the prevalence of violence (exposure to different forms of violence, fear of violence, self-efficacy to prevent and deal with violence, etc.) among the various types of professionals: physicians, nurses, pharmacists, social workers and others (chiefly administrative staff).

- No significant differences were found between the professions with regard to experiencing verbal violence. However, there were fewer reports from nurses than from other professionals about experiencing violence of this kind 3 or more times.
- At the primary care clinics, physicians experienced physical/spatial violence more frequently than the other professionals (physicians 44%, vs. nurses 33%, pharmacists and social workers 37%, and secretaries and administrative workers 28%).
- At the specialist clinics, no significant differences were found among the various professions.
- The pharmacists tend to fear verbal violence more than other professionals do and to feel medium to low self-efficacy to calm down an angry or tense patient.

The Correlation between Various Aspects of Violence and the Socioeconomic Level of the Locality in which the Clinic is Situated

The clinics were classified in 3 socioeconomic groups based on the ranking given by the Central Bureau of Statistics to the locality in which they are situated.

- No significant differences were found between the groups for the various aspects of violence.

Policy Implications and Directions for Action

The study brought to light several directions for action that could increase the effectiveness of endeavors at Clalit to prevent violence and cope with its implications. These include:

- Re-examination of the procedures in place at clinics regarding situations reported by the staff that contribute to violent behavior by patients (e.g., patients wanting to be seen without an appointment, patient requests for a referral or refund, waiting times, etc.), in order to reduce the incidence of confrontation between staff and patients
- Re-examination of the content of in-service training to impart knowledge and skills and increase self-efficacy to prevent and cope with violent incidents, with greater emphasis on the latter. About a third of the staff members reported moderate or less-than-moderate ability to calm down angry or tense patients. Furthermore, staff members who had participated in in-service training on communication with patients or coping with violence reported higher self-efficacy to prevent violence, but not to actually cope with violent incidents.
- When referring staff members to workshops and in-service training, thought could be given to prioritizing those at elevated risk from violence: those in managerial positions, full-time employees, those with less work experience and those working in districts with the highest rates of violence.

In light of the extensive violence found in this study, it is important to continue studying the matter, the reasons for it and the implications for other health services, such as other health plans, Magen David Adom and district health offices.

It is important to remember that this study examined the viewpoint of the staff. Violent incidents occur in the context of interaction between staff members and patients and it is therefore important to examine the patients' perspective of the factors that lead to violence in order to plan effective responses.

Following the initiative of Clalit to conduct a survey among its staff, the research team has been asked by other agencies in the community to conduct similar surveys and we hope that over time we will be able to build a comprehensive and reliable violence database. It is important, too, to monitor the success of preventive programs being implemented at Clalit and to conduct follow-up surveys over time.

In addition, it is important for future research to examine the connection between violence and costs (unnecessary tests, etc.) and between violence and medical quality measures, in order to assess the "cost of violence" in other areas not examined in this study. A comprehensive assessment of the costs of violence could well constitute an additional incentive for system-wide efforts to address the problem.

Finally, given the efforts already being made by Clalit to address the problem of violence, it will be important to re-examine the scope and nature of the problem in a few years.

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