Does workplace Physical and Psychological violence exist against physicians and nurses in Primary Health Care Centers in Kuwait? A cross-sectional study

Huda Al-Ghareeb (1)
Rehab Al-Wotayan (2)

(1) Consultant Family Physician, Working in Technical affairs department in MOH, Kuwait
(2) Consultant Family Physician, Director of International relations, MOH, Kuwait

Corresponding author:
Dr. Huda Al-Ghareeb
Kuwait
Email: alghareeb.huda@gmail.com

Received: March 2021; Accepted: April 2021; Published: May 1, 2021.
Citation: Huda Al-Ghareeb, Rehab Al-Wotayan. Does workplace Physical and Psychological violence exist against physicians and nurses in Primary Health Care Centers in Kuwait? A cross-sectional study. World Family Medicine. 2021; 19(5): 13-27 DOI: 10.5742/MEWFM.2021.94043

Abstract

Background: Workplace violence by definition is a violent act (including physical assault and threats of assault) directed toward persons at work . Workplace violence in the health care sector may lead to poor quality of care, turnover and absenteeism of healthcare professionals, reducing health services available to the general public, unhealthy work environment, improper societal behaviors, increasing health costs, and deterioration of staff's health.

Material and Methods: A retrospective cross-sectional study was conducted in Kuwait in one year (January 2020 to January 2021) in 50 PHC centers in five health regions in Kuwait and surveyed 446 participants (220 physicians, 226 nurses) who have been working in PHC centers for at least a year and have regular contact with patients or clients by using a designed WHO self-administered questionnaire. The frequency and consequences of physical and psychological violence among physicians and nurses in PHC centers were investigated.

Results: The response rate for all staff was 89%. The highest respondent rate was from nurses (90%) and the lowest respondent rate was from physicians (88%). A total of 6.4% of the respondents had experienced physical violence and 77.3% had experienced psychological violence divided into 48.8% verbal Abuse, 10.1% bullying/Mobbing, 1.9% sexual harassment and 20.3% racial harassment.

Conclusions: The presented results showed that violence towards health care professionals (physicians and nurses) occurs frequently and exists against physicians and nurses in Primary Health Care Centers in Kuwait. Health care workers should feel secure and confident in their working environment by reducing the prevalence of violence and increasing job satisfaction by understanding the causes and factors that influence the increasing levels of violence. More research is needed on occupational support provisions that reduce the risk of staff experiencing physical and psychological violence and the stress that is associated with it.

Key words: violence, primary health care centers, physical, psychological.

Background

Workplace violence is a concept with ambiguous boundaries: "Violent acts (including physical assaults and threats of assault) directed toward persons at work or on duty". In another definition, workplace violence includes physical and psychological violence, abuse, mobbing or bullying, racial harassment and sexual harassment and can include interactions between co-workers, supervisors, patients, families, visitors, and others [1].

The World Health Organization (WHO) defined violence as: "The intentional use of power, threatened or actual, against another person or against oneself or a group of people that results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation [2,3,5,9,11].

Recognizing and addressing the interconnections among the different forms of violence will help us better prevent all forms of violence [4].

Health care violence is a significant worldwide problem with negative consequences on both the safety and well-being of health care workers as well as workplace activities. Patients and their relatives may behave aggressively or violently either due to their medical conditions, side effects of their medications, or dissatisfaction with the services provided by the health care facilities. There are many factors that increase the risk of workplace violence against health care workers. Those factors are either related to offenders, coworkers, or the workplace environment [5].

The CDC defines workplace violence as violent acts (including physical assault and threats of assault) directed toward persons at work or on duty [6].

Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored [7]. Violence is not only an occupational health issue but also may have significant implications for the quality of care provided [8].

Violence is an emerging problem in the PHC setting, and there is informal commitment to reveal its magnitude and circumstance [9]. Health workers have a 3 to 4-fold increased risk of experiencing violence at work [10].

The prevalence of workplace violence in healthcare settings remains unacceptably high. Workers in health care settings are at higher risk of verbal and physical abuse than any other occupational group. Workplace violence in the health care sector may lead to poor quality of care, turnover and absenteeism of healthcare professionals, reducing health services available to the general public, unhealthy work environment, improper societal behaviors, increasing health costs and deterioration of staff health [11].

High costs are involved in violence in healthcare settings. Individually, violence leads to decreasing well-being and job satisfaction among healthcare workers [12].

Method

Study design, setting, and duration:
This descriptive cross-sectional study was conducted over a period of one year (January 2020 to January 2021) in 50 PHC Centers in five health regions in Kuwait for physicians and nurses who had worked in PHC centers for at least a year, by using a designed WHO self-administered questionnaire. The researcher was responsible for the distribution and explanation of the objectives of the study to the PHC workers.

