Original Article

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Prevalence, Associated Factors, and Impact of Workplace Violence among Physicians

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ABSTRACT

Background: There is a dearth of objective data and studies pertaining to the prevalence and consequences of workplace violence against physicians in Nepal. This study aims to assess the prevalence, associated factors, and implications of workplace violence on Nepalese physicians.

Methods: We conducted a cross-sectional study from March 2021 to August 2021. Nepal Medical Council-certified physicians currently working in Nepal were included in the study. Baseline characteristics, types of violence experienced, patterns, psychosocial impacts, and changes in patient management were collected.

Results: Out of 318 responses received, 302 responses met the inclusion criteria and were included in the final analysis. One-hundred and ninety (62.9%) respondents had ever faced workplace violence. Madhesh Province had the highest prevalence (81.5%). Verbal abuse (93.2%) was the most common type of violence encountered. We found a significant association between workplace violence and hours worked each week. We also found an association between workplace violence and years of experience. Our study found a significant increase in stress/depression/anxiety/idea of persecution, sense of defeat, job turnover, and loss of productivity/income with the increase in severity of workplace violence.

Conclusions: Workplace violence is largely prevalent among Nepalese physicians. In the aftermath of workplace violence, a physician can undergo a multitude of adverse psychosocial consequences leading to a further decrease in productivity. More insights through research, formal training, and policy implementation are necessary to overcome this largely ignored problem of the medical fraternity in Nepal.

Keywords: Abuse; Nepal; physicians; workplace violence.

INTRODUCTION

Workplace Violence (WPV) is defined as any incident where workers are abused, threatened, or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being, or health.[1] It may be in the form of verbal abuse/threats, physical assault, sexual violence, or damage to physical property.

4 healthcare workers (HCWs) in Nepal jumped off the second floor when relatives of a deceased patient attacked.[2] In India, 77.3% of doctors had ever faced some form of WPV.[3] Acts of violence against healthcare workers in the workplace have been largely persistent,

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under-reported, tolerated, and ignored.[4] WPV can have detrimental effects on the health and well-being of healthcare providers leading to reduced job satisfaction, burnout, decreased quality of care and increased job turnover.[5]

This study aims to assess the patterns, associated factors, and impact of WPV among Nepal Medical Council (NMC) certified physicians.

METHODS

This is an observational, cross-sectional study conducted among doctors working in Nepal to collect information regarding workplace violence. Data were collected via an internet-based survey from March 2021 to August 2021, a duration of six months.

Ethical approval for the study was obtained from the ethical review board of Nepal Health Research Council, Nepal: proposal ID: 98-2021. Only after agreeing to consent to the study voluntarily, the participants could access the questionnaire form.

All medical graduates (Bachelor of Medicine & Bachelor of Surgery, MBBS) and post-graduates (specialists) certified by the Nepal Medical Council and managing patients in a private or public healthcare setting in Nepal were included in the study. Any medical professionals who did not have an MBBS degree (nursing staff, paramedics, pharmacists, and others) or were not practicing medicine were excluded from the study.

Due to the lack of previous studies from Nepal assessing the prevalence of WPV among physicians, for power analysis, we assumed the prevalence to be similar to the findings from a recent study conducted in India which showed that 77.3% of doctors had ever faced violence.[3] The practice of medicine in Nepal and India are quite similar including the training and the medical administrative systems. We calculated the sample size assuming the prevalence (p) of violence faced by practicing doctors as 77.3%, the precision (d) of 0.05, and a 95% level of confidence (Z value=1.96). Using the formula: $Z^2p(1-p)/d^2$, the required sample size calculated was 281.

A semi-structured study questionnaire was prepared in "Google forms" (developed by Google LLC). The study questionnaire included selected socio-demographic details, academic qualification, practice setting, details of violence faced, its psycho-social impact, and effect on the management of patients. The link to the form was shared across multiple online forums and social media (including social media groups of registered Nepalese doctors on Facebook).

