Perceptions and Experiences of Health-care Personnel Regarding Violence Against Health Care: a Qualitative Multiple Case Study

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Abstract

Background

Health-care workers are at high risk of facing violence all over the world. The sanctity, respect and protection of health care is threatened by violence in health-care settings. The study aims to explore the perception of health-care personnel about violence in health-care settings in district Peshawar.

Methods

This qualitative multiple case study uses a participatory approach to develop an understanding of the processes and themes that explain the health-care personnel’s experience of violence. Ten focus group discussions and three individual in-depth interviews were conducted with eighty-three participants recruited through purposive sampling.

Results

Three distinct recurrent themes emerged from the responses of the different stakeholders and consensus was reached on seven broad categories. The themes were: (a) Not all the wounds are visible: the theme describes the nature, frequency, and characteristics of violence and explores that violence is not merely any physical action taken against men or women to cause visible physical wounds, but also includes verbal or emotional abuse that attempts to hurt the feelings or affects the health of an individual. (b) But violence is never the answer: different categories including the perpetrators of violence, causes, and contributing factors, and the consequences and effects of violence on individuals and institutions were explored and summarized that there could be many causes to provoke violence but still violence cannot be justified. (c) Vaccine for violence: described the various strategies for the prevention of violence and suggests various measures at the public and institutional levels to be incorporated for a future without violence.

Conclusion

The study concluded that violence against health care is a frequently occurring phenomenon in health-care settings. Most of the incidents are not highlighted as they are verbal/emotional but have far more impact on the health-care personnel. A holistic approach was suggested for ending violence in the health-care settings and the need to involve all relevant stakeholders was emphasized. The recommended measures include policy formulation, promoting awareness and education, capacity building of health-care personnel on communication strategies/consultation skills, improved security of the health-care settings, and positive role of media in promoting the respect of health-care personnel. Further research should then focus on evaluating the effectiveness of these measures.

Background

Globally, violence against health-care providers is a persistent public health problem that is ubiquitous, under-reported, and largely ignored (1). According to the World Health Organization (WHO), violence is defined as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either result in or has a high likelihood of resulting in injury, death, psychological harm,
mal-development or deprivation” (2,3). It has been shown by many research studies that incidents of violence occur frequently and repeatedly in health-care settings (4). Violence affects people belonging to all professional categories including doctors, nurses, paramedics, and others (4). Violence affects health-care staff in all working environments, but the most frequent victims are those working in high-risk and stressful settings such as the emergency department and the psychiatry wards (4,5). Various forms of violence including physical and non-physical violence are common in the industrialized world as well as in the developing and transitional countries (6).

Literature has revealed that violence in health-care settings causes serious health, safety, and legal consequences (7). The victims suffer from the feelings of being left on their own by the institutions; scared, hurt, and angry (8). The prevalence of violence in health-care settings is greater than other occupational settings and health-care workers have a five times greater risk of being the victims of violence compared to workers in all other industries combined (1,9). Similar findings were reported from a study in Karachi, Pakistan, where one in six and three in five physicians reported physical or verbal abuse, respectively, in the past 12 months (9).

According to a report released by ILO/ICN/WHO/PSI, violence in health-care settings is a universal issue causing psychological and physical problems and its prevalence varies by country (10). A cross-sectional survey was conducted in Chinese hospitals to determine the prevalence of workplace violence against nurses. A total of 71.9% of the nurses reported non-physical violent experiences and 7.8% reported physically violent experiences in a year. Perpetrators were patients or their relatives (93.5% and 82% respectively) (10). A nationwide study in the major tertiary care hospitals in Pakistan found more than 70% health-care personnel facing violence in the emergency departments during the preceding two months of the survey. Verbal abuse was 65% while physical abuse was faced by around 12% of the emergency physicians (11).

The purpose of the current study was to explore the perceptions of health-care personnel about violence health-care settings in district Peshawar. This is further broken down to factors leading to incidence of violent events, perpetrators of the violence, consequences of the violence on the victims and the existing social or legal services, and the recommendations for the prevention of such incidents in the future.