The infrastructure data regarding number of staff, number of health centers and number of working hours were taken from the health statistic section in primary care central department of the Ministry of Health (MOH).

Sample:
Questionnaires were distributed to 50 PHC centers in the five Governmental health regions to all full time PHC centers' physicians and nurses. The respondents were those who completed more than 50% of the items of the questionnaire and the selected 50 PHC centers were representative of 106 PHC centers in Kuwait.

Inclusion and exclusion criteria:
The inclusion criteria were all physicians and nurses at the PHCs who were available at the time of the study and willing to participate for 1 year. The exclusion criteria included those who were working in PHC for less than 1 year and those who decided not to participate in the research.

Data collection Tool:
Following permission from the MOH in Kuwait to conduct the study with ethical approval the questionnaire was sent to the PHC centers through the principal investigator.

Data collection was conducted using a validated version of the WHO English Questionnaire that consisted of two parts:
Part one included the personal and workplace data of the participants regarding age, gender, marital status, nationality, education, occupation, profession, years of work experience, time of work, work shift, interaction with patients/clients during work, the patients/clients they most frequently work with and their sex, the number of staff present in the same work setting, worry about violence in the current workplace, procedures for reporting of violence in the workplace and if there is any encouragement to report workplace violence and name of health districts.
Part two included the Physical workplace violence questionnaire which included three questions (exposure to violence whatever its type, incident witness and incident reporting) during the past year.

Participants were requested to complete the questionnaire during their free time and to return it to the head of clinic within 2 weeks of receiving it. Each participant was given a code number instead of their names and the privacy of their information given was secured.

Data analysis:
The collected data was reviewed, coded, verified and statistically analyzed by using statistical package for social sciences (SPSS) version 20. Descriptive statistics for all studied variables and chi-square test were used and P-value level of <0.05 was considered significant throughout the study.

Results

Respondents' characteristics:
Only 446 of the 500 physicians and nurses answered the questionnaire and returned it completed after distribution to 50 PHC centers in five health regions in Kuwait.

The highest percentage of staff response rate per health region was from Farwaniya (94%) and the lowest from Capital area (84%) as shown in Table 1.

Table 1: Staff response rate /health region

Health Area	No of participating centers /health region	No of respondents staff /health region
Capital	10	84
Farwaniya	10	94
Hawali	10	93
Ahmadi	10	85
Jahra	10	90

A total of 90% of nurses responded and 88% of physicians responded, as shown in Table 2.

Table 2: Staff position respondent rate:

Work type	Number of respondents	Total number	Response rate (%)
Physician	220	250	88%
Nurse	226	250	90%
Total	446	500	89%

Participants ranged in age from 25 to above 60 with a mean age of 4.81(SD=1.74%); (24.7%) were females and (75.3%) were males with a mean 1.25 (SD=0.43). (81.8%) were non-Kuwaiti and (17.9%) were Kuwaiti with a mean 1.82 (SD=0.38%). The majority of them were married (89.9%) and the rest were single, separated or widowed (9.6%). Regarding the work experience in Kuwait for the participants (0.7%) had worked under 1 year, (9.4%) worked for 1-5 years, (22.9%) worked for 6-10 years, (33.6%) worked for 11-15 years, (13.9%) worked for 16-20 years and (19.1%) worked for over 20 years. 92.2% of participants worked full time 4.3% worked part time and 0.2% were temporary. A total of 90.4% of the participants worked in shifts in which 76% of them worked between 6 pm and 7am. They interacted with 97.5% of patients in which 25.1% were newborn, 41.3% infant, 36.5% children, 62.1% adolescents, 92.8% adults and 69.7% elderly. The most frequent patients that the participants worked with were females and males in (66.6%), females in (21.5%) and males in (32%). The number of staff who were present in the same working setting with the participants in more than 50% of the work time were none in (6.7%), 1-5 staff in (47.3%), 6-10 staff in (17.9%), 11-15 staff in (11.2%), and over 15 staff in (9.2%). The participants were not worried at all about violence in the current workplace in (15.5%), not worried in (30.3%), neutral in (29.6%), worried in (12.8%) and very worried in (8.7%). The presence of procedure of reporting of violence in the workplace reached (63.5%) in which (49.8%) of participants knew how to use them. 55.8% of participants encouraged reporting workplace violence by manager/employer in (50%), colleagues in (5.6%), own family/friend in (0.4%) and others in (1.3%) as shown in Table 3.