The study participants filled out the form and submitted it electronically. Study participants were provided information regarding the study and were needed to provide consent before proceeding with filling questionnaire. The google form automatically saved the data. There was no follow-up of the participants.

Sociodemographic and professional information including age, gender, marital status, highest qualification, department of practice, years of experience, area of practice, workplace, province, employment type and title, and working hours (average per week) were collected. Information on WPV included: prevalence and types of workplace violence, type of psycho-social impact following workplace violence, impact on patient management. Trauma Screening Questionnaire (TSQ), a ten-item scale was used to assess the presence of post-traumatic stress following WPV taking a cut-off of six. A systematic review found TSQ to have an overall efficiency of 92% to predict post-traumatic stress among crime victims over a cut-off value of six.[6]

Verbal abuse (VA) was defined as a doctor's perception of being professionally and personally attacked, devalued, or humiliated via the spoken word. Verbal Threat (VT) was defined as a doctor's perception of an intention to inflict pain, harm, injure, or damage with or without an object or weapon. Intimidation (IN) was defined as an act of frightening or threatening a doctor usually to pursue to something which the doctor did not want to do. Physical violence (PI) was defined as an attack to create bodily injury, and included slapping, pinching, pushing, shoving, and spitting or kicking. PI was further classified as Minor PI (an injury that required no or minimal medical attention) and Major PI (an injury that required hospital admission or was not minor PI). Sexual abuse (SV) was defined as a doctor's perception of unwelcome or uninvited action of a sexual nature. Damage to physical property (PD) included loss of use of the tangible property.[3,7,8]

These types of violence were further grouped according to the severity of WPV faced as classified by a similar study:[3]

Group 1: VA only

Group 2: VT and/or IN with or without VA (VT+IN)

Group 3: PI, SV, and/or PD with or without VA, VT, or IN (PI+SV+PD)

The study participants were labelled as per the higher severity of WPV faced, i.e., if the participant faced all of VA, VT, and PI, he/she was labelled under group 3 (PI+SV+PD).

After receiving adequate responses, the data was exported in Microsoft excel, and coded and analyzed using Statistical Package for the Social Sciences. Categorical variables were presented as percentages (%), and continuous variables were presented as mean and standard deviation (SD). Pearson's Chi-square test was used to evaluate the differences between groups for categorized variables. Fisher's exact test was used for smaller samples with cell values less than 5. A p-value of less than 0.05 was considered statistically significant.

RESULTS

A total of 318 forms were received, of which 14 were excluded based on the exclusion criteria and 2 were non-responses. More than half of the responses were from the doctors working in the Bagmati province (175, 57.9%), mostly from the Kathmandu district (92, 35.0%). The mean age was 29.3 years (SD: 3.9), and around 77% of respondents were aged ≤30 years. Most were males (219, 72.5%) and unmarried (225, 74.5%). Most respondents had the highest qualification of MBBS (230, 76.2%), and a mean experience of 2.9 years (SD: 3.2).

Most doctors practiced in city/metropolis (166, 55%), mostly in contract or temporary setting (270, 89.4%). Almost half of the doctors worked in government and non-government settings each. Most doctors worked as medical officers (205, 67.9%). One-third worked in general practice followed by internal medicine, emergency, anesthesiology/critical care, surgery, pediatrics, and others. The mean working hours in a week for the doctors was 57.6 hours (SD: 26.5). Only 13 doctors (4.3%) said that they had taken any formal training or classes to deal with violence in the workplace.

Of the 302 responses included in the study, 190 (62.9%) doctors had faced WPV at least once till the completion of the survey. The highest prevalence of WPV was found in the Madhesh province (22/37, 81.5%), followed by Karnali province (4/5, 80%), and the lowest prevalence in Sudurpashchim province (2/8, 25%), as shown in figure 1 below.