**Methods**

**Study Design**

This qualitative research used multiple case study approach to explore the perceptions of different stakeholders including doctors, nurses, support staff (ward orderlies, ambulance drivers, and gatekeepers), administration (Deputy Medical Superintendent), physiotherapists, media personnel, and police regarding violence against health-care personnel in district Peshawar, Khyber Pakhtunkhwa, Pakistan. The health-care personnel were largely invited from the three tertiary care public sector hospitals of district Peshawar. Apart from these physiotherapists working at a teaching Institute, and police and media personnel were also invited to participate. These were recruited through purposive sampling and staff who had experienced and/or witnessed violence in the past year was included. A total ten Focus Group Discussions (FGDs) and three individual in-depth interviews were conducted. The minimum number of participants was five and a maximum of twelve in each FGD.
Data Collection

Three FGDs each with doctors, nurses, and support staff were conducted in each of the three main tertiary care hospitals. Similarly, one FGD was conducted with the physiotherapists from the teaching institute. Apart from these, individual in-depth interviews were conducted with the deputy medical superintendent (administration), police representative of the hospital, and media personnel. Ethical approval was obtained from the Ethics Review Board of Khyber Medical University. Along with this permission was also obtained from the respective institution where the FGDs and in-depth interviews were conducted. All methods and procedures were performed in accordance with the relevant guidelines and regulations. The participants were apprised of the purpose of the study and their informed consent was obtained. At the start of the interview, the moderator assured the respondent about confidentiality. Open-ended questions were used to gather data from individual participants and during group interviews. Guiding questions were searched from literature and further authenticated by three experts in the field of qualitative research at Khyber Medical University. A discussion was generated about the participant’s perspective of violence against health-care personnel, the context of workplace violence, causes of violence, institutional response, and suggestions/recommendations to prevent the incidents of violence. All the responses were kept confidential and anonymous. All the FGDs and in-depth interviews were conducted by the same moderator.

Data Analysis

Transcriber software was used for the transcription of data. The first cycle of coding or initial analysis was done by Open Coding. The second cycle of coding was done to find out relationships by Axial Coding. Then, Thematic Analysis was done to create meaningful patterns. Thematic analysis was performed through the process of coding in six phases to create meaningful patterns. These phases were: familiarization with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and producing the final report (12,13).

Results

A total of 52 codes were extracted from the transcripts that were categorized under seven broad categories. The seven broad categories led to three distinct themes under which twelve specific areas were identified as subthemes.

The three themes were;

1. Not all the wounds are visible
2. But violence is never the answer
3. Vaccine for violence

Theme I:

Not all the wounds are visible:

The first theme that emerged from this study metaphorically describes that violence is not merely any physical action taken against men or women to hurt them or cause visible physical wounds, but it includes verbal or
emotional abuse of any form that directly or indirectly attempts to hurt the feelings or affects the health of an individual. Five sub-themes were identified for the theme-I and consensus was reached on two broad categories: description of violence, and prevailing status of violence (including experiences of workplace violence and nature, characteristics, and frequency of violence). The subthemes were:

1. Perceived personalization of violence

The narrative illustrates the meaning that the health-care providers ascribed to violence. The violence that was directed towards health-care providers as representative of the the ‘system’ had a less negative impact on their emotional wellbeing as compared to violence perceived as ‘personal’. Participants reported feelings of emotional distress by the acts of violence which they perceived as directed to their ‘person’. One of the representative quotes was:

“Once a patient's attendant ran to hit me because his patient died of an end-stage organ disease that cannot be cured, he started yelling at me and was staring aggressively” (FGD Doctors-I)

2. Verbal abuse as a weapon of choice

Findings indicated that the health-care staff experienced frequent verbal abuse at the hands of patients and their relatives. Verbal abuse was an almost daily occurrence and appeared as the first choice of violence by the perpetrators. One of the representative quotes was:

“Most of the time when the patients' attendants are told to stay out of ER/ward, they start misbehaving, yelling/ staring aggressively”. (FGD Nurses-I)

3. Victimization of health-care personnel

The narrative illustrates that health-care personnel were being victimized easily in different ways such as threats, physical assaults, and verbal abuse by the perpetrators. One of the representative quotes was:

“Once a patient’s attendants came with guns and they wanted to fight with CMO (Casualty Medical Officer) on duty because CMO told them to wait outside the ER.” (Interview Administrator)

4. Psychological/emotional abuse: a hidden form of violence

Psychological or emotional distress was identified as lethal as physical violence by the participants. One of the representative quotes was:

“I have observed the incidents of emotional abuse and verbal threats against workers at or outside the hospital.” (Interview Media-I)

5. No excuse for physical abuse

This subtheme described that physical abuse cannot be justified on any ground. There should be no room for any form of physical abuse, and it should be legally addressed. One of the representative quotes was:
“Workplace violence is an occupational safety and health hazard. It produces a bad impact on individuals’ mental health and institutions’ integrity.” (Interview Media-II)

**Theme II:**

**But violence is never the answer:**

The second theme of the qualitative study explored that there can be many causes to provoke violence but still violence cannot be justified.