Table 3: personal and workplace characteristics data of the studied participants

Socio-demographic characteristics	Frequency (%)	Mean	SD	P-value
Age in years:				
25-29	19 (4.3%)	4.81%	1.74%	0.00
30-34	67 (15%)			
35-39	159 (35.7%)			
40-44	84(18.8%)			
45-49	44 (9.9%)			
50-54	25(5.6%)			
55-59	20(4.5%)			
60+	28(6.3%)			
Total	446(100%)			
Gender:				
Female	110 (24.7%)	1.25%	0.43%	0.00
Male	336(75.3%)			
Total	446(100%)			
Marital status:				
Single	24(5.4%)	2%	0.37%	0.63
Married	401(89.9%)			
Separated/divorced	13(2.9%)			
Widow/widower	6(1.3%)			
Total	444(99.6%)			
Nationality:				
Kuwaiti	80(17.9%)	1.82%	0.38%	0.94
Non-Kuwaiti	365(81.8%)			
Total	446(100%)			
Professional group:				
Physician	220 (49.3%)	1.51%	0.50%	0.18
Nurse	226(50.7%)			
Total	446(100%)			
Work experience:				
Under1 year	3(0.7%)	4.08%	1.25%	0.00
1-5 y	42(9.4%)			
6-10 y	102(22.9%)			
11-15 Y	150(33.6%)			
16-20Y	62(13.9%)			
Over20 Y	85(19.1%)			
Total	444(99.6%)			
Working time:				
Full time	411(95.4%)	1.05%	0.22%	0.98
Part time	19(4.4%)			
Temporary/casual	1(0.2%)			
Total	431(100%)			

Table 3: personal and workplace characteristics data of the studied participants (continued)

Working shift:				
Yes	403(92.4%)	0.92%	0.26%	0.43
No	33(7.6%)			
Total	436 (100%)			
Working time between 6 pm and 7 am:				
Yes	346(77.6%)	0.79%	0.40%	0.61
No	90(20.2%)			
Total	436(100%)			
Patient/Client interaction:				
Yes	425 (97.5%)	0.97%	0.15%	0.28
No	11(2.5%)			
Total	436(100%)			
Most frequent patients/client:				
Newborn	112(25.6%)	0.26%	0.43%	0.50
Infants	183(41.8%)	0.42%	0.49%	0.49
Children	275(62.8%)	0.62%	0.48%	0.53
Adolescents	272(62.1%)	0.62%	0.48%	0.40
Adults	414(94.5%)	0.94%	0.22%	0.77
Elderly	311(71.2%)	0.71%	0.45%	0.02
Total	446(100%)			
Patient sex:				
Female	94(21.5%)	2.4%	0.82%	0.90
Male	46(10.5%)			
Male and Female	297(68%)			
Total	437(100%)			
The number of staff in the same workplace:				
None	30(7.3%)	1.66%	1.10%	0.49
1-5	211(51.2%)			
6-10	80(19.4%)			
11-15	50(12.1%)			
Over15	41(10%)			
Total	412(100%)			
Current workplace violence worry:				
Not worried at all	69(16%)	2.68%	1.16%	0.65
Not worried	135(31.3%)			
Neutral	132(30.6%)			
Worry	57(13.2%)			
Very worried	39(9.0%)			
Total	432(100%)			
Workplace violence procedure reporting:				
Yes	283(66.6%)	0.66%	0.47%	0.99
No	142(33.4%)			
Total	425(100%)			
Reporting use:				
Yes	222(84.1%)	0.84%	0.36%	0.57
No	42(15.9%)			
Total	264(100%)			

Table 3: personal and workplace characteristics data of the studied participants (continued)

Reporting use:				
Yes	222(84.1%)	0.84%	0.36%	0.57
No	42(15.9%)			
Total	264(100%)			
Reporting encouragement:				
Yes	249(67.7%)	0.68%	0.46%	0.74
No	119(32.3%)			
Total	368(100%)			
Whom report:				
Manager/employer	223 (50%)	1.25%	0.86%	0.84
Colleague	25 (5.6%)			
Union	-			
Association	-			
Own family/friend	2 (0.4%)			
Other	6 (1.3%)			
Total	256 (57.4%)			
Health district:				
Capital	84(18.8%)	3.01%	1.40%	0.00
Farwaniya	94(21.1%)			
Hawaly	93(20.9%)			
Ahmadi	85(19.1%)			
Jahra	90(20.2%)			
Total	446(100%)			

*Non- physical violence includes Verbal abuse, Bullying, Racial harassment, sexual harassment

The descriptive association between respondents' characteristics and exposure to physical and nonphysical violence in the past 12 months indicated that there was no significant differences in relation to reported physical and non-physical violence by age, gender, marital status, work experience, work time and work time between 6 am and 7 pm ($p > 0.05$). However, the respondents reported a significantly higher percentage of physical violence incident regarding nationality ($p = 0.04$). The respondents reported a significantly higher percentage of non- physical violence incidents regarding profession group ($p = 0.04$). The respondents reported a significantly higher percentage of non-physical violence incident regarding profession group ($p = 0.04$). The respondents reported a significantly higher percentage of physical violence incidents regarding work shift ($p = 0.03$) as shown in Table 4.