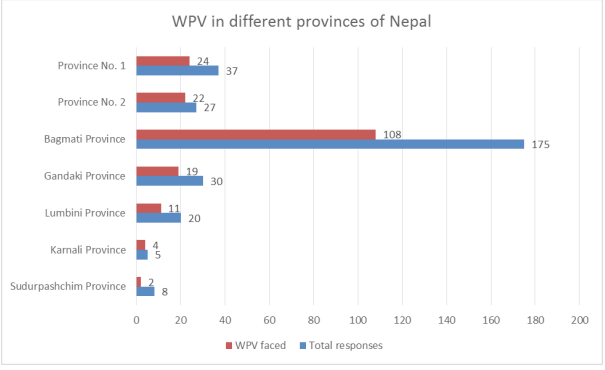

Figure 1. Workplace Violence (WPV) prevalence in different provinces of Nepal.

Of the 190 doctors who faced WPV, most doctors (177, 93.2%) had faced some form of verbal abuse, followed by verbal threat (71, 37.4%), intimidation (51, 26.8%), property damage (18, 9.5%), minor physical injury (6, 3.2%) and sexual violence (5, 2.6%). There were no reports of major physical injury in our study. Classification of WPV based on severity showed: 47.4% with VA only, 40.0% with VT+IN, and 12.6% with PI+SV+PD. Most of the violence took place in the in-patient department/ward (66.8%). More than half of those who faced violence reported that they last faced violence within the last year until the completion of the survey.

Perpetrators of violence were mostly relatives (60%), followed by family members (54.7%), friends of the family (32.1%), the patient himself/herself (15.8%), and onlookers (14.2%). One-third of the doctors responded that the perpetrator inciting violence was under the influence of alcohol and/or drugs. According to respondents, the most common reasons for the instigation of violence were: a) Distrust of the diagnosis/management, b) Delay in treatment, c) non-improvement/worsening of the condition of the patient, and d) Death of the patient. Most (89.9%) did not share the incident with media or on social media. While 72.1% reported the incident to any authority or senior, only 11.7 % filed a complaint with the police. In less than one-fifth of reported cases, there was complete or satisfactory redressal of the issue. The common reasons for not reporting the incident to the authority were: that the respondents thought it was not necessary or nobody was going to do anything about the incident.

In our study, WPV prevalence was found to be significantly associated with years of experience (p = 0.032) and working hours (p = 0.032). The prevalence was significantly increased from 55.4% for the less than 2 years of experience group to 72.4% for the 3-5 years of

experience group. Also, the prevalence was significantly raised from 49.2% for those working ≤40 hours/week group to 76% for those working 61-80 hours/week group. There was no significant difference in prevalence and severity of WPV across other factors as shown in table 1.

Table 1. Prevalence of workplace violence (WPV) and types of WPV across various factors.

