Workplace violence in the health sector

Relationship between work stress and workplace violence in the health sector

by

Vittorio di Martino

Geneva, 2003




ILO/ICN/WHO/PSI

Workplace violence in the health sector

Relationship between work stress and workplace violence in the health sector

by

Vittorio di Martino [*]

v.dimartino@worldonline.fr

Geneva, 2003

[*] Vittorio di Martino is an international consultant who specializes in health and safety at work, enterprise development and organizational well-being. He is Visiting Professor in Employment Policies at the University of Bath and Senior Research Fellow at UMIST in Manchester, UK. His recent books include *Work organization and ergonomics*, ILO, Geneva, 1998; *Violence at work*, ILO, Geneva, 1998 (1st ed.), 2000 (2nd ed.); *The high road to teleworking*, ILO, Geneva, 2001.

Foreword

Stress and violence are increasingly noted in health sector workplaces. Doctors, nurses and social workers are all high on the list of occupations with serious stress levels, while violence in the health sector constitutes almost a quarter of all violence at work. The enormous cost of work stress and violence at work for the individual, the workplace and the community at large is becoming more and more apparent. Employers and workers are equally interested in the prevention of violence and severe stress at the workplace.

In 2000, the International Labour Office (ILO), the International Council of Nurses (ICN), the World Health Organization (WHO) and Public Services International (PSI) launched a joint programme in order to develop sound policies and practical approaches for the prevention and elimination of violence in the health sector. When the programme was first established and information gaps were identified, it was decided to launch a number of country studies as well as cross-cutting theme studies and to conclude by drafting guidelines to address workplace violence in the health sector. A list of the Joint Programme working papers is included in the appendix to this document.

This study was carried out in the framework of the Joint Programme in 2001. It presents an analysis of the relationship between work stress and workplace violence in the health sector.

In response to the growing concern about work stress and workplace violence in all services sectors, the ILO's Sectoral Activities Department further commissioned a series of working papers in preparation for the Meeting of Experts to be held from 8 to 15 October 2003 in Geneva, to consider and review a draft and to adopt a *Code of practice on violence and stress at work in services: A threat to productivity and decent wor*k. That Meeting is part of the continuing work of the department on 22 sectors of economic activity, of which the health sector is one. More information is available online at http://www.ilo.org/public /english/dialogue/sector/themes/violence.htm .

It is hoped that this study can help to promote action to tackle violence and stress in health sector workplaces, and complement work being carried out by the ILO, ICN, WHO, PSI and other organizations at various levels to assist in reducing or eliminating stress and violence at workplaces in services sectors around the world.

Steering Committee of the ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector

Contents

Executive summary

Based on an extensive literature analysis, this study tackles the topical issues of stress and violence at work in the health sector. The paper highlights the magnitude of the problem; the key factors at stake; the way such factors interrelate; their impact on working conditions and employment; and the cost to the individual, the enterprise and the community. Part III of the paper offers innovative approaches to coping effectively with such problems.

Stress and violence are widespread in the health sector. Doctors, nurses and social workers are all high on the list of occupations with serious stress levels while violence in the health sector constitutes almost a quarter of all violence at work. When stress and violence interact at the workplace, and they often do, their negative effects cumulate in an exponential way, activating a vicious circle which is very difficult to break.

Focusing on the interrelationship between stress and violence at the workplace, the study identifies negative stress as a cause of violence. The more negative stress is generated the greater the likelihood of violence, up to the most extreme forms such as burnout, suicide and homicide. The connection is not, however, an automatic one. The vast majority of people under severe negative stress – and this happens to everyone at times – do not become perpetrators of violence. It is usually the combination of stress with a number of additional factors, such as alcohol abuse, that triggers violence at the workplace. While the relationship stress/violence is usually mediated, the relationship violence/stress is direct and straightforward. In practically all cases violence, including minor acts, generates distress in the victims with long-lasting, deleterious effects on their health.

Extensive restructuring in the health sector further exacerbates the situation. Privatization, decentralization and rationalization are deeply affecting conditions of work and employment. These processes are often accompanied, although with different intensity from country to country and from situation to situation, by downsizing, layoffs, freezes or cuts in salaries, heavier workloads and faster pace of work, longer hours of effective work, less comfortable shifts and working unsocial hours, more subcontracting, more temporary and occasional work. These are all recognized potential stressors and may eventually lead to a climate of violence driven by uncertainty, growing exasperation and vulnerability.

Health care is not only a high risk sector as far as stress and violence are concerned, but it is also typically a sector with high levels of female employment. Exposure to the risks of stress and violence is therefore particularly high for women. It is even higher for certain types of violence, such as sexual harassment, where the victims are predominantly women. And it can be extremely high for women who are especially vulnerable such as those in precarious, low-paid, low-status jobs. In the European Union the figures for sexual harassment of working women generally are twice the average, as well as those for workers with a precarious status. They are even higher for young women and workers in the service sector.

The costs involved for the individuals concerned, the enterprises and the community at large are enormous. Stress and violence cause immediate and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment. Data from the European Union show a very significant correlation between violence and stress with the cost of stress calculated at 20 billion euro each year. In the United States, the cost of stress has been calculated at US$350 billion per year and the cost of violence alone has been calculated at $35.4 billion. Altogether it is estimated that stress and violence account for approximately 30 per cent of the overall costs of ill-health and accidents. Based on the above figures it has been suggested that stress/violence may account for 0.5 to 3.5 per cent of GDP per year.

The present study shows that quantifying the cost of violence is crucial to the shaping of anti-violence strategies, both in the developing and the industrialized world. The proliferation of informal, precarious and marginal situations at work increasingly shifts attention towards a "high-road" response whereby the key role of cost-effective programmes and action which fit naturally into the socio-economic development of the enterprise is highlighted and used to enhance further initiatives.

Within this new approach the quality of the working environment, including its physical and organizational setting, can make a significant contribution to reducing the risks of stress and violence. The importance of these issues is increasingly recognized, with attention focusing on the fundamental role of prevention in effectively combating stress and violence at work. The emerging approach focuses on eliminating the causes of stress and violence rather than on treating its effects. This approach includes a long-term appreciation of each intervention.

The study also highlights the crucial role of social dialogue in defusing situations of work-related stress and violence in the health sector. A participatory approach whereby all parties concerned have an active role in designing and implementing anti-stress and anti-violence initiatives is therefore strongly recommended.

The high-road approach opens the way to a natural proliferation of initiatives largely based on self-sustainability. The study recommends that positive examples and best practices be widely disseminated among all parties concerned. The message delivered is very powerful, since it is based on real experience, deals with concrete issues, refers to situations in which the parties can recognize themselves and offers practical suggestions for immediate action. Policy-makers at all levels should sustain this natural process by offering stimulation and encouragement, creating networks, raising awareness, issuing guidelines and enacting appropriate legislation.

Part I

Understanding concepts

1. Definition of stress and violence

Defining stress and violence is a major challenge. Perceptions, attitudes, cultural backgrounds, academic theories, and operational approaches, all have a bearing on the way stress and violence are defined. Furthermore, they vary greatly from country to country and from one situation to another. While this complex problematic is beyond the scope of the present study, the following definitions are given in order to establish a shared basis of understanding on which to tackle the subject.

1.1. Stress

The physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources or needs of the employee.

Positive and negative stress

Under normal circumstances the reaction mechanisms of employees should enable them to find new balances and responses to new situations. Stress is, therefore, not necessarily a negative phenomenon. It would be a mistake to concentrate only on the pathological aspect of stress without emphasizing its importance in an individual's dynamic adaptation to a given situation. If health is considered as a dynamic equilibrium, then stress is part of it for there is no health without interaction with other people and with the environment. Only excesses are pathological.

Some stress, therefore, is normal and necessary. But if stress is intense, continuous or repeated, if the person is unable to cope or if support is lacking, then stress becomes a negative phenomenon leading to physical illness and psychological disorders. From early disorders to real illness, the harmful consequences of stress cover a broad range from chronic fatigue to depression, insomnia, anxiety, migraines, emotional upsets, stomach ulcers, allergies, skin disorders, lumbago and rheumatic attacks. It can culminate in the most serious consequences of all: heart attacks, accidents and even suicides.

1.2. Violence

Incidents where employees are abused, threatened, assaulted or subjected to other offensive behaviour in circumstances related to their work.