Three sub-themes were identified for Theme II and a consensus was reached on three broad categories i.e. perpetrators of violence, causes, and contributing factors, and effects of violence on individuals and institutions. The sub-themes identified:

1. **Health-care institutions are no longer ‘safe havens’**

The participants showed their concern that because of the everyday occurrence of violence in health-care institutions; the institutions have lost their identity as a place of protection. One of the representative quotes was:

> “Patients/attendants create problems on daily basis. Ward orderlies and admin staff are also responsible. They are involved in harassment (mostly psychological).” (FGD Nurses-II)

2. **Violence is the problem, not the solution**

This sub-theme identified numerous causes of violence and illustrated that despite all causes; violence initiated by the perpetrators was not the solution. One of the representative quotes was:

> “In my opinion, patients’ companion, illiterate and those who have political background come to the hospital with a traditional mindset. They look for excuses for creating violence.” (Interview Police-I)

3. **A fear that’s palpable**

This sub-theme illustrated that the emerging incidence of violence is notably fearful and emphasized the different causes of violence that can be addressed at the government level. Different causes of violence at the institutional, public, and government levels are described in Table 1.

Table 1: Causes and contributing factors of violence


| Health-care Institution: No longer safe havens | Violence is the problem, not the solution | A fear that’s palpable |
|-----------------------------------------------|------------------------------------------|-----------------------|
| (At institution level)                        | (At public level)                        | (At government level)  |

- Policy vacuum
- Inadequate management/administration support
- Heavy workload
- Improper service delivery
- Lack of cooperation/collaboration
- Lack of proper security system
- Deficiency of Human resource and facilities
- Chaotic workplace environment
- Desensitization or habituation
- Workplace negligence
- Illiteracy or lack of education
- Delayed attention/long waiting time
- Unreasonable expectations due to government claims
- Situational trigger
- Impatience and intolerance
- Increase poverty and unemployment
- A high rate of inflation
- Role of social media
- Lack of implementation of security act/policy
- Culture of political intrusion
- Culture of intercession
- Top-bottom cultural assumption
- Defamation of health-care institutes
- High economic costs
- Lack of a proper referral system
- Lack of proper monitoring
- Lack of population control
- Lack of assessment of data for planning and development

**Theme III:**

**Vaccine for violence:**

The third theme that emerged describes the various strategies for the prevention of violence (Table 2). Four sub-themes were identified for Theme-III and consensus was reached on two broad categories, that is, institutional response and prevention of violence. The sub-themes identified were: future without violence, the establishment of institutional regime/model for a safe working environment, strategies for trigger phase prevention, and strategies for crisis de-escalation and protection.

1. **Future without violence**

The study participants wished for a future without violence against health-care workers. The representative quote for this sub-theme was:

“People should be educated through awareness campaigns regarding avoiding violence. Media should play a positive role in portraying doctors’ image.” (FGD Doctors-III)

2. **Establishment of institutional regime/model for a safe working environment**

The study participants, especially the females, also proposed a safe institutional environment. The representative quote for this sub-theme was:

“People should be made aware of the punishment for violence at the hospital. There should be proper security system.” (FGD Nurses-II)
3. Strategies for trigger phase prevention

One of the study participants also suggested a strategy for trigger phase prevention, such as;

“There should be a rapid emergency response system at all the hospitals.” (Interview Administrator-II)

4. Strategies for crisis de-escalation and protection

Some of the participants also suggested crisis de-escalation and protection strategies such as;

“A culture of respect should be promoted at hospitals and government institutions. Coordination should be developed. (Interview Police-II)

“As we know that patients and their families are under stress, hospital staff should take good care of them. Furthermore, staff education, skills, security and health measures should be improved.” (Interview Media-III)

