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Abstract

Objectives

This study assessed patterns in reported violence against doctors working in 3 Babylon hospitals providing care for patients with COVID-19 and explored characteristics of hospital violence and its impact on health workers.

Method

Cross - sectional study conducted Meijan, Alimam Alsadiq, leaching hospital Babylon, the study included some doctors in these hospitals in different units of work, years of experience and specialty if applicable

Results

Questionnaires were completed by 270 hospital doctors (male 119, female 151) working in 3 Baghdad hospitals. No personal or identifying information was obtained.

Introduction:

Violence against health care workers is defined as incidents where workers are abused, threatened or assaulted in relation to their work and involving an explicit or implicit challenge to their safety, well-being or health . In some countries, workplace violence makes healthcare the most dangerous of occupations .

In addition to the common verbal aggression and harassment, perhaps a third of health workers will be exposed to physical violence such as rape, injuries, kidnapping and death during their careers .
The true extent of violence against health worker is underreported, perhaps.

quantitative survey was conducted at 3 general hospitals in Babylon in March and April 2022. Each general hospital had a designated COVID-19 ward and was specified as a COVID-19 treatment center by the Ministry of Health based on location, catchment area and resources available . Doctors from all departments at these hospitals were invited to participate with the assurance that no personal identifiers would be asked, and all answers would be anonymous and kept confidential.

For those providing oral consent, self-administered paper questionnaires were provided directly to the doctors to be completed in the presence of the

survey team, in case any questions arose.
Questionnaires were collected by the survey team upon their completion. The selected hospitals were visited several times to ensure all doctors had an opportunity to participate.

The questions were developed based on experiences of Iraqi medical staff with hospital violence, perceptions of patient tensions, and their own personal stresses. Questions were linked with previous work examining risks of violence to health worker in Babylon health facilities .

After testing the questionnaire, it was revised and used for training of the survey team prior to data collection. Forms requested no personal or privileged infonnation and contained no unique identifiers.

Descriptive analyses were conducted to understand health care worker experiences with violence.
This study reveals a distressing pattern of increasing violence against Iraqi doctors during the COVID-19 pandemic amidst ongoing non-intemational anned conflict and popular demonstrations against corruption and dysfimctional governance.

Reduced health resources and restricted salary related to low international oil prices and the economic impact of CO VID-19 further complicated health care .
nearly eight out of 10 doctors surveyed in the 3 Babylon had hospitals reported a verbal or physical assault. By a large majority, health workers see violence as substantially increased over an already prevalent pattern of violence in Iraqi hospitals. In this current Babylon study, the fear of being held accountable for a patient's death was a common concern of doctors.

Although the majority of participating doctors in the 3 hospitals were female, violence was directed equally against male and female doctors, unlike reports from India of higher rates against female doctors . However, physical assaults were directed only against male doctors, respecting Iraqi culture nonns. Female doctors were more likely to report fear while working in the hospital setting, whereas male doctors were more likely to report insomnia, a characteristic observed as well among Chinese doctors exposed to hospital violence .

Depression and anxiety were common experiences noted by Iraqi doctors. The self-identified sources of stress were most commonly focused on personal risks and possibilities of bringing home infections to their families, the latter a common finding in health care settings during the pandemic ,

Wliile the fear of diminished professional perfonnance in a violent hospital environment was common among Babylon doctors, it was mostly expressed by the younger doctors, findings reported among health workers elsewhere .

Physical exhaustion, psychological stress, increased absenteeism, and fear of personal safety all can contribute to the diminished quality of care. It was also the younger doctors who were more likely to feel unsafe in the hospital setting. The frequent reporting of violent events occurring to the colleagues of the doctors participating suggests that violence was pervasive in Iraqi hospitals.

Commonly these events were not reported to hospital authorities or hospital security, suggesting that doctors felt reporting would not lead to any change in hospital violence or feared repercussions from reporting Although there has been extensive documentation of the events and the reactions among health workers, less attention has been paid to the structural issues contributing to the violence.

In this Babylon study, the participating doctors categorized a number of contributing hospital or health systems issues.

These largely paralleled pre-COVID-19 findings in surveys of Babylon hospitals and PHC clinics as well as the opinions of medical students about relationships between health workers and patients . Patients and their families' perceptions of poor health services, lack of medicine, hospital overload, and risks of family members becoming infected were commonly noted by the doctors.

Many of these same factors were associated with health worker violence in Iraq.
In India dissatisfaction with inefficient service systems, long waiting time, overcrowding, and few staff or resources, were thought to instigate episodes of violence .

Inequities in access to services is a structural factor also identified . In Iraq, insufficient hospital security measures were at the top of the list of reasons for violence in this study, and also noted previously in Babylon hospitals.

A study of this nature has many limitations. Although the survey team made several visits to each hospital, some doctors were not included. We included hospitals designated for care of COVID-19, but hospitals without a COVID-19 ward may have shown a different pattern.

Matching hospitals with COVID-19 wards with other Babylon hospitals was not possible because of unique characteristics of designated hospitals

with COVID-19 wards. The study did not include nurses or other health workers who may have had different exposures to hospital violence. We did not sample patient or patient families to understand their perceptions. Experience of Iraqi doctors dealing with the pandemic in other Iraqi cities may have been different.

Questionnaires may not have captured many of the complexity of hospital violence or the complicated emotions generated in a complex and insecure environment. Finally, doctors may have been reticent to communicate sensitive events. In depth interviews about the origins of the violence, and interviews with patients, hospital management, and security personnel could have provided additional perspectives. This would be an important next step.