Physical violence and psychological violence

While the existence of physical violence at the workplace has been always recognized, the existence of psychological violence has been long underestimated and is only now receiving due attention. Psychological violence is currently emerging as a priority concern at the workplace leading to a new awareness and re-evaluation of the importance of all psychological risks at work.

It is also increasingly recognized that psychological violence is often perpetrated through repeated behaviour, of a type which by itself may be relatively minor but which cumulatively can become a very serious form of violence. Although a single incident can suffice, psychological violence often consists of repeated, unwelcome, unreciprocated and imposed action which may have a devastating effect on the victim.

Physical and psychological violence often overlap in practice, making any attempt to categorize different forms of violence very difficult. Some of the most frequently used terms related to violence are presented in the following list.

Assault/attack: Attempt at physical injury or attack on a person leading to actual physical harm. It includes beating, kicking, slapping, stabbing, shooting, biting, sexual assault and rape, among others.

Threat: Menace of hurt or injury resulting in fear of physical, sexual, psychological harm or other negative consequences to the victim(s).

Abuse: Behaviour that departs from reasonable conduct and involves the misuse of physical and psychological strength. ***It includes harassment, bullying and mobbing***.

Harassment: Unwanted conduct – verbal, non-verbal, visual, psychological or physical – based on age, disability, HIV status, domestic circumstances, sex, sexual orientation, race, colour, language, religion, political, trade union or other opinion or belief, national or social origin, association with a minority, birth or other status that negatively affects the dignity of men and women at work. ***It includes sexual harassment.***

Sexual harassment: Unwanted conduct that is perceived by the victims as placing conditions of a sexual nature on their employment, or that might, on reasonable grounds, be perceived by the victims as an offence, a humiliation or a threat to their well-being.

Bullying/mobbing: A form of psychological harassment consisting of persecution through vindictive, cruel, or malicious attempts to humiliate or undermine an individual or groups of employees, including unjustified, constant negative remarks or criticisms, isolating a person from social contacts and gossiping or spreading false information.

2. Stress as a source of workplace violence

A number of circumstances and various actors influence stress and violence at work. To connect these elements, two working models are presented, for stress and violence respectively, that can facilitate the understanding of these problems and their solution.

2.1. The Karasek model

The Karasek model is based on three variables:

I. *Demands (psychological demands)*: The pressures put on the individual by the work environment including workload, pace of work, length of working hours, time schedules, tight deadlines, etc.

II. *Control (decision latitude)*: The individual's capacity to respond to work demands and pressures, including autonomy, responsibility, skill, training, experience, etc.

III. *Support (social support)*: The characteristics of the social environment in which working activities are performed including organizational culture, working climate, management style, help from co-workers, involvement, participation, teamworking, etc.

By combining *control* and *demand* four situations can be identified; they are represented in four quadrants in the graph below:

1. Passive – **Low control/low demand**

   Passive situations where the employee has little control but where demands are also low. This leads to stress in the form of monotony and boredom.

2. High strain – **Low control/high demand**

   Situations where the employee has little control but demands are high. This leads to high stress.

3. Low strain – **High control/low demand**

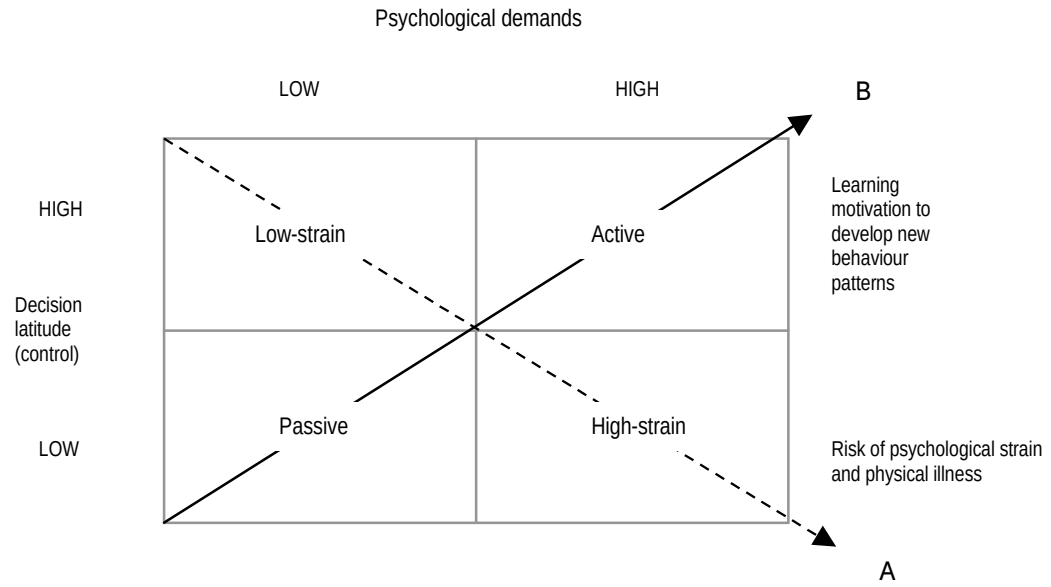
   Relaxed or low-strain situations where the employee has a lot of control and demands are low. This leads to little stress.

4. Active – **High control/high demand**

   Situation where the employee has to respond to high demands, but at the same time can exercise high control. This leads to an active situation were most people feel they can somehow manage stress.

These are not static situations. By operating on the levels of *demand* and *control* along arrow A or arrow B in the graph below it is possible to shift situations to more favourable/unfavourable positions within a quadrant or even to a more favourable/unfavourable quadrant.

The Karasek model



Source: Karasek and Theorell, 1990, p. 32.

According to the model:

– Stress increases when control declines in combination with rising psychological demands or stressors.

– Stress decreases when control increases in combination with falling psychological demands or stressors.

– Social support (not shown in the graph) operates as a "facilitator" in reducing stress at work. Stress will decrease when social support increases.

2.2. How stress generates violence

Within this model the more one moves into the lower-right part of the high-strain area, the more negative stress is generated; this can lead to the most extreme consequences such as burnout, suicide and violence. Negative stress as a source of violence has been identified for several occupations (Kop et al., 1999, pp. 326-340; Guinn, 1983, p. 185).

On the victim's side, stressors have been identified as predictors of violence. In a 1997 American study covering a sample of approximately 7,000 state employees of the State Bureau of Employee Health, the relationship between the occurrence of on-the-job physical assaults and 11 different job stressors was examined. Four of the 11 stressor variables examined were found to be associated with assaults on both men and women. Limited job control, high levels of responsibility for other people, limited opportunities for alternative employment and skill under-utilization were all found to be significant predictors associated with assault for both sexes. The authors concluded that assaults may occur more frequently among highly stressed workers than among those experiencing less stress (Hurrell et al., 1997, pp. 163-170).

It important, however, to point out that the connection is not an automatic one. The vast majority of people under severe negative stress – and everyone experiences this at some time – do not become perpetrators of violence. It is usually the combination of stress

with a number of additional factors, such as alcohol abuse, that triggers violence at the workplace.

2.3. Applying the model to the health sector

By applying the Karasek model to the health sector, we can identify a number of occupational situations which are at special risk of negative stress and which may be involved with workplace violence. Karasek himself has analysed the occupational distribution of physicians, nurses, health technicians and nurses' aides in a sample of 4,495 male and female US workers. While physicians and nurses were placed in the active job quadrant, health technicians and nurses' aides were placed in the high-strain quadrant, the one most at risk.

The position of health sector occupations in the Karasek model

Low-strain	Physician Active Nurse
Passive	Heath technician High-strain Nurses' aides

Source: Karasek and Theorell, 1990, p. 43.

According to Karasek more favourable positions were obtained for all categories of health workers when the variables of social recognition and social support were included in the analysis. Other studies confirm the importance of social support in this respect. A cross-cultural study involving 554 Canadian and 272 Jordanian nurses indicated that support was the most important predictor of job-related satisfaction for nurses in both countries (Armstrong-Stassen et al., 1998, pp. 41-47).

While stress may increase the likelihood of workers in the health sector becoming violent towards their patients and co-workers, patients, as well as their family members and other visitors, may in turn be subject to intense negative stress and this may generate acts of violence against those workers, particularly those perceived as more vulnerable such as nurses' aides (Boyd, 1995, pp. 451-519).