Table 4: Characteristics of exposure to physical and non-physical violence in the last 12 months

	Physical violence			Non- physical violence*		
	N	%	P-VALUE	N	%	P-VALUE
Age						
25-29	1	0.2%	0.50	16	3.6%	0.43
30-34	7	1.6%		48	11.1%	
35-39	8	0.8%		139	32.4%	
40-44	5	1.1%		56	13%	
45-49	3	0.6%		37	15.6%	
50-54	3	0.6%		17	3.9%	
55-59	1	0.2%		13	2.9%	
60*	0	0%		19	4.3%	
Gender						
Male	19	4.3%	0.80	263	28.9%	0.40
Female	9	2%		82	19.1%	
Marital status:						
Single	2	0.4%	0.89	6	4.3%	0.53
Married	25	5.7%		151	73.4%	
Separated/divorced	1	0.2%		3	1.3%	
Widow/widower	0	0%		4	1.8%	
Nationality:						
Kuwaiti	9	2%	0.04	80	27.5%	0.19
Non-Kuwaiti	19	4.3%		275	64.5%	
Professional group:						
Physician	18	4.1%	0.12	236	55.4%	0.04
Nurse	10	2.2%		109	25.4%	
Work experience:						
Under1 year	0	0%	0.93	3	0.7%	0.642
1-5 years	2	0.4%		28	6.4%	
6-10 years	5	1.1%		80	18.7%	
11-15 years	11	2.5%		122	28.6%	
16-20 years	5	1.1%		44	10.2%	
20+	5	1.1%		68	15.8%	
Work time:						
Full time	2	6.4%	0.48	152	76.6%	0.61
Part time	0	0%		6	4.2%	
Temporary/casual	0	0%		1	0.2%	
Work shift:						
Yes	5	1.1%	0.03	20	4.8%	0.29
No	27	6.3%		85	24.7%	
Work time between 6 pm and 7am:						
Yes	9	2.1%	0.08	44	10.3%	0.28
No	77	4.2%		273	70.9%	

*Non- physical violence includes Verbal abuse, Bullying, Racial harassment, sexual harassment

Prevalence of violence:
Most health care workers (physicians and nurses) were subjected to at least one incident of physical and psychological violence in the 12 months prior to the survey, with verbal abuse being the most prevalent type of workplace violence. All violence committed against PHC health care workers was nonfatal. The most frequent causes of violent acts by visitors were physical harm (6.3%), verbal abuse (48.8%), Bullying/Mobbing (10.1%) sexual harm (1.9%), and racial harm (20.3%) in the past 12 months as shown in Table 5.

Table 5 :Types of violence in reported events:

Types of violence	Number (%)
- Physical	28(6.3%)
- Psychological:	
Verbal Abuse	209(48.8%)
Bullying/Mobbing	42(10.1%)
Racial harassment	86(20.3%)
Sexual harassment	8(1.9%)

The health care workers who were exposed to violence varied in using coping mechanisms in response to violence between taking no action (21.3%), tried to pretend it never happened (14.1%), told the person to stop (29.2%), tried to defend him/herself physically (0.2%), told friends/families (24.2%), told a colleague (28.3%), sought counseling (3%), reported to a senior (28.8%),transferred to another position (4.5%), sought help from the union (1.3%), completed incident/accident (5%) pursued prosecution (0.6%), completed a compensation claim (0.2%) and others (1.1%) as shown in Table 6.

Table 6: Coping mechanisms of health care workers exposed to violence

Coping mechanisms	Numbers (%)				
	PV	VA	B/M	SH	RH
-took no action	2(0.4%)	45(10.1%)	7(1.6%)	4(0.9%)	37(8.3%)
-tried to pretend it never happened	2(0.4%)	32(7.2%)	18(4%)	-	11(2.5%)
- told the person to stop	19(4.3%)	73(16.4%)	16(3.6%)	2(0.4%)	20(4.5%)
-tried to defend myself physically	1(0.2%)	-	-	-	-
-told friends/family	2(0.4%)	60(13.5%)	17(3.8%)	1(0.2%)	28(6.3%)
-told a colleague	7(1.6%)	68(15.2%)	23(5.2%)	1(0.2%)	27(6.1%)
-sought counseling	2(0.4%)	5(1.1%)	6(1.3%)	-	1(0.2%)
-reported it to a senior staff member	11(2.5%)	85(19.1%)	11(2.5%)	1(0.2%)	20(4.5%)
-transferred to another position	3(0.7%)	10(2.2%)	3(0.7%)	-	4(0.9%)
-sought help from association	-	3(0.7%)	1(0.2%)	-	2(0.4%)
-sought help from the union	1(0.2%)	4(0.9%)	-	-	1(0.2%)
-completed incident/accident form	1(0.2%)	18(4%)	2(0.4%)	-	2(0.4%)
-pursued prosecution	2(0.4%)	1(0.2%)	-	-	-
-completed a compensation claim	-	1(0.2%)	-	-	-
-other	-	4(0.9%)	-	-	1(0.2%)

The actions taken to investigate the cause of incidents during the last year by the participants who experienced violence was (8.2%) by management/employer (7%) or union (1.3%) or community group (0.4%) or police in (1.6%) or others (0.4%) as shown in Table 7.