Variables	Groups	Not experienced WPV N (%)	Experienced WPV N (%)	P-value	VA only N (%)	VTIN N (%)	PISVPD N (%)	P-value
Age groups	≤30 years	82 (35.2%)	151 (64.8%)	0.451	74 (49%)	62 (41.1%)	15 (9.9%)	0.143
	31-40 years	27 (44.3%)	34 (55.7%)		15 (44.1%)	12 (35.3%)	7 (20.6%)	
	41 years and above	3 (37.5%)	5 (62.5%)		1 (20%)	2 (40%)	2 (40%)	
Gender	Female	37 (44.6%)	46 (55.4%)	0.097	23 (50%)	15 (32.6%)	8 (17.4%)	0.592
	Male	75 (34.2%)	144 (65.8%)		67 (46.5%)	61 (42.4%)	16 (11.1%)	
Marital Status	Married	32 (41.6%)	45 (58.4%)	0.347	18 (40%)	21 (46.7%)	6 (13.3%)	0.662
	Unmarried	80 (35.6%)	145 (64.4%)		72 (49.7%)	55 (37.9%)	18 (12.4%)	
Highest Qualification	Bachelor (MBBS)	84 (36.5%)	146 (63.5%)	0.957	72 (49.3%)	58 (39.7%)	16 (11%)	0.356
	Doctorate/Diploma (after MBBS)	2 (40%)	3 (60%)		1 (33.3%)	1 (33.3%)	1 (33.3%)	
	Postdoctoral courses (DM/MCh)	1 (25%)	3 (75%)		0 (0%)	2 (66.7%)	1 (33.3%)	
	Postgraduate Master's degree (MD/MS)	25 (39.7%)	38 (60.3%)		17 (44.7%)	15 (39.5%)	6 (15.8%)	
Years of experience	0-2 years	70 (44.6%)	87 (55.4%)	**0.028**	42 (48.3%)	33 (37.9%)	12 (13.8%)	0.293
	3-5 years	34 (27.6%)	89 (72.4%)		42 (47.2%)	39 (43.8%)	8 (9%)	
	6-10 years	5 (41.7%)	7 (58.3%)		3 (42.9%)	3 (42.9%)	1 (14.3%)	
	11 years and above	3 (30%)	7 (70%)		3 (42.9%)	1 (14.3%)	3 (42.9%)	
Workplace	Government	58 (36.5%)	101 (63.5%)	0.818	47 (46.5%)	42 (41.6%)	12 (11.9%)	0.983
	Non-government	54 (37.8%)	89 (62.2%)		43 (48.3%)	34 (38.2%)	12 (13.5%)	
Area of practice	City/Metropolis	62 (37.3%)	104 (62.7%)	0.993	43 (41.3%)	48 (46.2%)	13 (12.5%)	0.218
	Town/Municipality	37 (36.6%)	64 (63.4%)		33 (51.6%)	21 (32.8%)	10 (15.6%)	
	Village/Rural	13 (37.1%)	22 (62.9%)		14 (63.6%)	7 (31.8%)	1 (4.5%)	
Working hours	≤40 hours	30 (50.8%)	29 (49.2%)	**0.032**	12 (41.4%)	12 (41.4%)	5 (17.2%)	0.531
	41-60 hours	52 (37.4%)	87 (62.6%)		43 (49.4%)	34 (39.1%)	10 (11.5%)	
	61-80 hours	12 (24%)	38 (76%)		19 (50%)	12 (31.6%)	7 (18.4%)	
	81 hours and above	18 (33.3%)	36 (66.7%)		16 (44.4%)	18 (50%)	2 (5.6%)	

Almost half of the WPV resulted in "loss of self-esteem and feeling of shame" (49.5%) in the doctors, followed by: "a sense of defeat" (31.1%), "increased aggressiveness" (28.4%), and "stress/depression/anxiety/ideas of persecution" (25.8%). Fifteen (10.0%) said that they had to change their place of work/shift to another place after the incident. Thirty-one doctors (16.3%) had TSQ scores more than or equal to six. Table 2 summarizes the effects of WPV on physicians.

Table 2. Effects of workplace violence (WPV) on physicians and its impact on patient management.			
Effects of WPV		**Frequency**	**Percentage**
Psychosocial impact on physician			
Loss of self-esteem and shame		94	49.5
Stress/depression/anxiety/idea of persecution		49	25.8
Increased aggressiveness towards patients		54	28.4
Sense of defeat		59	31.1
Had to change the place of work/shift to another place		19	10.0
Avoidance/missing work & loss of productivity and income		38	20.0
Avoiding social gatherings/Social disruption		12	6.3
Engaging in risky behaviors & substance use		4	2.1
Other		7	3.7
No impact		6	3.2
TSQ score reported			
< 6		169	83.7
>/= 6		31	16.3
Impact on patient management			
Prescribing drugs	Decreased	41	21.6
	Increased	30	15.8
	Same as before	119	62.6
Surgical or medical interventions	Decreased	57	30.0
	Increased	25	13.2
	Same as before	108	56.8
Suggesting investigations	Decreased	37	19.5
	Increased	56	29.5
	Same as before	97	51.1
Handling emergency/critical/ complicated cases	Decreased	85	44.7
	Increased	35	18.4
	Same as before	70	36.8
Handling non-complicated cases	Decreased	42	22.1
	Increased	39	20.5
	Same as before	109	57.4
Referral/consultation with other specialists	Decreased	17	8.9
	Increased	110	57.9
	Same as before	63	33.2