3. Workplace violence as a source of stress

3.1. The Chappell – di Martino model

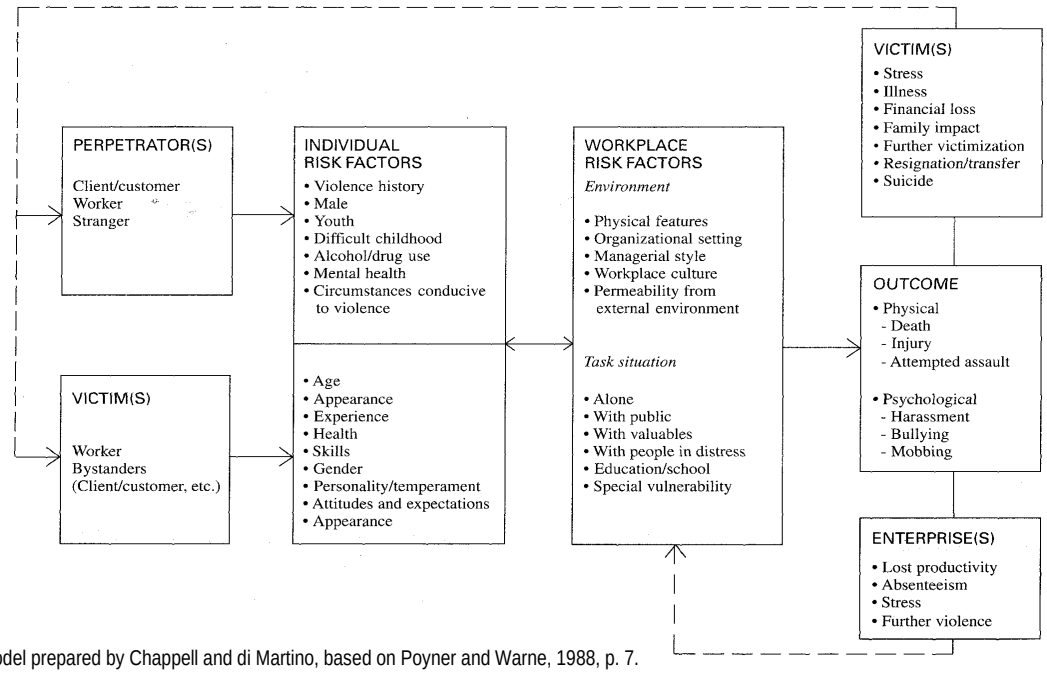
The model is based on an interactive analysis of all the elements generating stress, linking together personal, occupational and environmental factors.

On the personal side the assailant and the victim come into consideration. The perpetrator of violence is likely to fall into one of three principal categories – a client of a particular enterprise, a colleague, or a bystander. The victim is likely to be an employee or a bystander, such as a customer or an employee of another enterprise accidentally present when violence takes place.

The individual characteristics of both the perpetrator and the victim play an important role in the determination of violent situations. The model suggests that violence is more likely to occur when people with "conflicting" personal characteristics meet. However, given the variety of such characteristics, it is practically impossible to predict the occurrence of violence on this basis. A further complication is the fact that individuals operate in different working environments that may, in turn, defuse or trigger violence.

The model focuses therefore on the relationship between personal and environmental factors at work, highlighting their combined role in generating or defusing violence. Finally the model identifies the likely impact of all relevant factors and situations on the victim and the enterprise, and assesses the "feedback" of this impact as a regenerator of violence at the workplace. It is a model that strongly emphasizes the difficulty of eliminating violence once it is in place and the absolute necessity of combating violence by preventive action tackling all the elements involved in an integrated way (Chappell and di Martino, 1998, p. 63).

The Chappell – di Martino model



Source: New model prepared by Chappell and di Martino, based on Poyner and Warne, 1988, p. 7.

3.2. How violence generates stress

The build-up of violence and the sequence leading to its negative impact on the physical and psychological well-being of the workers concerned are both clearly shown in the model. While the relationship stress/violence is usually mediated, the relationship violence/stress is direct and straightforward. In practically all cases violence, including minor acts, generates distress in the victims with long-lasting, deleterious effects on their health. A major study of the European Foundation for the Improvement of Living and Working Conditions, Dublin, based on 21,500 face-to-face interviews with workers throughout the European Union indicated that:

– 40 per cent of workers exposed to physical violence experience stress;

– 47 per cent of workers exposed to bullying experience stress;

– 46 per cent of workers exposed to sexual harassment experience stress (European Foundation for the Improvement of Living and Working Conditions, 2000, p. 4).

A Canadian survey conducted in 1995-96 on home health-care workers fully confirms the major contribution of workplace violence to stress generation in this sector. The situations of work-related violence shown in the following table were reported by the 674 home health-care workers who participated in the survey to be highly correlated with stress.

Home health-care workers
Situations of work-related violence highly correlated with stress

Crime
You fear being a victim of crime on the job
You have been the victim of crime on the job
Dealing with difficult clients
You deal with difficult clients
You deal with difficult family members
Safety hazards in homes and neighbourhoods
You are exposed to hazards in clients' homes and neighbourhoods (ice, dim lighting, dogs, scatter mats, etc.)
Racial and sexual harassment
Exposure to inappropriate racial/ethnic comments or behaviour
Exposure to inappropriate sexual comments or behaviour

Source: Denton et al., 2000, p. 425.

3.3. Applying the model to the health sector

Within the Chappell – di Martino model a number of occupational situations have been identified where the risks of exposure to violence and resulting stress are particularly significant.

Working alone

People working alone are at special risk of physical and sexual attacks. Many workers in the health sector, such as night nurses, do work alone or in relative isolation and are therefore subject to a greater risk of violence.

Working in contact with the public

A wide variety of occupations, including many in the health sector, involve contact with the public. While in most circumstances this type of work does not generate special problems, there are cases where exposure to the public can create a higher risk of violence.

Working with valuables and handling cash

Whenever "valuables" (such as drugs) are, or seem to be, within easy reach, there is a risk that crime, and increasingly violent crime, may be committed. Workers in many sectors, including the health sector, are exposed to such a risk.

Working in an environment increasingly "open" to violence

Working environments which were quite immune from violence in the past are becoming progressively affected. The increase of violence in schools, but also in health care institutions, is part of this trend.

Working in conditions of special vulnerability

Increasing numbers of workers are becoming engaged in occasional and precarious employment, exposed to the risk of poor working conditions, downsizing and job loss as well as violence. Those in the health sector are not immune from this trend.

Working with people in distress

Frustration and anger arising out of illness and pain, problems of old age, psychiatric disorders, alcohol and substance abuse can affect behaviour and make people verbally or physically violent. Violence is so common among workers in contact with people in distress that it is often considered an inevitable part of the job. Health-care workers are at the forefront of this situation.

The fact that health professionals are exposed to practically all the situations where there is a risk of violence at work makes this category of workers unique in terms of the importance and spread of violence and consequent stress.

It must be emphasized, however, that, while all health workers are particularly vulnerable to workplace-related violence, the risk, as we have already observed for stress, is quite unevenly distributed. The table below, which relates to the National Health Service in the United Kingdom, demonstrates the point.

Incidence of violence by occupation (UK)

	Major acts of violence (%)	Minor acts of violence (%)
Student nurses	1.6	36.4
Staff nurses	0.0	20.2
Charge nurses	1.6	17.2
Ambulance staff	1.7	17.4
General practitioners	0.5	0.5
Porters	0.0	8.1
Hospital doctors	0.5	5.9

Source: C. Cardwell, 1991, p. 49.

4. Cumulative effects of stress and violence

When stress and violence combine at the workplace, and they often do, their negative effects cumulate in an exponential way and activate a vicious circle which is very difficult to break. The combined, negative impact of stress and violence is further magnified by the dimension of the two problems.

4.1. Magnitude of the problem

Several occupations in the health sector are high on the list of occupations with serious stress levels. The following table, listing those occupations which equal or exceed the rate of 6 on a scale of 0 to 10, has been elaborated by the University of Manchester Institute of Science and Technology.

Occupations with high stress levels

Occupation	Rating scale
Miner	8.3
Police officer	7.7
Prison officer	7.5
Construction worker	7.5
Airline pilot	7.5
Journalist	7.5
Advertising executive	7.3
Dentist	7.3
Actor	7.2
Doctor	6.8
Broadcasting personnel	6.8
Nurse	6.5
Film production crew	6.5
Ambulance personnel	6.3
Musician	6.3
Firefighter	6.3
Teacher	6.2
Social worker	6.0
Personnel manager	6.0

Source: University of Manchester Institute of Science and Technology, 1987.

In turn, violence in the health-care sector, as the following table shows, may constitute almost a quarter of all violence at work. Only when these figures are considered together can one fully appreciate the devastating effects of the combined action of stress and violence on health workers.