Table 7 : Action taken to investigate the cause of incident

	Numbers (%)				
	PV	VA	B/M	SH	RH
Action taken to investigate the causes of incident:					
-Yes	6(1.3%)	22(4.9%)	7(1.6%)	1(0.2%)	1(0.2%)
-No	10(2.2%	118(26.5%)	22(4.9%)	4(0.9%)	55(12.3%)
-Don't know	10(2.2%)	57(12.8%)	12(2.7%)	4(0.9%)	19(4.3%)
By whom:					
-manager/employer	6(1.3%)	16(3.6%)	6(1.3%)	2(0.4%)	2(0.4%)
-union	2(0.4%)	3(0.7%)	-	-	1(0.2%)
-association	-	-	-	-	-
-community group	-	1(0.2%)	1(0.2%)	-	-
-police	3(0.7%)	4(0.9%)	-	-	-
-others	-	-	-	1(0.2%)	1(0.2%)

Almost (5.8%)of the consequences for the attacker reported by the participants who exposed to different types of violence did nothing, on the other hand, 2% of the participants issued a verbal warning, 1.5% reported the violence they experienced to the police and only 0.4% of aggressors were prosecuted as shown in Table 8.

Table 8: The consequences for the attacker reported by the participants exposed to violence during the last year

Consequences	Numbers (%)				
	PV	VA	B/M	SH	RH
none	7(1.6%)	12(2.7%)	5(1.1%)	1(0.2%)	1(0.2%)
verbal warning issued	-	6(1.3%)	3(0.7%)	-	-
care discontinued	-	-	-	-	-
reported to police	1(0.2%)	5(1.1%)	-	1(0.2%)	-
aggressor prosecuted	-	2(0.4%)	-	-	-
other	-	1(0.2%)	-	-	-
don't know	-	2(0.4%)	-	-	1(0.2%)

The employer/supervisor provided different offers to the participants who were affected by violence such as counseling (24%), opportunity to speak/report (41%), and other support (26.8%) as shown in Table 9.

Table 9: Employer/supervisor offers

	Numbers (%)				
	PV	VA	B/M	SH	RH
Employer/ supervisor offers:					
Counseling	11(2.5%)	50(11.2%)	17(3.8%)	4(0.9%)	25(5.6%)
Opportunity to speak/report	16(3.6%)	99(22.2%)	28(6.3%)	6(1.3%)	34(7.6%)
Other support	9(2%)	70(15.7%)	18(4%)	2(0.4%)	21(4.7%)

The majority of the participants who experienced different types of violence were either unsatisfied regarding the handling of the incident in (17.6%) or very unsatisfied (21.7%), while the remaining were satisfied (4.1%) or very satisfied (3.9%) as shown in Table 10.

Table 10: Handling incident satisfaction

Handling incident satisfaction	Numbers (%)				
	PV	VA	B/M	SH	RH
-very dissatisfied	6(1.3%)	53(11.9%)	9(2%)	3(0.7%)	26(5.8%)
-dissatisfied	15(3.4%	63(4.1%)	16(3.6%)	1(0.2%)	28(6.3%)
-neutral	4(0.9%)	51(11.4%)	13(2.9%)	5(1.1%)	12(2.7%)
-satisfied	1(0.2%)	10(2.2%)	2(0.4%)	-	6(1.3%
-very satisfied	2(0.4%)	13(2.9%)	2(0.4%)	-	1(0.2%)

The reasons for not reporting by the participants included the belief that reporting was not important (14.1%), felt ashamed (8%), felt guilty (4.3%), afraid of negative consequences (17.4%), did not know whom to report to (6.4%) and useless (33%) as shown in Table 11.