Findings

Of 270 doctors, 202 (74.5%) had experienced hospital violence during CO VID-19 pandemic. Doctors reported that patients were responsible for 70 (25.5%). instances of violence, patient family or relatives for 102 (37.8 %), police or military personnel for 19 (4.3%), and other sources for 9 (3.3%). The proportion of violent events reported did not differ between male and female doctors, although characteristics varied.

There were 222 of the 300 doctors who reported that violence had increased since the beginning of the pandemic, and many felt the situation would only get worse. COVID-19 has heightened tensions in an already violent health workplace, fiirther increasing risks to patients and health providers.

Questionnaires were completed by 300 doctors, and participation declined by 10 who cited pressing clinical responsibilities. Because of ongoing clinical rotation of doctors, it was hard to judge the representativeness of the sample, but we estimate that more than 50% of doctors providing direct clinical care completed questionnaires. The demographic characteristics of the sample are set out in Table 1. Younger age groups predominated, with 149 (55.2%) being under age 30, and 151 (55.9 %) female.

2.Gender					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	119	44.1	44.1	44.1
	Female	151	55.9	55.9	100.0
	Total	270	100.0	100.0	

Table 1 participant group

Of the 300 doctors there were 190 specialists, with the majority being family medicine (15), internal medicine (5), or general surgery (10). The remaining 200 were junior doctors who had not completed specialty training. The personal experiences with violence are shown in Table 3.

1Age					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<30	149	55.2	55.2	55.2
	30-39	57	21.1	21.1	76.3
	40-49	38	14.1	14.1	90.4
	>50	26	9.6	9.6	100.0
	Total	270	100.0	100.0	

Table2: gender

Of the 300 doctors, 202 (74.8 %) doctors reported verbal or physical violence in the pandemic . Most reports of hospital violence were reported among the younger doctors . There was no difference in reports of violence between male and female doctors. Among those with no specialty qualifications,

7.Have you experienced any sort of violence(verbal/physicaljnsult,assault,threat (during the period of covid 19?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	202	74.8	75.1	75.1
	No	67	24.8	24.9	100.0
	Total	269	99.6	100.0	
Missing	System	1	.4		
Total		270	100.0		

Table3. Violence during COVID-19

Among healthcare workers who experienced violence, 240 who indicated that violence came from the patients or family members. There were statistically significant differences between male and female doctors in the circumstances of hospital violence. Violence directed at doctors by police or military was reported more commonly by male than female doctors, (18.1% vs 1.8%) whereas the reverse was true for violence from the patients themselves (23.4% vs 18.0% $p<0.001$).
Female doctors more commonly reported daytime violence (75.3 %vs 48.3%), though this may have represented scheduling patterns. In the face of violent events, male doctors were more likely to fight the assailants (20.3 % vs 12.1%) and female doctors were more likely to take no action (39.5% vs 26.0%).

Younger doctors were more likely to express fear as a reason for not reporting a violent event to hospital authorities (29.7% vs 16.7%). The majority of attacks were verbal assaults or superficial contact, though

fractured bones, lacerations, dislocations, contusions and residual psychological trauma occurred. No female doctors reported being physically attacked though one in five male doctors were struck by patients or family members during incidents.

9.time of the day at which you experienced violence?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	3	1.1	1.5	1.5
	day	151	55.9	75.1	76.6
	night	47	17.4	23.4	100.0
	Total	201	74.4	100.0	
Missing	System	69	25.6		
Total		270	100.0		

Table 4 time where violence happened.

Many reasons were suggested for the increased violence, from perceived poor quality of hospital care to popular unrest in the country. Current tension levels among patients and their family members were judged to be high by 55 doctors compared with only 30 doctors thinking tensions were high before the pandemic. Among doctors, self-reported stress levels were substantial. Deaths among fellow health workers from COVfD-f9 and concerns about bringing the infection to the family at home were major concerns reported. Anxiety was reported by 125 (46.6%) of doctors and depression by 32 (11.9%). Fear was more commonly reported emotion among female doctors (18.6% vs 9.5%) while insomnia was more common among males (12.5% vs 4.9%). Changes in reported tension levels reported were not significantly different among doctors exposed to hospital violence compared with those who were not.

27.Have you experienced any mental symptoms you think are attributed to this violence?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	anxiety	125	46.3	65.4	65.4
	fear	20	7.4	10.5	75.9
	depression	32	11.9	16.8	92.7
	insomnia	14	5.2	7.3	100.0
	Total	191	70.7	100.0	
Missing	System	79	29.3		
Total		270	100.0		

Table 5

Most doctors felt there was little assistance to be expected from local authorities to reduce hospital violence. There were 111 (41.5 %) who felt unsafe from violence in their hospital unit,

24.Do you feel local authorities are supporting you against violence?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	1	.4	.4	.4
	Yes	51	18.9	19.3	19.7
	No	92	34.1	34.8	54.5
	partly	120	44.4	45.5	100.0
	Total	264	97.8	100.0	
Missing	System	6	2.2		
Total		270	100.0		

25.Do you feel safe from physical violence in your workplace?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	42	15.6	16.1	16.1
	No	111	41.1	42.5	58.6
	partly	108	40.0	41.4	100.0
	Total	261	96.7	100.0	
Missing	System	9	3.3		
Total		270	100.0		

Conclusion

The pandemic lias exacerbated what was already a major problem with patient relationship to doctors and workplace violence in al hilla hospitals. The extent of violence is most certainly underreported to hospital authorities. Younger doctors were especially affected by hospital violence. Male doctors were more likely to have been struck during violent incidents than were female doctors. The survey team noted that the doctors participating looked physically and mentally tired. Although some doctors reported increased hospital security, it was not clear how effective these increased efforts had been in reducing hospital violence toward doctors. Much of the patient dissatisfaction, which likely gives rise to the violence, is related to perceptions of the quality and adequacy of hospital care by patients and family members.

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