Sectors with high violence levels (Sweden)

Health care	24 %
Social services	23 %
Retail	4 %
Post	7 %
Banking	7 %
Transport	7 %
Security	2 %
Police	5 %
Education	7 %
Child care	4 %

Source: Nordin, 1995, p. 3.

4.2. Broader inter-connections

It is becoming clear that stress and violence not only interact with each other but also with a range of other major health-related concerns, such as alcohol, drugs, tobacco and HIV/AIDS. Drugs and alcohol, violence, stress, tobacco and HIV/AIDS are major threats to the workplace. Taken together they are likely to be responsible for a great number of occupational accidents, disease, disability and fatalities at work and in society. The problem affects nearly all countries, all sectors and all categories of workers. The combination of these factors exacerbates the problem.

The interrelationship between these problems, particularly between stress, violence, alcohol and drugs is increasingly recognized. It has been the object of many studies, although a full understanding of the factors involved and the mechanisms by which they operate is far from being achieved. What appears certain, in any case, is that the appearance of one of these problems at the workplace is unlikely to remain an isolated case but will be linked with the other areas of health and safety deterioration, spreading rapidly and proliferating across the entire workplace (Ugon, 2001, p. 565).

The importance of these connections is also emerging in the health sector. Several studies of medical students conducted over the last decade suggest that there is a high prevalence of experiences perceived as abusive – such as being yelled at, physically assaulted, sexually harassed and psychologically humiliated – and that these experiences constitute risk factors for stress and serious psychopathological damage. It has also been postulated that one specific outcome includes alcoholism (Rosenberg and Silver, 1984, pp. 739-742; Richman et al., 1996, pp. 391-403).

Part II

Specific implications for the health sector

5. Sector-specific environment and change processes as causes of stress and violence

A great number of factors contribute to stress and violence generally, and in the health sector particularly. Analysing these elements effectively is a very complex matter because the relevant factors often overlap and interact with each other.

5.1. Identifying the relevant factors

The lists in the following tables provide a good starting point for the analysis of this problem. The first table covers the stressors of nursing, while the second one identifies the factors associated with violence against health-care workers.

Stressors of nursing: Psycho-social and organizational hazards

Source of stress	Psycho-social or organizational hazard
1. Job design and workload	– ambiguity – work overload – lack of control – dealing with death and dying
2. Interpersonal relationships at work	– conflict with other staff – conflict with medical staff; doctors' behaviour – conflict with other nurses
3. Relationships with patients and their families	– inadequate preparation for dealing with emotional needs of patients and their families
4. Work organization and management of work	– lack of staff support – staff movement – difficulties with management and supervisors – lack of resources and staff shortages
5. Technical aspects of nursing	– concern about treatment and patient care
6. Personal	– concern about technical knowledge and skills

Source: T. Cox et al., 1996, p. 9.

Factors associated with violence against health-care workers

Factor level	Worker characteristic	Violence initiated by		
		Client	Other employees	Outside assailant
Individual				
– Cognitive deficits		x		x
– Psychiatric diagnosis	x	x	x	x
– Use of drugs or alcohol	x	x	x	X
– Length of stay		x		
– Victim of violence or other trauma	x	x	x	x
– Level of hostility	x	x	x	x
– Fatigue	x		x	
– Level of professionalism	x		x	
– Training in violence prevention	x		x	
– Age	x	x	x	x
– Gender	x	x	x	x
– Job title	x		x	
– Personality variables	x	x	x	x
Interactional				
– Confrontational style	x	x	x	
– Rushed	x		x	
– Presence of others	x	x	x	x
Work organization				
– Job demands and control (and other factors associated with job stress)	x		x	
– Wait time for service		x		
– Level of bureaucratic demands	x	x	x	
– Presence of security features		x	x	x
– Visibility of work area		x	x	x
– Shift worked	x		x	
– Job turnover rates	x		x	
Community/neighbourhood				
– Level of crime		x		x
– Level of poverty		x		x
– Level of drug use		x		x
– Density		x		x
– Home ownership		x		x
– SES		x		x
– Level of gang violence		x		x

Factor level	Worker characteristic	Violence initiated by		
		Client	Other employees	Outside assailant
Societal				
– Economic situation (e.g., expanding vs. shrinking number of jobs, unemployment rate, global competition)	x	x	x	x
– Cultural acceptance of the expression of anger	x	x	x	x
– Cultural acceptance of the expression of violence	x	x	x	x
– Increased diversity in the workplace	x	x	x	x
– Shifting family structures	x	x	x	x

Source: Curbow, 2001.

5.2. Selecting common key issues

Despite the significant differences in the two lists, it is evident that they reflect a very similar approach in identifying the factors leading to stress and violence in the health sector and in the way they are organized. A number of common key issues emerge from the two lists. They can be summarized as follows:

- Personal
- Interpersonal
- Gender
- Environmental
- Organizational
- Change

This convergence is extremely significant. By concentrating on the common key issues, it is not only possible to better "read" the factors leading to stress and violence in the health sector but also to gain a better understanding of the combined impact of stress and violence. This is most important.

6. Impact on working conditions and employment

Before embarking on an analysis of the specific factors leading to stress and violence and their impact in the health sector, the following general implications at the individual, workplace and societal level, need to be highlighted.

For the individual

Negative stress activates a variety of physical and emotional symptoms that can lead to serious illness if the situation persists. These include a broad band of pathological consequences, ranging from chronic fatigue to depression, and including insomnia, anxiety, migraine, emotional upsets, allergies and abuse of tobacco and alcohol.

In the longer term, stress can contribute to hypertension, and consequently to the development of heart and cerebrovascular disease, as well as to peptic ulcers, inflammatory bowel diseases and musculoskeletal problems. It may also alter immune functions, which may in turn facilitate the development of cancer (ILO, 1992, p. 13).

Suffering and humiliation resulting from violence usually lead to lack of motivation, loss of confidence and reduced self-esteem. As with stress, if the causes of violence are not eliminated or its impact contained by adequate intervention, these symptoms are likely to develop into physical illness, psychological disorders or dependence on tobacco, alcohol or drugs.

At the workplace

Stress and violence cause immediate, and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment. Employers bear the direct cost of lost production and more expensive security measures. They are also likely to bear the indirect cost of reduced efficiency and productivity, the deterioration of product quality, poor company image and a reduction in the number of clients.

In the community

Stress may eventually result in unemployment, psychological and physical problems that strongly influence an individual's social position. The costs of violence include health care and long-term rehabilitation for the reintegration of victims, unemployment and retraining costs for victims who lose their jobs as a result of such violence, and disability and invalidity costs where the working capacities of the victims are impaired by violence at work.

6.1. Personal/interpersonal issues

The importance of early recognition of pre-conditions and signals of stress and violence needs to be emphasized since it allows for intervention before stress becomes a major problem or violence manifests itself. The following should be considered:

Stress

Symptoms

- dry throat, muscle tension, headaches, indigestion, tics, insomnia, high blood pressure;
- irritability, impulsive behaviour, difficulty in making decisions, sudden increase in smoking or alcohol use;
- excessive worrying, feeling of worthlessness, brooding, forgetfulness, nervousness, daydreaming, etc.

Several studies conducted in various hospitals in Sweden have suggested that coffee drinking and smoking at work, together with the use of alcohol after work, represent socially acceptable habits for staff to deal with high stress levels at work. This implies that staff are taking frequent breaks during working hours and not attending to patients, which could be an indirect form of provocation to patients who feel the need for staff attention (Arnez, 1998, p. 26).

Type A and type B behaviour

A variety of personal factors contribute to stress and the individual's capacity to cope with it. A major effort in organizing such factors has been the identification of two major types of behaviour: type A and type B associated with proneness to coronary diseases. The "personality" characteristics of the typically coronary-prone individual, include:

– an intense sustained drive to achieve self-selected but poorly defined goals;

– a profound inclination and eagerness to compete;

– a persistent desire for recognition and advancement;

– continuous involvement in multiple and diverse functions constantly subject to time restrictions;

– habitual propensity to accelerate the rate of execution of many physical and mental functions;

– an extraordinary mental and physical alertness.

The coronary-immune type, type B, displays the opposite characteristics (Cox, 1978, p. 9).

A high ratio of type A workers in health care has been suspected, particularly in the case of doctors. Evidence, however, is far from conclusive in this respect. A British study on a sample of 917 general practitioners showed that the distribution of type A behaviour among GPs was consistent with population norms, with no differences observed between men and women (Sutherland and Cooper, 2000, p. 144).