The association of the psychosocial impact and TSQ scores with the severity of WPV is shown in table 3. As seen in the table, there was a significant psycho-social impact on physicians with increasing severity of WPV. The doctors who had faced PISVPD had significantly higher rates of stress/depression/anxiety/idea of persecution (41.7%); a sense of defeat (41.7%); avoidance/missing work & loss of productivity and income (33.3%). Almost one-in-five doctors who faced VTIN had to change their place of work/shift to another place.

The most notable changes in patient management due to WPV were: Suggesting investigations increased (29.5%); Referrals increased (57.9%); and handling of emergency, critical, complicated cases decreased (44.7%), as shown in table 2.

There was no significant difference in changes in different domains of patient management and severity of WPV as shown in table 4.

Table 3. Psychosocial impact and severity of workplace violence (WPV).

Impact on physician	WPV classification types						P-value
	VA only		VTIN		PISVPD		
	N	%	N	%	N	%	
Psycho-social Impact							
Loss of self-esteem and shame	41	45.6%	41	53.9%	12	50.0%	0.723
Stress/depression/anxiety/idea of persecution	15	16.7%	24	31.6%	10	41.7%	**0.01**
Increased aggressiveness towards patients	21	23.3%	26	34.2%	7	29.2%	0.371
Sense of defeat	19	21.1%	30	39.5%	10	41.7%	**0.009**
Had to change the place of work/shift to another place	3	3.3%	13	17.1%	3	12.5%	**0.007**
Avoidance/missing work & loss of productivity and income	10	11.1%	20	26.3%	8	33.3%	**0.005**
Avoiding social gatherings/Social disruption	4	4.4%	4	5.3%	4	16.7%	0.093
Engaging in risky behaviors & substance use	2	2.2%	1	1.3%	1	4.2%	0.613
Other	3	3.3%	1	1.3%	3	12.5%	0.059
No impact	4	4.4%	1	1.3%	1	4.2%	0.412
TSQ score							
< 6	78	86.7%	63	82.9%	18	75.0%	0.611
>/= 6	12	13.3%	13	17.1%	6	25.0%	

Table 4. Impact on patient management and severity of workplace violence (WPV).

Impact on patient management		WPV classification types						P-value
		VA only		VTIN		PISVPD		
		N	%	N	%	N	%	
Prescribing drugs	Decreased	19	21.1%	17	22.4%	5	20.8%	0.997
	Increased	15	16.7%	12	15.8%	3	12.5%	
	Same as before	56	62.2%	47	61.8%	16	66.7%	
Surgical or medical interventions	Decreased	23	25.6%	25	32.9%	9	37.5%	0.745
	Increased	13	14.4%	10	13.2%	2	8.3%	
	Same as before	54	60.0%	41	53.9%	13	54.2%	
Suggesting investigations	Decreased	18	20.0%	15	19.7%	4	16.7%	0.999
	Increased	27	30.0%	22	28.9%	7	29.2%	
	Same as before	45	50.0%	39	51.3%	13	54.2%	
Handling emergency/ critical/complicated cases	Decreased	36	40.0%	38	50.0%	11	45.8%	0.573
	Increased	17	18.9%	15	19.7%	3	12.5%	
	Same as before	37	41.1%	23	30.3%	10	41.7%	
Handling non-complicated cases	Decreased	18	20.0%	19	25.0%	5	20.8%	0.943
	Increased	18	20.0%	16	21.1%	5	20.8%	
	Same as before	54	60.0%	41	53.9%	14	58.3%	
Referral/consultation with other specialists	Decreased	9	10.0%	5	6.6%	3	12.5%	0.729
	Increased	49	54.4%	46	60.5%	15	62.5%	
	Same as before	32	35.6%	25	32.9%	6	25.0%	