Table 11: Reasons for not reporting incidents by the participants:

Reasons for not reporting the incidents	Numbers (%)				
	PV	VA	B/M	SH	RH
- it was not important	4(0.9%)	43(9.6%)	1(0.2%)	-	15(3.4%)
- felt ashamed	6(1.3%)	10(2.2%)	11(2.5%)	2(0.4%)	7(1.6%)
- felt guilty	-	4(0.9%)	8(1.8%)	-	7(1.6%)
- afraid of negative consequences	6(1.3%)	34(7.6%)	14(3.1%)	3(0.7%)	21(4.7%)
- did not know who to report to	7(1.6%)	15(3.4%)	3(0.7%)	-	3(0.7%)
- useless	6(1.3%)	71(15.9%)	27(6.1%)	3(0.7%)	40(9%)

The health care administration in PHC centers developed specific policies in health and safety (79.8%), physical workplace violence (49.1%), verbal abuse (41.9), sexual harassment (28%), racial harassment (25.8%), Bullying/ Mobbing (28.9%) and threat (36.5%) as shown in Table 12.

Table 12: Development of specific policies in the workplace by employer:

Development of specific policies in the workplace by employer:	Frequency (%)	Mean	SD	P value
Health and safety				
yes	356(79.8%)	1%	0.36%	0.19
no	25(5.6%)			
don't know	29(6.5%)			
Physical workplace violence				
yes	219(49.1%)	1%	0.67%	0.28
no	88(19.7%)			
don't know	90(20.2%)			
Verbal abuse				
yes	187(41.9%)	0.97%	0.72%	0.63
no	110(24.7%)			
don't know	99(22.2%)			
Sexual harassment				
yes	125(28%)	1.08%	0.82%	0.87
no	115(25.8%)			
don't know	149(33.4%)			
Racial harassment				
yes	115(25.8%)	1.10%	0.83%	0.83
no	117(26.2%)			
don't know	156(35%)			
Bullying/Mobbing				
yes	129(28.9%)	1.08%	0.81%	0.80
no	113(25.3%)			
don't know	144(32.3%)			
Threat				
yes	163(36.5%)	1.08%	0.75%	0.66
no	97(21.7%)			
don't know	129(28.9%)			

The prevention action against violence in the workplace includes different measures that exist like security measures (69.1%), improved surroundings (45.1%), restrict public access (30.3%), patient screening (32.7%), patient protocols (28.5%), restrict exchange (19.3%), increased staff numbers (27.1%), check in procedures for staff (18.8%), use special equipment or clothing (22.4%), changed shifts (30.3%), reduced periods of working alone (33.4%), training (33.9%), investment in human resource development (20%) and other measures (0.9%) as shown in Table 13.

Table 13: workplace violence measures to deal with it in the workplace:

Do measures to deal with workplace violence exist in your workplace?	Frequency (%)	Mean	SD	P value
Security measures				
yes	308(69.1%)	0.72%	0.44%	0.12
no	117(26.2%)			
Improve surroundings				
yes	201(45.1%)	0.47%	0.49%	0.59
no	223(50%)			
Restrict public access				
yes	135(30.3%)	0.31%	0.46%	0.00
no	289(64.8%)			
Patient screening				
yes	146(32.7%)	0.34%	0.47%	0.33
no	278(62.3%)			
Patient protocols				
yes	127(28.5%)	0.30%	0.45%	0.15
no	296(66.4%)			
Restrict exchange of money at the workplace				
yes	86(19.3%)	0.20%	0.40%	0.02
no	338(75.8%)			
Increased staff numbers				
yes	121(27.1%)	0.28%	0.45%	0.05
no	303(67.9%)			
Check-in procedures for staff				
yes	84(18.8%)	0.19%	0.39%	0.18
no	340(76.2%)			
Special equipment or clothing				
yes	100(22.4%)	0.23%	0.42%	0.18
no	324(72.6%)			
Changed shifts or rotas				
yes	135(30.3%)	0.31%	0.46%	0.71
no	288(64. 6%)			
Reduced periods of working alone				
yes	149(33.4%)	0.35%	0.47%	0.09
no	275(61.7%)			
Training				
yes	151(33.9%)	0.35%	0.47%	0.53
no	273(61.2%)			
Investment in human resource development				
yes				
no	89(20%)	0.20%	0.40%	0.40
	335(75.1%)			
None of these		0.07%	0.26%	0.24
yes	33(7.4%)			
no	390(87.4%)			
Other				
yes	4(0.9%))	0.00%	0.09%	0.34
no	418(93.7%)			

The participants' opinions on the impacts of the workplace changes on the daily work was nothing done (14.8%), staff worsening in work situation (13%), staff improvement in work situation (28.3%), worsened work situation for patients/clients (2.2%), improved work situation for patients/clients (8.1%), don't know (14.1%) and other opinions (0.7%) as shown in Table 14.