Violence

Perpetrator

The following factors appear to be particularly relevant:

- history of violent behaviour;
- being *male*;
- being a young adult;
- experience of difficulties in childhood, including inadequate parenting, troubled relationships within the family and low levels of school achievement;
- problems of psychotropic *substance abuse*, especially problematic *alcohol use*;
- severe *mental illness*, whose symptoms are not adequately identified or controlled through therapeutic regimes;
- being in situations conducive to self-directed or interpersonal violence, including access to firearms (McDonald and Brown, 1997, p. 2).

The most frequently recurring characteristics of people who are violent towards health workers are shown in italics in the above list: the length of stay, particularly in residential care, and a high level of hostility and anger should be added to the list (Curbow, 2001). Other features in the list may be more difficult to detect immediately and this may explain their absence from the evidence gathered so far.

While the above features deserve consideration, it should be borne in mind that violence is always difficult to predict and that, since both the perpetrators and the victim vary widely in age, sex, race and background, it is important to avoid stereotyping, which can lead to discrimination.

Victim

There are many attributes of a victim of workplace violence which could be associated with the degree of risk. These include appearance, health, age and experience, gender, personality and temperament, attitudes and expectations.

Appearance and first impressions are important in any job, as they can set the tone of the interaction and establish the role characteristics for an encounter. In occupations involving direct contact with members of the public, for instance, the wearing of a uniform may encourage or discourage violence. Uniforms are often worn in occupations where employees are expected to act with authority or have the respect of members of the public. Uniforms also identify staff and distinguish them from the public. It is likely that in many circumstances uniforms will discourage violence, but there are situations in which the presence of uniformed staff is resented, and which can provoke abusive or violent behaviour. In the United Kingdom, for example, an increasing number of cases of aggression against ambulance staff has been reported because of general public hostility towards people wearing a uniform like that of police officers. For this reason, ambulance staff are now beginning to wear green boiler suits rather than blue uniforms, to distinguish them from law enforcement officials.

The health of workers can also influence how they interact with clients and the public at large. Stress from a heavy workload, and we have seen how much stress is on workers in the health sector, may lead to misunderstandings or misleading behaviour which precipitate aggressive responses. The age and experience of workers is another factor that can either increase or diminish the possibility of aggression. Previous experience of handling similar difficult situations, which is obviously associated with age, should enable workers to react more wisely than inexperienced staff. This explains the higher risk of violence towards young nurses' aides compared with the risk for more experienced older nurses.

The personality and attitude of workers is also relevant in considering risks of victimization. Some workers are better than others at handling difficult situations, a quality which is usually associated with less tangible personality characteristics and style of behaviour. The attitude of workers, and their job expectations, can also be factors influencing aggressive behaviour. For example, staff members who are working in an enterprise which is about to be shut down, or undergoing major restructuring as in the case of many health care institutions nowadays, are less likely to be tolerant in their encounters with clients.

6.2. Gender issues

The health sector is not only a high risk sector as far as stress and violence is concerned, but also typically a sector with high levels of female employment. Exposure to the risk of violence is therefore particularly high for women. The risk is even higher for certain types of violence, such as sexual harassment, where the victims are predominantly women. And it can be extremely high for women who are especially vulnerable such as those in precarious, low-paid, low-status jobs.

In the European Union the figures for sexual harassment of women are twice the average, as well as those for workers with a precarious status. They are even higher for young women and workers in the service sector (European Foundation for the Improvement of Working and Living Conditions, 2000, p. 3). Although these percentages cannot be simply added one to the other, it is evident that a young woman, on a short-term job in the health sector, can be at very high risk of violence.

The relationship between gender, work and stress is complex. Several factors appear to magnify the impact of stress on women, chief among them being the preponderant role that women still play in family care. Research carried out in Sweden found that the total workload of women employed full time is much higher than that of men employed full time, and that the total workload for women employed part time is as much as that of men employed full time. Sweden is a country in which 86 per cent of women are in the workforce, but the division of labour between spouses at home has remained much the same (Frankenhauser, 1991).

As with violence, other factors also tend to make women more vulnerable to work-related stress. These include:

- lower levels of control in their jobs, since the great majority of women still occupy less senior jobs than men;
- discrimination suffered by many women in more senior positions, such as managerial jobs, both as a result of organizational and corporate policy and from their colleagues at work;

- the need, in order to overcome prejudice, to show that they perform better than their male colleagues;

- the higher proportion of women who work in precarious forms of employment.

Sex segregation of women in the health sector is a fact all around the world. A major ILO study indicates that nursing is still a female-dominated occupation in practically all countries, and that women comprise over 80 per cent of nursing professionals in the vast majority of countries. In contrast, working as a physician is most often a "male" occupation. The same study shows that 78.8 per cent of physicians are men in the United States, 70.6 per cent in the Netherlands, and 70.5 per cent in France (Anker, 1998, p. 265). This situation is, of course, reflected in quite substantial earning differences. But significant differences in earnings are reported even for the same job. A recent study that examined women's average earnings as a percentage of men's in selected medical occupations revealed that the average monthly earnings of a female physician in the countries concerned was 31.87 per cent less than those of a male colleague, 27.57 per cent less for a dentist, 15.79 per cent less for a professional nurse, 7.90 per cent less for an auxiliary nurse and 6.95 per cent less for an X-ray technician (Robinson, 2001, p. 169).

On the positive side is the progressive movement of women into managerial jobs, particularly in areas traditionally dominated by women – so called women's jobs. These include health services, among others (Wirth, 2001, p. 240).

6.3. Environmental issues

Within this framework the working environment, including its physical and organizational setting, can greatly influence the risks of stress and violence. The importance of these issues is increasingly recognized, with attention focusing on the fundamental role of prevention in effectively combating stress and violence at work.

General environment

The physical design of a workplace can be a factor in either defusing or triggering stress and violence. Poor ventilation, bad lighting, uncomfortable temperatures, dirty and noisy premises can generate stress and experience higher rates of violence than well-designed workplaces. A bad environment is shameful in institutions such as those providing health care, which should be an example in this respect. The abovementioned study on health-care workers in Canada found a high correlation between work-related violence and stress generated by safety hazards in visited homes and neighbourhoods (Denton et al., 2000, p. 425). It has been suggested that good lighting, high visibility of work areas, room to manoeuvre around patients and equipment, inaccessible storage for drugs and money and reduced hiding places for perpetrators, should all be adopted as basic measures to reduce the risks of violence to workers in the health sector.

Exposure to hazards and dangerous substances can also be a relevant factor in this respect and workers in the health sector, such as those in hospitals and laboratories, are exposed to such risks. New hazards also emerge on a continuous basis, as in the case of HIV/AIDS. These put a special strain on the workers directly involved, contribute to a climate of dissatisfaction and uncertainty, and may even generate violence in the form of marginalization and discrimination against certain categories of patients. The existence and even the increase in this type of risk in the health sector has been highlighted in the 1998 ILO sectoral report (ILO, 1998, pp. 59-61).

The interrelation between the external environment and the working environment also appears significant in terms of predicting violence. In the specific context of possible violence and aggression in the workplace, especially premises open to the public, such as hospitals, the design of workplaces requires special attention and involves the following additional factors: comfortable seating, which is crucial especially where waiting is involved; comfort and size of waiting rooms; toilet facilities; supervised entrances; alarms; security guards; protective barriers; surveillance cameras and systems to alert other employees when urgent help is needed.

The importance of the general environment in determining exposure to violence in the health sector has been analysed and fully confirmed by a national study of the work environment, and the physical and mental well-being of more than 2,600 Swedish nurses. Thirty per cent reported that they had experienced violence at work. One of the occupational factors mentioned as having a significant correlation with workplace violence was the type of ward or facility.

Lifetime prevalence of exposure to violence by nursing discipline

Nursing discipline	Violence more than once (%)	Violence on one occasion (%)	Violence never (%)
Outpatient care	5.6	11.2	83.2
Inpatient care	12.7	15.4	71.9
Geriatrics	30.3	9.8	59.9
Psychiatry	61.4	15.0	23.5
Total	15.7	13.5	70.9

Source: Arnez et al., 1996, p. 122.

6.4. Organizational issues

The organizational setting appears to be just as important as the physical environment, if not more so. Poor organization may, for instance, lead to an excessive workload for a specific group of workers, slow down their performance, create unjustified delays and queuing, develop stress and negative attitudes among such workers and induce aggressive behaviour among the customers.