DISCUSSION

In our study, we found the prevalence of WPV among NMC certified physicians working in Nepal to be 62.9%, a high proportion that fell within the range of WPV worldwide.[9] Among those who had experienced violence at the workplace, verbal abuse (93.2%) was the most common. The doctor, expected to be a healer, ironically is time and again broken apart through such acts of violence. These acts can leave the physician with severe mental and physical scars thus unable to carry out their duties to the best of their efficiency, thus perpetuating a vicious cycle.

In our study, relatives (60%) and family members (54.7%) of the patient were the most common perpetrators of the violence. And one-third of the perpetrators were under the influence of drugs, alcohol, or both at the time of WPV. In countries like Nepal, where families' perspectives can sometimes come above patient autonomy, a perceived inadequacy of care can lead the people close to the patients to instigate violence. Nepal has poor penetration of health insurance with almost all health expenses borne out-of-pocket. Frustrations stemming from a poor prognosis and increasing financial expenditure can lead patients' families and relatives to resort to consumption of alcohol and drugs thus leading to impaired impulse control and instigation of violence.

Respondents perceived that the delay in treatment, deterioration or non-improvement of the patient's condition, a distrust with the diagnosis, and the death of the patient were the most common reasons for the instigation of the violence. In Nepal, where the overall doctor-to-patient ratio is 1:1724, there is a wide variation in the ratio across rural and urban areas—some rural areas have just one doctor for 15000 patients.[10] The lack of a sufficient number of physicians can lead to increased waiting times, short times to assess and care for each patient, and the difficulty to focus care on each patient. This can in turn result in poor patient satisfaction, inability to closely follow the patient, and errors in management purely due to the large workloads. Late patient presentation, unavailability of acute-advanced care, diminutive doctor-patient ratio, and crushing financial burden are some of the factors that amalgamate together to precipitate WPV.

We found that with increased work hours the prevalence of WPV increased, with 76% of those working 61-80 hours/week experiencing WPV. Increased working hours can cause decreased performance of physicians, the inability to communicate adequately with the patients or their families which can lead to unmet expectations or a sense of the inadequacy of care perpetuating violence. WPV prevalence also increased with years of experience, with the 3-5 years group showing the highest (72.4%) prevalence of WPV. The prevalence is likely to rise with increased years of experience, given that over years the WPV incidents will accumulate. The deviation with the higher years of experience groups (6-10 years group, 11 years and above group) is most likely spurious resulting from a small number of respondents from those age groups.

WPV can have a severe psycho-social impact on physicians, with loss of self-esteem and shame being the most common. These results were similar to those from studies conducted across the world.[11] WPV can lead to detrimental psychological consequences such as anxiety, burnout, and depression. Healthcare workers who are victims of WPV, also frequently suffer emotional consequences (e.g., anger, fear) and adverse impacts on work functioning (e.g., sick leave, job satisfaction) and finances.[11] The results of our study show a significant association between WPV and avoidance of/missing work following the incident, resulting in loss of productivity and income. These effects of WPV on healthcare workers can lead to poor patient care and have an indirect adverse effect on the quality of life of patients.[12] Our study found that stress/depression/anxiety/idea of persecution, sense of defeat, avoidance/missing work, and loss of productivity and income were significantly associated with the severity of WPV. These psychosocial impacts were significantly high in the physicians who experienced PISVPD, compared to milder forms of WPV.