Table 14: Participant opinion regarding the impact of workplace and health care setting in the changes on daily work

HE5 changes opinion	Frequency (%)	Mean	SD	P value
None.	66(14.8%)	2.25%	1.71%	0.33
Work situation for staff worsened	58(13%)			
Work situation for staff improved	126(28.3%)			
Work situation for patient worsened	10(2.2%)			
Work situation for patient improved	36(8.1%)			
Don't know	63(14.1%)			
Other	3(0.7%)			
Total	362(81.2%)			

Discussion

The result of this study demonstrated the types of violence (physical, psychological, verbal, sexual, racial, Bullying/Mobbing) caused by attacker among physicians and nurses and the risk factors associated with workplace violence. This is in agreement with the study in Saudi Arabia [9].

Regarding the Characteristics of the study population (demographic and work characteristics):
The nurses were more exposed to violence than physicians which is similar to a study in Serbia [10,13]. The high percentage of violence against nurses is probably due to spending more time in contact with patients, language barriers, inadequate communication skills and a lack of security measures and control. A study in Greece showed equal exposure in physicians and nurses (19), while another study showed that physicians were slightly more exposed to violence than nurses [5,20].

The majority of the participants were married (89.9%) and the rest were single (5.4%), separated (2.9%) or widowed (1.3%). (19.1%) of the participants worked in Kuwait over 20 years, (13.9%) worked for 16-20 years, (33.6%) of the participants worked for 11-15 years, (22.9%) worked for 6-10 years, (9.4%) worked for 1-5 years and (0.7%) worked for less than 1 year. In a previous study in Kuwait a shorter professional experience in general is a significant risk for physical violence [2].

The participants (92.2%) worked full time, (4.3%) part time and (0.2%) were temporary as most of them worked in a shift in (90.4%) and (76%) of them worked between 6 pm. and 7 am.

The number of staff present in the same working setting (more than 50%) most of the time ranged from 1-5(47.3%), 6-10 (17.9%), 11-15(11.2%), 15+ (9.2%) and none (6.7%).

Working in shifts is very stressful for health workers. Night shift work is considered to be a high-risk factor for exposure to violence [10]. In other study, night shifts had significantly lower rates of verbal and physical violence when compared to the day and evening shifts. The evening shift had a significantly higher rate of physical aggression than the other shifts [13].

Higher rates of violence during this time can be also attributed to lower presence of administration and shortening of staff numbers during the evening and night shifts that would require personnel to work alone [20].

Regarding the prevalence of violence:
In this study, (6.2%) of participants were exposed to physical violence and (77.3%) were exposed to psychological violence during the last year.

Nonphysical violence is widespread, with verbal abuse being the most common form. Verbal abuse as a single non-physical act was experienced by (48.8%) of the participants in the current study. In comparison to the verbal abuse, from the countries included in WHO case studies (39.5 %) of the respondents had experienced verbal abuse in the last year in Brazil, (32.2%) in Bulgaria, (52 %) in South Africa with (60.1%) in the public sector, (47.7 %) in Thailand, (51%) in the health center complexes and (27.4 %) in a hospital in Portugal, (40.9 %) in Lebanon and up to (67 %) in Australia [2].

The second main type of violence is racial harm which was experienced by (20.3%) in our study, (25.6%) in Greece, (2.5%) in Al-Hessa.

In comparison to the physical violence investigated from the countries included in WHO case studies, (7.5%) of the respondents reported had been physically attacked in the previous year to the study, in Bulgaria, (6.4 %) in Brazil, (5.8 %) in Lebanon, (10.5 %) in Thailand, (9 %) in the private sector and up to (17 %) in the public sector in South Africa. Even in Portugal, where the percentage is limited to (3%), physical violence has been indicated as being very important for emergency care crews. The extremely high level of physical violence in the public health sector in South Africa comes as a shock even to the country's researchers. Even more shocking when one considers that up to (71.1%) of the respondents in the public sector, as against (51.6 %) in the private one, reported having experienced at least one incident of workplace violence, while (25.5 %) in the public sector and (10.1%) in the private sector had witnessed episodes of physical violence in the previous twelve months [2].

The important result of the study was the relatively low prevalence of sexual harassment. Although even these low rates of incidence could be alarming because of underreporting and some type of bias a slightly higher prevalence of sexual harassment was found in another similar study [10].

Regarding the descriptive association between respondents' characteristics and exposure to physical and nonphysical violence:

Certain characteristics have been found to increase the risk of workers being targets of workplace violence in the healthcare setting, including the workers' age, gender, marital status, work experience, work time and work time between 6 am. and 7 pm.

In this study there was no significant differences in relation to reported physical and non- physical violence by age, gender, marital status, work experience, work time and work time between 6 am. and 7 pm. ($p > 0.05$). However, the respondents reported a significantly higher percentage of physical violence incident regarding nationality ($p = 0.04$). The respondents reported a significantly higher percentage of non-physical violence incident regarding profession group ($p = 0.04$). The respondents reported a significantly higher percentage of physical violence incidents in relation to work shift ($p = 0.03$).