A study conducted on 1,505 women, the vast majority working in direct health care in 12 public hospitals in the Paris region, revealed that 38 per cent were interrupted in their tasks *sometimes* and 49 per cent *often*; 51 per cent had to reorganize their work programme *often* and 9 per cent *always*; 22 per cent felt overworked in their job (Estryn-Behar et al., 1990, p. 27).

The same effects may be induced by labyrinthine bureaucratic procedures, putting both employees and customers under serious stress. In the already cited study on British general practitioners, “the stress of practice administration and routine medical work” was indicated as one of the main stressors, together with the pressures and demands of the job and patients; role ambiguity; the implications of making mistakes and being “visible”. According to the doctors who participated in the survey, the strain of “being in the organization” included “a lack of consultation and communication, having to do mundane administrative work, having insufficient resources to do the job effectively, lack of feedback about one’s performance, and low morale” (Sutherland and Cooper, 2000, p. 145).

Lack of consultation and communication can be a significant generator not only of stress but also of violence at work, while circulation of information and open communication can greatly reduce these risks by defusing tension and frustration among workers. They are of particular importance in removing the taboo of silence which often surrounds cases of sexual harassment, mobbing and bullying.

In the health sector, particularly for employees in contact with the public, effective communication can do much to prevent stress and violence. In the case of hospitals, the provision of information to patients, their friends and relatives is crucial in lessening the risk of assault. This is particularly the case in situations involving distress and long waiting periods where even the usually well-balanced individual may become anxious, distressed, and eventually more prone to violence. Recent reporting from Mexico confirms the close connection between the length of waiting periods and the emergence of violence in work settings of the health sector (Nieto and Sancedo, 2001).

In a broader context, the type of interpersonal relationship, the managerial style, the level at which responsibilities are decentralized, and the general culture of the workplace, must also be taken into consideration. A participatory working environment, for instance, where dialogue and communication are extensively exercised, may help defuse the risks of violence. In contrast, a "closed" authoritarian working environment where people work in isolation, with mutual suspicion and defensive attitudes towards outsiders, may increase the risk of stress and violence.

While experts agree on the importance of workers' early involvement in combating stress and violence, few reliable studies have been carried out to confirm the validity of this message. A major effort in this area has been conducted in the Netherlands by M. Kompier at the University of Nijmengen. Ten Dutch projects from several branches of industry (three from the health sector) aimed at reducing work stress, physical overload and sickness absenteeism, were selected, analysed and compared. In the health sector the case of a hospital with 859 workers; homes for the elderly with 5,500 workers altogether; and a home care institute with 400 workers were considered. In all three cases high sickness absenteeism, frequent complaints and problems with continuity of service were at the origin of the projects. The measures introduced, including changes in the working climate, improved work organization, job enrichment, working in pairs, better work planning, were all conducted in consultation and with the close involvement of the workforce concerned. The results showed that absenteeism was reduced in most cases and the benefits exceeded the costs of the interventions. A participative approach to stress problems emerged as a primary factor in achieving success (Kompier et al., 1998, pp. 155-168).

The arrangement of working time, particularly shift work and night work, may also play a key role in generating stress and violence. Health care is a round-the-clock business and shift work is the norm for many workers in the sector. Numerous studies have shown that night work can be harmful to the health of workers, particularly those who adjust poorly. While two major risks to the health of workers on night shifts have been traditionally identified, namely harmful effects on sleep and gastro-intestinal and other disorders related to change in eating habits, a third major concern is now emerging in the form of exposure to violence, related anxiety, fear and consequent stress. Women, especially those working or commuting alone at night, are particularly exposed to and aware of these risks.

Average percentage of fear reported by males and females

Fear	Male average (%)	Female average (%)
Evening shift	16	28
Night shift	25	75
Travel	10	73

Source: European Foundation for the Improvement of Living and Working Conditions, 1990, p. 19.

Both night work and shift work have a negative effect on the workers' participation in family life and social activities. These are additional, important sources of stress. A study on 133 hospital doctors working in six hospitals at Dhaka city, revealed that their mental state of health was associated with their perception of the work schedule being a problem to their family members (Sharmin and Rahaman, 1997, p. 104).

The type of shift and the way shifts are organized is also of extreme importance. This is a complex matter and one with a wide, often very specific, literature from which it is very difficult to draw general conclusions. We will only mention here evidence of nurses on rotating shifts reporting significantly higher tension, anxiety, depression and fatigue than nurses on other shifts or other workers, including nightworkers (OTA, 1991, p. 165).

Changes in work organization and work practices often cost little or nothing and they can bring important economic advantages both in terms of enterprise efficiency and in reducing the burden of stress and violence. In the health sector, particularly for workers in contact with the public, change in work practices can be extremely important in limiting stress, dissatisfaction and violence from clients. The most influential factor in reducing client aggression is speedy and efficient service, which can be stimulated by various measures such as staff rotation for particularly demanding jobs, rostering more staff at peak periods, designing how staff move between different working areas, tailoring client flow to suit needs and resources, and keeping waiting times to a minimum.

6.5. Change issues

Widespread restructuring in the health sector through privatization, decentralization and rationalization is having a profound effect on conditions of work and employment. Various ILO reports indicate that these processes may be accompanied, although with different intensity from country to country and from situation to situation, by downsizing, layoffs, freezes or cuts in salaries, heavier workloads and faster pace of work, longer hours of effective work, less comfortable shifts and working unsocial hours, more subcontracting, more temporary and occasional work (ILO, 1998; Ullrich, 1998; Bach, 2000). These are all recognized potential stressors and may eventually lead to a climate of violence driven by uncertainty, growing exasperation and vulnerability. Technological innovation may act as another multiplier of stress and violence at work, especially when such innovation is not accompanied by adequate training and jobs are, or seem to be at risk. The impact of all this may negatively affect the commitment and motivation of the workforce concerned and jeopardize the quality of the health-care services as well as the very success of the reforms undertaken.

Two main areas of concern deserve special attention in connection with stress and violence generation. Their implications for the health sector have not yet been investigated specifically but the alternatives and issues at stake are increasingly clear.

Job insecurity

Job insecurity is always associated with stress and with the risk of violence at work. The association is fully confirmed even when stress is not reported to be severe or is declining as appears to be the case in some of the countries covered by an ILO survey on the privatization of health care in Central and Eastern Europe (Afford, 2001, p. 13).

Although job insecurity usually originates in macro situations that go far beyond the framework and scope of this report, two interpersonal and organizational issues have been identified that appear relevant in defusing at least part of the stress and violence generated by job insecurity. First is the support that supervisors and co-workers offer the workers whose jobs are at risk (Lim, 1996, pp. 171-194). Second, and most important, involving health workers as change agents by circulating adequate information increases their understanding of the reform, their acceptance and appropriation of its goals; it also increases their tolerance of temporary transitional difficulties (German Foundation for International Development, 2000, p. 51).

Vulnerability

If the number of temporary employees in the health sector is increasing, the proportion of workers who are exposed to the risks of stress and violence is also likely to increase. The survey of the European Foundation in Dublin (2001) reveals that temporary work (employees on fixed-term contract and temporary agency workers) is linked to poor working conditions. These include a low level of control over their working time and performing less skillful jobs, two major elements in stress building. Violence at work is also associated with real or perceived vulnerability. The above survey clearly indicates that workers in precarious jobs are more exposed to violence at work in the form of bullying than those with permanent contracts.

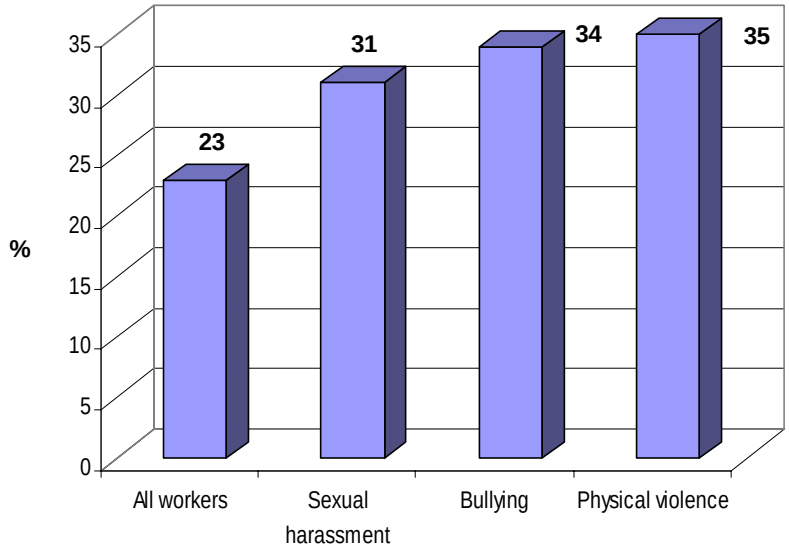
7. The impact on costs

7.1. Direct and indirect costs

What is the cost? Stress and violence cause immediate and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment. Cost factors will include direct costs such as those deriving from absenteeism, turnover, accidents, illness, disability and death; and indirect costs, including diminished function, performance, quality and timely production and competitiveness. Increasing attention is also given to the negative impact of violence on intangible factors such as company image, motivation and commitment, loyalty to the enterprise, creativity, working climate, openness to innovation, knowledge-building, learning, etc.

