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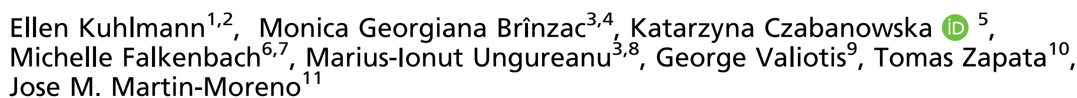
Commentary

Violence against healthcare workers is a political problem and a public health issue: a call to action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Violence against healthcare workers (HCWs) strongly increased during the COVID-19 pandemic and this trend seems to continue.[1–3] The attacks have exacerbated occupational stress and the physical and mental health risks of individual HCWs while also creating new threats for healthcare and societies. The violence has spilled over to social media and the private sphere and created new forms of hate crimes and harassment.[4] Live-threatening physical aggression, primarily known from war and conflict settings, now occurs in ordinary workplace settings.[5] International estimations highlight that about every second HCW globally have been affected by violence once in their work lives[6] and up to 38% suffer physical violence at some point in their careers.[1] The frequency and patterns may vary between countries, but violence against HCWs is now also a problem in countries with developed healthcare systems and high levels of trust in institutions and professionals.

The COVID-19 pandemic emerged as a focal point for this violent trend and created new areas of confrontation. The reasons behind the violence are complex and the threats are not limited to HCWs and the workplace. Violence against HCWs is often aimed at the healthcare system and their political representatives and, finally, the democratic state and humanitarian values. Violence seeks to destroy trust in health policy and hamper the right to health for all. Furthermore, it is an attack on democratic states, humanitarian values and civil society.

Systematic monitoring and data are still poor, but the World Health Organization (WHO) and other international organizations and professional associations have taken action.[1,6–9] Recently, the 'Framework guidelines for addressing workplace violence in the health sector', developed jointly by WHO, International Labour Organization, International Council of Nurses and Public Services International to support the development of violence prevention policies in non-emergency settings and document and research violence in such settings, have become available.[1] However, no protective measures and prevention policies have been implemented so far. Most importantly, violence against HCWs is not adequately recognized as a political issue and public health crisis.[3,5] It is largely absent from health workforce policy and the European and national pandemic recovery plans and debates over health system resilience.

Understand the threats and public health dimensions of violence against HCWs

This Commentary seeks to address the complex political and public health dimensions of violence against HCWs and highlights the need for action. We argue that public health can, and should, play an important role to raise awareness and improve protection of HCWs, connect different stakeholder groups and establish coordination across sectors and policy areas. A transsectoral and multiprofessional governance approach may help us to better understand the different forms of violence and the factors that worsen the attacks. Four major target groups of violence can be identified for non-conflict settings. The situation of HCWs in war and conflict regions is not considered in this work, but it should be mentioned that this group also needs greater public health attention and solidarity.

Frontline HCWs

During the pandemic, verbal and physical violence against frontline HCWs, especially physicians and nurses but also many others, have strongly increased.[2,3] Frontline HCWs were obliged to implement the COVID-19 lockdown and distancing policies in practice, oversee quarantines, check vaccination status and protective mask-wearing, and communicate service delays as well as severe illness and death to patients and family. The violence of patients and relatives towards individual HCWs was often a reaction to these conditions resulting in high levels of frustration, fear and emotionally difficult situations. The result, for many HCWs, was that violence became an everyday threat and part of their routine work. Some frontline HCWs even employed, and paid for, private security services to improve

protection. In addition, the levels of stress, exhaustion and burn-out for HCWs dramatically increased, thereby worsening recruitment and retention and exacerbating workforce shortages.

HCWs in emergency care and highly politicized healthcare services

HCWs in emergency care are generally at higher risk for violent attacks.[1,2] However, new anti-democratic movements in the form of coronavirus denial and anti-vaccination as well as an increase in right-wing populism and neo-fascism in Europe worsened the situation.[10] A common denominator of these developments is their anti-democratic nature and rejection of scientific evidence, government institutions, equality, diversity and human rights, including the right to health. Within this context, HCWs in emergency care and those providing vaccination, abortion and reproductive health services, among others, as well as services for minority and vulnerable groups (e.g. asylum seekers, migrants, LGBTQ people) became the target and surrogate for attacks on the state and its institutions. A strong and coordinated political response to these attacks is therefore necessary.

HCWs affected by the gender-based and sexual violence dimension

Women account for the vast majority of the health workforce and violence is no gender-neutral threat.[8] Gender-based and sexual violence is widespread and most often affects women HCWs. Unfortunately, there is a severe lack of data, research and knowledge resulting in a scarcity of political will and policy-making. There is an urgent need to break the silence and improve protection and create more sensitivity,[8] also for sexual violence against minority women HCWs and some men.

HCWs affected by the racialized violence dimension

Healthcare systems increasingly rely on migrant HCWs. We can therefore assume that this group is also affected by growing violence. Specific protection may thus be necessary against the backdrop of anti-democratic political movements in some areas. Similar to gender-based violence, data in this area are scarce leading to a lack of political action in the realm of public health.

Policy recommendations

- Prepare HCWs. Integrate violence prevention in education and training, e.g. training in self-protection against violent attacks; coping strategies for mental health and wellbeing; communication strategies to de-escalate violence; team-based multi-professional training models to improve coordinated action—*micro-level, actor-centred*.
- Protect HCWs. Improve the scope and enforcement of existing laws and define violence prevention as a management task; implement zero tolerance guidelines, prevention and protection strategies; establish information, helplines and mental health support—*organization and management level*.
- Establish monitoring and reporting systems, improve research evidence and funding programmes—*health policy level*.
- Engage the public, media and communities, including the police. Improve sensitivity; launch a coordinated campaign—*local public policy level*.
- Strengthen civil society and leadership of international public health organizations to respond with coordinated action—*global/EU public health policy level*.
- Take action against violence on HCWs on all levels of governance, including addressing its gender-based and racialized forms.

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