Table 2: Strategies for prevention of violence
### Future without violence  
*(Primary prevention at government level)*

| Establishment of institutional regime/model for a safe working environment  
*(Primary prevention at institution level)* | Strategies for trigger phase prevention  
*(Secondary prevention)* | Strategies for crisis de-escalation and protection  
*(Tertiary Prevention)* |
|---|---|---|
| • Education  
• Peace education  
• Advocacy/awareness/outreach  
• A collaboration of all stakeholders/departments  
• Influencing policy and legislation  
• Increase in employment opportunities  
• Decrease in poverty  
• The positive role of social media | • Proper service delivery  
• Implementation of security act (making health-care institutions as “zero-tolerance for violence” zones)  
• Establishment of 24 hours security surveillance system  
• Good environmental policy  
• Collegial awareness  
• Averting violence  
• Increase human resource  
• Increase institutional capacity  
• Staff education, training, and skill development | • Empathizing with patients and their attendants/family  
• Conveying caring  
• Fostering resilience  
• Situation analysis and problem-solving  
• Development of good communication skills | • Establishment of rapid and effective emergency response system (REERS)  
• Establishment of counseling and rehabilitation center  
• Development of compensation system |

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### Discussion

This study contributes knowledge regarding the issue of violence against health-care staff, particularly in district Peshawar, Khyber Pakhtunkhwa where little qualitative research on this subject has been done previously. This study aimed to explore the views of hospital system stakeholders regarding the incidents of violence. The three main themes that emerged from the qualitative analysis reflected the stakeholders’ overall view of workplace violence as a health and safety issue for hospital system employees.

Most of the stakeholders described the violence as any form of verbal, physical, and psychological abuse. Almost all the stakeholders regarded verbal abuse as a weapon of choice and the most common form of violence. They agreed that incidents of verbal abuse occur frequently at our hospitals. Similar findings were
highlighted in a qualitative study from Turkey (14). The results of the study showed that among 85.2% of the participants that had been subjected to at least one kind of violence, 79.6% were subjected to verbal abuse (14).

In the present study it was found that compared to physical abuse, the incidents of verbal abuse and psychological or emotional abuse occur more frequently. A study conducted in Barbados described verbal abuse as the most common form of violence against health-care personnel (15). Similarly, higher prevalence of verbal abuse was reported in literature from both local and international literature (16,17).

The present study found that health-care professionals were finding themselves as a victim of violence. They described that such situations were unavoidable and most of the time they felt scared and emotionally drained. They perceived emotional or psychological abuse as a hidden form of violence being practiced routinely. Similar findings were found in a review by Sukhpreet Singh Dubb in which it was stated that reported incidents of violence represent only the tip of the iceberg, being under-reported because of the perception that it comes with the job. The resulting consequences to the victim included psychological burn-out (18).

Our data indicated that some of the health-care professionals shared their negative experiences regarding the behavior of people towards them. They believed most of the time people wanted self-directed care and any disagreement with them provides an excuse for creating violence. Most of the victims of physical abuse were those who tried to stop the perpetrators. Similar findings were highlighted in a cross-sectional study from Iran (19). In this study, it was found that most of the victims of physical violence were those who were trying to stop the aggressors and lack of people’s knowledge about employees’ tasks was the contributing factor (19).

Different stakeholders were of different opinion regarding the causes and contributing factors of violence, such as, “there are many causes that provoke violence such as lack of facilities or malfunctioning of equipment, long waiting times, intolerance or illiteracy of the public, but does that give anyone the right to abuse the service provider?” Moreover, they believed that policy vacuum, inadequate management of administration, and lack of collaboration and security system at institutes create a chaotic workplace environment that results in improper service delivery and frequent incidents of violence. Staff were desensitized to incidents of violence and considered them as a part of their daily routine. Similar findings were identified in a mixed-method study from Gambia in which the stakeholders believed that desensitization comes with the everyday incidents of violence (20).

Based on our analysis, most of the stakeholders believed that lack of education in the general public is the most important cause of violence followed by delayed attention or long waiting time at hospitals, and unmet increased expectation from the health-care institutes that sparks situational triggers and results in such incidents. Similar findings were highlighted in a local study from Karachi city in which illiteracy and lack of awareness among the public were considered as an important cause of violence (21). Furthermore, the lack of implementation of security acts and political involvement were found to be the most important reasons for violence that should be addressed at the level of government. These findings are consistent with previous studies (20–22).