Data from the European Union (European Foundation for the Improvement of Living and Working Conditions, 2000, p. 5), show a very significant correlation between health-related absences and violence at work. Thirty-five per cent of workers exposed to physical violence, 34 per cent of those exposed to bullying and 31 per cent of those exposed to sexual harassment were found to be absent from work, compared to an average of 23 per cent among workers in general.

Violence and absenteeism in the European Union



Furthermore, as we have already seen in Part I, a clear and important correlation is now established in the European Union between violence and stress, with the cost of stress calculated at 20 billion euro each year (European Commission, 1999, p. 13). In the United States, the cost of stress has been calculated at $350 billion per year (Reed Group, 2001) while the cost of violence alone has been calculated at $35.4 billion (The Workplace Violence Research Institute, 1995).

A number of reliable studies have estimated that stress and violence could account for approximately 30 per cent of the overall costs of ill-health and accidents. Based on the above figures it has been suggested that stress/violence may account for 0.5 to 3.5 per cent of GDP per year (Hoel et al., 2000, p. 52).

7.2. Costs in the health sector

Because stress and violence in the health sector account for a high proportion of all stress and violence at work, their cost must necessarily reflect this balance and must also be high. A number of specific studies confirm this assumption.

A recent Finnish study of more than 5,000 hospital staff found that those who had been bullied took 26 per cent more certified sick leave than those who were not bullied (Kivimaki et al., 2000, pp. 656-660). In the United States, workers in the health care and related occupations have the highest share of work time lost because of workplace assaults (Llewellyn, 2001). A Canadian study that looked at the incidence of violence among nurses in Ontario found that 59 per cent had been physically assaulted at some time during their nursing careers. It also found that their compensation claims represented about 10 per cent of all claims arising from violence allowed by the board in the province (Liss and McCaskell, 1994, pp. 384-390).

The realization and quantification of the cost of violence is crucial to the shaping of anti-violence strategies both in the developing and the industrialized world. The proliferation of informal, precarious and marginal situations at work increasingly shifts attention towards an economically self-sustainable response whereby the key role of cost-effective programmes and actions which fit naturally into the socio-economic development of the enterprise is highlighted and used to enhance further initiatives. Combining economic and social issues in a positive-sum game results in this new type of response being quickly adopted for its own merits rather than being artificially and less effectively imposed from the top down.

Part III

Approaches to coping

8. In search of the "high road"

There is growing awareness that confronting stress and violence requires a comprehensive approach. Instead of searching for a single solution good for any problem and situation, the full range of causes which generate stress and violence should be analysed and a variety of intervention strategies adopted. There is also growing awareness that stress and violence at work is not merely an episodic, individual problem but a structural, strategic problem rooted in wider social, economic, organizational and cultural factors. It is increasingly recognized that stress and violence at work are detrimental to the functionality of the workplace, and that any action taken against such problems is an integral part of the organizational development of a sound enterprise. Much of this anti-stress, anti-violence response would in any case be needed to develop a healthy, competitive enterprise thus making the violence-conscious manager a "smart" manager. It is increasingly clear that a high-road response based on combined enterprise/individual development is not only possible but necessary.

8.1. Prevention

In the past, manifestations of stress and violence have often been approached as problems to be tackled with remedial, occasional and often palliative interventions. The emerging approach focuses instead on a proactive response to stress and violence with the emphasis on prevention. Its objective is to eliminate the causes of stress and violence, rather than to treat its effects; this requires a long-term appreciation of each intervention.

Attention is consequently shifting from the consideration of stress and violence as a merely personal problem to the key role played by the workplace in creating or defusing stress and violence. If the working environment – *the shoe* – does not fit the employee – *the foot* – one can either act on the foot by forcing it into the wrong shoe, obliging employees to work in unhealthy, dangerous conditions with negative effects on their motivation, commitment and performance, and eventually on the entire organization's efficiency; or one can act to make the shoe fit the foot, either by changing the shoe – improving as far as possible the conditions of work; or by finding the right shoe for each individual foot – putting the right person in the right place; or by allowing the owners of the feet to adjust the available shoes to match their own feet – encouraging responsible employees to make reasonable adjustments to their working environment to improve the job employee fit.

Whatever the preventive approach used and the concrete measures introduced, prevention is certainly the most effective way to tackle stress and violence: "*An ounce of prevention is worth a pound of cure*" (Levi, 1981).

8.2. Participation

The crucial role of social dialogue in defusing situations of work-related stress and violence is increasingly recognized. Consequently a participatory approach whereby all parties concerned have an active role in designing and implementing anti-stress and anti-

violence initiatives, is highly recommended. "*Employee knowledge and experience should be incorporated into any written plan to abate and prevent safety and security hazards*" (OSHA, 1996).

8.3. Diffusion of best practices

It is also recommended that positive examples and best practices be widely disseminated among all parties concerned. The message delivered in this way is a most powerful one since it is based on real experience, deals with concrete issues, refers to situations in which the parties can recognize themselves and offers practical solutions for immediate implementation.

The adoption of a "high road" to combat stress and violence in the health sector requires refocusing the entire approach to stress and violence from an exclusively normative one to a socio-economic and eventually a developmental one. The traditional response to workplace stress and violence based on the mere enforcement of regulations fails to reach many working situations in both the developing and the industrialized world, including small/micro enterprises, the informal sector and the virtual workplace.

Attention has therefore increasingly focused on the socio-economic costs of stress and violence at work. A quantification of these costs shows how great is the negative impact of these problems on the efficiency and performance of the enterprise. The introduction of an economic dimension in organizing the response to stress and violence is proving a powerful weapon in effectively addressing these problems. A high-road response is thus progressively emerging whereby workers' health, safety and well-being become integral parts of enterprise growth. Here the focus is on the new intangible assets of the modern enterprise – knowledge, learning, quality and, most of all, people, whose development is totally incompatible with the presence of stress and violence at work. By directly linking health and safety issues with managerial and developmental issues, this response offers the tools for immediate, self-sustained action at the workplace to reduce and eliminate stress and violence at work.

The high-road approach opens the way to a natural proliferation of initiatives largely based on self-sustainability. Policies should support this natural process by offering stimulation and encouragement, creating networks and raising awareness. These elements should be accompanied by the issuing of guidelines, the diffusion of best practices and the enactment of framework and support legislation.

The high-road approach thus activates a virtuous circle which develops from inside the workplace: it then progressively expands in a strategic prospective independently of short-term influences and forced interventions. Triggering the virtuous circle is the great challenge at stake.

References

Afford, C.: *Privatization of health care in Central and Eastern Europe*, draft report (Geneva, ILO, 2001).

Anker, R.: *Gender and jobs: Sex segregation of occupations in the world* (Geneva, ILO, 1998).

Armstrong-Stassen, M. et al.: "The relationship between work status congruency and job attitudes of full-time and part-time Canadian and Jordanian nurses", in *International Journal of Human Resource Management*, 1998, Vol. 9, No. 1.

Arnetz, J.: *Violence towards health care personnel: Prevalence, risk factors, prevention and relation to quality of care* (Stockholm, Karolinska Institute, 1998).

– et al: "Violence in the nursing profession: Occupational and lifestyle risk factors in Swedish nurses", in *Work and Stress*, 1996, Vol. 10, No. 2.

Bach, S.: *Decentralization and privatization in municipal service: The case of health services*, Working Paper No. 169 (Geneva, ILO, Sectoral Activities Programme, 2000).

Boyd, N.: "Violence in the workplace in British Columbia: A preliminary investigation", in *Canadian Journal of Criminology*, Oct., 1995.