Regarding the reporting of workplace violence by the health care workers (physicians and nurses):

It is found that the procedures of reporting of violence in the workplace of PHC centers was around (49.8%) with those encouraged to be reported by manager in (50%), colleagues in (5.6%), own family/friend in (0.4%) and others in (1.3%). Many of those did not report a violent incident because they did not believe it would lead to any action[2].

Underreporting of workplace violence against participants in another study was very common ranging from (46 to 80%) [9].

In other studies, the HCW felt that the violence was part of their job, had negative experience when reporting, feared consequences for reporting, believed that reporting was an inefficient reaction and some feared losing their job [5]. It is also possible that health care professionals may not want to report an incident due to a desire not to further stigmatize individuals who may have mental illness or impairment of some kind [6]. The health-care workers were reluctant to report injuries and illnesses because they feel that it might compromise how they are perceived by management [13]. Respondents believed that reporting is useless because health center management will not take any action, and because of fear of negative consequences such as blame which was similar to a previous study[20].

Regarding the workplace violence measures to deal with it in the workplace:

The measures that exist in the workplace related to workplace violence includes security measures in (69.1%), improved surroundings in (45.1%), restriction on public access in (30.3%), patient screening in (32.7%), patient protocols in (28.5%), restrict exchange in (19.3%), increased staff numbers in (27.1%), check in procedures for staff in (18.8%), special equipment or clothing in (22.4%), changed shifts in (30.3%), reduced periods of working alone in (33.4%), training in (33.9%), investment in human resource development in (20%) and others in (0.9%). The importance of increasing preparedness through training in the management of violence is supported by previous studies [6].

It was suggested that maintaining staffing patterns, which would limit working being alone and limiting after-hour care, and producing firm penalties for offenders are needed to reduce the risk of workplace violence[5].

Availability of security measures, improved surroundings, restrict public access, patient screening, patient protocols, restrict exchange of money at the workplace, increased staff numbers, check-in procedures for staff, special equipment or clothing, changed shifts or rotas, reduced periods of working alone, training and investment in human resource development are the most frequent suggestions to prevent and control violence. This is in agreement with other studies [9,12,15,18,20].

The formal support systems should include the provision of legal and administrative advice, and implementation of organizational measures to prevent future incidents [6].

Regarding the workplace health care setting changes and the opinions of the health care workers:

The workplace/health care setting changes in the last 2 years differed from no changes in (25.1%), restructuring/ reorganization in (15.7%) staff cuts in (12.3%), increased staff member in (10.8%), restriction of resources in (1.6%), additional resources in (1.3%), others in (0.9%) and don't know in (14.1%).

There were no participants' opinions on the impacts of the workplace changes on the daily work in (14.8%), (13%) found the work situation for staff worsening, (28.3%) found that work situation for staff improved, (2.2%) found that the work situation for patients/clients worsened in work situation, (8.1%) found the work situation for patients/ clients improved and (14.1%) don't know.

Conclusion

Violence towards health care professionals (physicians and nurses) occurs frequently and affects physicians and nurses in Primary Health Care Centers in Kuwait.

Working in a safe environment should be a priority as employees are at serious risk of violent incidents. Health care workers should feel secure and confident in their working environment. Therefore, building a good medical environment and reducing violence prevalence is one of the effective measures in reducing job burnout, stabilizing the health care workers teams and increasing job satisfaction. It is also necessary to establish a unified and appropriate reporting system and provide training programs for health professionals.

Recommendation:
Based on the finding of this study and the opinions of the participants, different recommendations that are needed to be followed in the future:

1. Developing a human-centered safe workplace culture.
2. Reinforce relevant human resources policies.
3. Management commitment and worker participation.
4. Worksite analysis and hazard identification.
5. Organizational interventions.

The implementation of strategies and preventive measures seems imperative for health care staff to feel secure and confident in the health care environment like:

Staffing: Ensure adequate presence of staff, in terms of numbers and qualifications.

Information and communication among the staff and working areas: Circulation of information and open communication among the staff and working areas can greatly reduce the risk of workplace violence by defusing tension and frustration among workers.

Management style: Openness, communication and dialogue, in which caring attitudes and respect for the dignity of individuals are priorities.

Work practices: Changing and improving work practices is a most effective, inexpensive way of diffusing workplace violence.

Working time: working time management should avoid excessive work pressure.

6. Environmental Intervention:
Changing and improving work practices is a most effective, inexpensive way of diffusing workplace violence.

7. Individual-focused interventions should be developed and adapted having regard to the specific situations, and priorities among the various types of interventions available should be established in consultation with the local stakeholders.

8. Future research:
Future research on workplace violence in other sectors along with causes of violence in health care settings is needed to improve the reporting process.

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