Our study also found that such incidents of violence harmed individuals’ health and institutions. Victims passed through psychological stress and remained silent most of the time. They described that such incidents negatively affected their lives and patient care. To further add to their anxiety, there was a lack of coping
mechanisms at institutions. Similar findings were also reported that there is a relationship between stress and workplace violence. The stress generated due to violence can take the most extreme forms such as burnout or suicide (23).

Our study participants reported that most of the time patients’ attendants, family members, or sometimes the patients themselves were the perpetrators of violence. They were directly involved in such situations. These people were either uneducated or politically spoiled. However, in some situations, the colleagues, hospital staff, and the administration were also indirectly involved by practicing personal, psychological, or power harassment. Similar findings were also reported in Korea and in the same settings through a quantitative survey (16,24).

It was identified that among the many prevention strategies, promoting education is the key to prevent violence. It was found that creating awareness among the public regarding avoidance of violence can make a big difference. Advocacy for violence prevention and implementation of policies regarding the security of health-care institutes were found to be an important step towards a safe working environment. Making hospitals “zero-tolerance zones” for violence was identified as an important factor in averting violence. Similar findings were highlighted in a study conducted by Gordon Lee Gillespee et al, in which they described the importance of education and violence prevention programs for a safe working environment (25).

In the present study, it was found that staff education, collaboration, and skill development was necessary for conveying care and averting violence. Good communication skills and fostering resilience was found important for preventing and handling situational triggers. De-escalation training of hospital staff has shown promising results in the local context (26). Facilitating hospital processes and managing attendants were identified as important factors in preventing violence supported by literature (27).

Our study findings also suggested the establishment of an effective emergency response and security system for crisis de-escalation and protection. The participants said that should be a 24-hours security surveillance system including scanners, cameras, security surveillance officers, and a security center at all hospitals. It was also identified that there should be a rehabilitation center and development of a compensation system for the victims of violence which is consistent with the results of a previous study (28).

The study is limited in that it did not include the experiences of health-care staff in small and remote areas’ health facilities. The study did not include the perspectives of patients and their attendants. The findings also did not thoroughly differentiate the risks for violence by specific occupation or type of facility. Despite these limitations, the study was informative. It revealed that, in the experience of health-care workers interviewed, violence in the Khyber Pakhtunkhwa health-care system has become normalized or as an unavoidable risk.

Conclusion

Results of the study indicate the need to recognize that workplace violent events are observed frequently. The causes and contributing factors for violence against health-care personnel have been documented in this study and many solutions have been put forward. Ending violence against health-care staff is dependent on efforts from various levels. National strategies should be developed to respond to violence against health-care personnel. Stakeholders should be widely and comprehensively consulted about their views and ideas. The recommended measures include policy change, promoting education and awareness, training of health-care
staff, improved security, promoting the role of media to respect and reward the image of health-care staff, and to increase the institutional capacity. Further research should focus on evaluating the effectiveness of these measures.

**Abbreviations**

CMO Casualty Medical Officer  
ER Emergency Room  
FGD Focus Group Discussion  
ICRC International Committee of the Red Cross  
REERS Rapid and Effective Emergency Response System  
WHO World Health Organization

**Declarations**

**Ethics approval and consent to participate**

The study was approved by the Ethics Review Board of Khyber Medical University, Peshawar. Informed written consent was obtained from study participants following an explanation of the study aims and objectives. All procedures were performed with strict ethical standards.

**Consent for publication**

N/A

**Availability of data and materials**

The interview data generated and analyzed during the current study are not publicly available to protect patient confidentiality but are available from the corresponding author on reasonable request.

**Competing interests**

The authors declare that they have no competing interests.

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**Authors Contributions**
MNK, BA, ZUH, MK and MP conceived the idea of this research study and participated in its coordination. BA, MZ, FB, and SK conducted field research activities and were involved in the data collection, cleaning, and initial analysis. Further analysis was supported by MNK, UM, BA, and MK. All authors contributed towards preparing the first draft as well as editing and reviewing the subsequent drafts. The authors read and approved the final manuscript.

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