Cardwell, C.: *Violence towards National Health Service employees: A socio legal analysis*, MA thesis, Law and Employment Relations, University of Leicester, 1991, cited in Standing, H.; Nicolini, D.: *Review of workplace-related violence*, HSE Research Report 143/1997 (London, Tavistock Institute, 1997).

Chappell, D.; di Martino, V.: *Violence at work* (Geneva, ILO, 1st ed., 1998; 2nd ed., 2000).

Cox, T.: *Stress* (London, MacMillan, 1978).

– et al.: *Work-related stress in nursing: Controlling the risk to health*, Working Paper CONDIT/WP.4/1996 (Geneva, ILO, 1996).

Curbow, B.: "Origins of violence at work", in Cooper, C.: *Violence in the health sector*, ILO/WHO report (Geneva, ILO, WHO, 2001).

Denton, M. et al.: "Work-related violence and the OHS of home health-care workers", in *Journal of Occupational Health and Safety, Australia and New Zealand*, 2000, Vol. 16, No. 4.

Estryn-Behar, M. et al.: "Stress at work and mental health status among female hospital workers", in *British Journal of Industrial Medicine*, 1990, No. 47.

European Commission: *Guidance on work-related stress* (Luxembourg, 1999).

European Foundation for the Improvement of Living and Working Conditions: *Women and night work*, BEST, No. 2 (Dublin, 1990).

– : *Violence at work in the European Union*, Unpublished paper (Dublin, 2000).

– : *Working conditions in atypical work*, TJ-39-01-619-EN-C (Dublin, 2001).

Frankenhauser, M.: *The measurement of the total workload of men and women* (Stockholm, 1991).

German Foundation for International Development: *Public service reforms and their impact on health sector personnel*, Round Table, Berlin, 13-15 Oct. 1999 (Berlin, 2000).

Guinn, B.: "Job satisfaction, counterproductive behaviour and circumstantial drug use among long-distance truckers", in *Journal of Psychoactive Drugs*, 1983, No. 15.

Hoel, H. et al.: *The cost of violence and stress at work and the benefits of a violence and stress-free working environment* (Manchester, University of Manchester Institute of Science and Technology, 2000).

Hurrell, J.J., Jr. et al.: "Job stress, gender and workplace violence: Analysis of assault experiences of state employees", in VandenBos, G.R.; Bulatao, E.Q.: *Violence on the job* (Washington, DC, American Psychological Association, 1997).

ILO: "Stress at work", in *Conditions of Work Digest*, Geneva, 1992, Vol. 11, No. 2.

– : *Terms of employment and working conditions in health sector reforms* (Geneva, 1998).

Karasek, R.; Theorell, T.: *Healthy work: Stress, productivity and the reconstruction of working life* (New York, Basic Books, 1990).

Kivimaki, K. et al.: "Workplace bullying and sickness absence in hospital staff", in *Occupational and Environmental Medicine*, 2000, No. 57.

Kompier, M. et al.: "Cases in stress prevention: The success of a participative and stepwise approach", in *Stress Medicine*, 1998, Vol. 14.

Kop, N. et al.: "Burnout, job stress and violent behaviour among Dutch police officers", in *Work and Stress*, London, 1999, Vol. 13, No. 4.

Levi, L.: *Preventing work stress* (Reading, Massachusetts, Adison-Wesley, 1981).

Lim, V.K.: "Job insecurity and its outcomes: Moderating effects of work-based and non-work-based social support", in *Human Relations*, 1996, Vol. 49, No. 2.

Liss, G.M.; McCaskell, L.: "Injuries due to violence: Workers' compensation claims among nurses in Ontario", in *AAOHN Journal*, 1994, No. 42.

Llewellyn, B.: *Workplace violence: Implications for workers' compensation in the United States*, Paper presented at the Tri-National Conference on Violence as a Workplace Risk, 29-30 Nov. 2001, Montreal, Quebec, Canada.

McDonald, D.; Brown, M.: *Indicators of aggressive behaviour: Report to the Minister for Health and Family Services from an Expert Working Group*, Research and Public Policy Series, No. 8 (Canberra, Australian Institute of Criminology, 1997).

Nieto, H.; Sancedo, E.: *Violencia en el lugar de trabajo entre el usuario y el trabajador*, Paper presented at the Tri-National Conference on Violence as a Workplace Risk, 29-30 Nov. 2001, Montreal, Quebec, Canada.

Nordin, H.: *Fakta om vaold och hot i arbetet*, Solna, Occupational Injury Information System (Swedish Board of Occupational Safety and Health, 1995).

OSHA: *Guidelines for workplace violence prevention programs for health care workers in institutional and community settings* (Washington, DC, 1996).

OTA: "Registered nurses and resident physicians", Case study, in Congress of the United States: *Biological rhythms: Implications for the worker* (Washington, DC, 1991).

Poyner, B.; Warne, C.: *Preventing violence to staff* (London, Tavistock Institute of Human Relations, 1988).

Reed Group: *Dramatic increase in stress-related problems costing companies $350 billion annually*, 24 May 2001.

Richman, J. et al.: "Perceived workplace harassment experiences and problem drinking among phyicians: Broadening the stress/alienation paradigm", in *Addiction*, 1996, No. 91.

Robinson, D.: "Differences in occupational earnings by sex", in Loutfi, M. (ed.): *Women, gender and work* (Geneva, ILO, 2001).

Rosenberg, D.A.; Silver, H.H.: "Medical student abuse: An unnecessary and preventable cause of stress", in *Journal of the American Medical Association*, 1984, No. 251.

Sharmin, S.; Rahaman, A.: "Mental health, occupational stress, job satisfaction and life satisfaction of hospital doctors by job nature and work schedule", XII International Symposium on Night and Shiftwork, New Challenges for the Organisation of Night Work and Shiftwork, 23-27 June 1997, Majvik, Finland, in *Shiftwork International Newsletter*, 1997, Vol. 14, No. 1.

Sutherland, V.J.; Cooper, C.: Strategic stress management: An organisational approach (MacMillan, 2000).

Ugon, D.: "Collegamenti e interdependenze tra stress da lavoro, consumo di alcool, sostanze stupefacenti e violenza", in *Rivista Italiana di Medicina Legale*, 2001, Vol. 23.

Ullrich, G. (ed.): *Labour and social dimensions of privatization and restructuring: Health care services* (Geneva, ILO, 1998).

University of Manchester Institute of Science and Technology: *Understanding stress*, Part II (London, HMSO, 1987).

Wirth, L.: "Women in management: Closer to breaking through the glass ceiling?", in Loutfi, M. (ed.): *Women, gender and work* (Geneva, ILO, 2001).

Workplace Violence Research Institute: *The cost of workplace violence to American business* (Palm Springs, 1995).

Appendix

List of documents

ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector

Study reports and working papers

ILO/ICN/WHO/PSI (2002). *Framework guidelines for addressing workplace violence in the health sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector.

di Martino, V. (2002). *Workplace violence in the health sector – Country case studies: Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand, plus an additional Australian study: Synthesis report*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Country case studies

Palácios, M.; Loureiro dos Santos, M.; Barros do Val, M.; Medina, M.I.; de Abreu, M.; Soares Cardoso, L.; Bragança Pereira, B. *Workplace violence in the health sector – Country case study Brazil*. Geneva: ILO/ICN/WHO/PSI Joint Programme in Workplace Violence in the Health Sector, forthcoming working paper.

Tomev, L.; Daskalova, N.; Ivanova, V. *Workplace violence in the health sector – Country case study Bulgaria*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Deeb, M. *Workplace violence in the health sector – Lebanon country case study.* Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Ferrinho, P.; Antunes, A.R.; Biscaia, A.; Conceição, C.; Fronteira, I.; Craveiro, I.; Flores, I.; Santos, O. *Workplace violence in the health sector – Portuguese case studies.* Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Steinman, S. *Workplace violence in the health sector – Country case study: South Africa*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Sripichyakan, K.; Thungpunkum, P.; Supavititpatana, B. *Workplace violence in the health sector – A case study in Thailand*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Theme studies

Cooper, C.; Swanson, N. (2002). *Workplace violence in the health sector – State of the art*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector.

di Martino, V. (2003). *Relationship between work stress and workplace violence in the health sector*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector.

Richards, J. *Management of workplace violence victims.* Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

Wiskow, C. *Guidelines on workplace violence in the health sector – Comparison of major known national guidelines and strategies: United Kingdom, Australia, Sweden, USA*. Geneva: ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.