The victims of WPV might often be transferred to another position in the workplace.[12] Studies have also shown that the victims have higher levels of intent to leave and increased odds of quitting the profession or switching employers when compared to those who have not experienced WPV.[13,14] The results of our study corroborate these previous findings. There was a significant association between WPV and the victims having to shift positions/change their place of work. These changes often have significant adverse social and financial consequences for the victims.

WPV can also lead the victim to modify their practice and change workplace behavior.[15] Our study found changes in patient management among physicians after experiencing WPV. The biggest change in patient management were: increased referrals and investigations and decreased handling of critical cases. As physicians become more defensive in the light of previous mental or physical trauma, there is a tendency to refer patients

with higher frequency.[3] This increase in referrals, and the reduction in managing critical or complicated cases can lead to increased health-related expenditure. This increase in the tendency to make referrals can further exacerbate the public notion of a doctor being labeled as "money-minded". It can also infuriate patients and their relatives as their expectations grow with the referral. Unmet expectations can lead the unsatisfied or bereaved patient party to act out on their impulses, not caring for the law or repercussions.

It is imperative to prevent violence against physicians and healthcare workers. Concerned authorities have been vocal about the implementation of formal training and teaching programs in the curriculum to prevent WPV.[4,16,17] Only 13 (4.3%) participants in our study had received formal training against WPV. There is also a need to design studies that compare the efficacy of methods to prevent violence—little research has been done to identify efficacious methods. Designing such scientific experiments has been quite difficult,[4] but headway needs to be made.

There has also been little done by the legislative bodies. Ineffective reporting systems and a lack of action despite reporting are significant obstacles on the road to preventing violence in the workplace.[18] In the lack of proper reporting channels and the dearth of focused laws to implicate the perpetrators, physicians have little to feel secure about [19]. The effectiveness of extensive and strategic policies in reducing workplace violence has been shown by research conducted in other industries and educational institutions.[20] Concerned authorities like the Nepal Medical Association (NMA) or the NMC should actively and strongly lobby to ask the lawmakers to table stringent and well-defined laws along with severe punishment to create a safe environment for physicians to practice in. The government of Nepal is currently drafting a law that if passed, can jail perpetrators for up to 4 years or fine them up to NRs 200,000, or both.[21] The law if passed can provide much respite to the battered spirits of Nepalese health workers.

There is also a need to study violence against physicians from the aspect of patients and service seekers. Our study only gives the physicians' aspect relating to the violence, but to better prevent future episodes of WPV, studies must be conducted to appreciate the expectations and perceptions of the patients. Behaviors of the physician as perceived by the patient that make him likely to be violently confronted require an in-depth investigation.[22] Such studies can help further reduce incidents of workplace violence.

In our study, most of the participants were young doctors working in urban settings—the region of the country where most of the hospitals are located. Due to the poor reach of internet facilities across the country, our study does not portray a homogenous picture of the occurrence and consequences of WPV across the country, nor does it show a homogenous occurrence of WPV among doctors of all age groups. Given the voluntary and open access to the Google form across social media platforms, it could be possible that a doctor who had undergone WPV was more likely to fill the form compared to one that had not undergone WPV thus leading to overreporting of the cases, but as the prevalence of WPV in our study is comparable to WPV in other countries, that seems unlikely.

CONCLUSIONS

Workplace violence is a common occurrence among physicians working in Nepal and can lead to a wide spectrum of adverse psychological consequences like stress, depression, anxiety, a sense of defeat, and high job turnover. Overworked physicians are more likely to be victims of WPV while at the same time being prone to burnout—a lethal combination that can further perpetuate a downward spiral of workplace violence and poor/inadequate patient care. There lies a great need to address the issue of WPV against physicians (and all healthcare workers) to ensure a safe and conducive working environment that can bring the best out of the physicians. Introduction of a formal training curriculum to deal with (and deescalate) WPV, stringent and well-defined laws that protect healthcare workers and infrastructure, and research to find ways to prevent and deal with WPV are some of the pertinent needs of the hour.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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