Scientific Paper Entitled: Factors Affecting the Behaviour of Violence Against Health Personnel in The Government Health Sector in The Kingdom of Saudi Arabia

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Abstract

The safety and wellbeing of healthcare workers, as well as workplace operations, are negatively impacted by health care violence, which is a major global issue. There are few studies looking into health care violence in Saudi Arabia, and the findings are mixed. One of the most vulnerable groups to regular verbal and physical abuse while performing their jobs is the healthcare industry; this type of violence is a global concern. The absence of system privacy and the employees' perception that violent episodes were routine parts of their employment prevented the majority of victims from reporting incidents. Furthermore, it has been disclosed that a significant proportion of healthcare personnel did not have training on the reporting system, which accounts for their ignorance of the official reporting method. Ultimately, there has been a notable decrease in the incidence of violence among healthcare personnel as a consequence of the MOH program and the sanctions imposed for managing workplace violence.

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Introduction

The intentional use of force, whether actual or threatened, against an individual or group in a work-related setting that causes harm to the victim's mental state, poor performance, deprivation, or injury is known as violence in the workplace. The World Health Organization (WHO) defines workplace violence as situations in which employees are harassed, threatened, or physically abused while doing their jobs, including while traveling to and from work, and in which their safety, wellbeing, or health is directly or indirectly in jeopardy. In hospitals, violence can take the form of verbal, physical, or psychological abuse. Compared to workers in any other industry, healthcare professionals are more likely to experience verbal and physical abuse. The healthcare system as a whole as well as the continuity of patient treatment in particular are seriously compromised by these pervasive unethical attacks. Research indicated that workplace violence in the healthcare industry could lead to subpar care, employee turnover, absenteeism, a decline in public health services, hazardous workplaces, inappropriate social behaviour, higher health care costs, and a degradation of healthcare personnel. These days, it's common knowledge that workplace violence occurs frequently in the medical field; research revealed that between 24 and 88.8% of healthcare professionals report experiencing violent episodes annually (Zainal et al., 2018).

A Chinese study discovered that inadequate care was the primary cause of this kind of violence; each year, one million incidents of violence against medical professionals were recorded. 78.2% of doctors in Egypt reported experiencing violence on a yearly basis. The Emergency Department was the most frequently targeted hospital unit for violence, with the patients' Middle Eastern relatives and acquaintances being the main source of the violence. Studies have shown that extended wait times, unfulfilled expectations for patients and families, and overcrowding are the main causes of violence. Given that 70% of doctors would prefer that their children not pursue careers in medicine due to violent behaviour, these violent occurrences significantly damaged the self-esteem of healthcare providers. Recent years have seen a thorough investigation of workplace violence in the Middle East targeting healthcare personnel. Despite the existence of laws and regulations, there is a significant prevalence of workplace violence across the Middle East, including Saudi Arabia. More than two thirds of medical workers in Saudi Arabia report having been the victim of violence, either from patients or their families. Studies show that verbal abuse is the most frequent kind of violence; staff shortages, lengthy wait periods, and low expectations for patient demands are the main drivers of this kind of abuse (Alshehri, 2017).

In addition, the media has portrayed healthcare misconduct in an unfavourable light, which has been detrimental. Reports that break on medical professionals' negligence-related patient deaths on television and in the media have only worked against the interests of patients and against them. Because of the mistrust that has arisen between patients and healthcare professionals as a result of these instances, many practitioners are striving to receive self-defence training in order to protect themselves. The majority of violent crimes go unreported and stay unknown. As a result, we are unaware of the true incidence of workplace violence. This entails examining the actions of medical personnel after experiencing abuse at work and determining the causes of the majority of victims' inappropriate silence about violent crimes. Unfortunately, because patient happiness has historically taken precedence over employee safety, healthcare institutions have a poor violence prevention system and serious training program concerns. In actuality, the staff's psychological state had been severely harmed by all of these violent occurrences against

medical professionals who were left unsupported by the hospital administration (Sun et al., 2018).

Study Problem

Exploring factors affecting the behaviour of violence against health personnel in the government health sector in the Kingdom of Saudi Arabia.

Study questions:

1. What are the factors affecting the behaviour of violence against health personnel?

2. What is the effect of violence on healthcare workers?

3. How to control violence in healthcare facilities?

Study objectives:

1. To explain the factors affecting the behaviour of violence against health personnel.

2. To show the effect of violence on healthcare workers.

3. To discuss how to control violence in healthcare facilities.

Study limitations:

• Geographical boundaries: The study will be applied in the Kingdom of Saudi Arabia.

• Time limits: The study will be implemented in 2022.

• Human limitations: The study will be applied to a sample of health personnel in the government health sector in the Kingdom of Saudi Arabia.

• Subject limits: limited to studying the "Factors affecting the behaviour of violence against health personnel in the government health sector in the Kingdom of Saudi Arabia".

Literature Review

The majority of violent crimes go unreported and stay unknown. As a result, we are unaware of the true incidence of workplace violence. This entails examining the actions of medical personnel after experiencing abuse at work and determining the causes of the majority of victims' inappropriate silence about violent crimes. Unfortunately, because patient happiness has historically taken precedence over employee safety, healthcare institutions have a poor violence prevention system and serious training program concerns. In actuality, the staff's psychological state had been severely harmed by all of these violent occurrences against medical professionals who were left unsupported by the hospital administration (Tonso et al., 2016).

As a result, documenting violent incidents is crucial to the development of future, successful preventative strategies. Underreported incidents may be linked to a lack of staff training on managing violent behaviour and a system or procedure for preventing violence. According to a Saudi Arabian study, nurses' reluctance to report acts of violence is due to three factors: a lack of confidence in the efficacy of the violence prevention system, poor reporting procedures, and mistrust of the reporting system (Al Ubaidi, 2018).

Workplace violence is described as "violent acts (including physical assaults and threats of assaults) directed to persons at work or on duty" by the National Institute for Occupational Safety and Health (NIOSH). Patients, their families, visitors, and co-workers are among those who commit violent acts (collegial or horizontal violence) (Edward, et al., 2014).

Forms of violence

The World Health Organization states that there are various forms of violence, including physical and psychological ones, which frequently overlap. The use of physical force against another person that causes them to suffer bodily, sexual, or psychological harm was referred to as physical violence. It could involve shoving, biting, pinching, shooting, kicking, slapping, and stabbing. The deliberate use of power, such as verbal abuse, threats, intimidation, bullying/mobbing, and harassment, was characterized as psychological violence. The excessive use of language to violate someone's security and dignity by making fun of them or making fun of them is known as verbal abuse or violence. Threats are statements of intent to inflict harm, including written threats, threatening body language, and vocal threats, according to the National Institute for Occupational Safety and Health. An intentional act of psychological assault, intimidation makes a normal person feel scared or afraid (Vezyridis et al., 2015).

The likelihood of violence against HCWs in the workplace is heightened by numerous circumstances. These elements have to do with co-workers, offenders, or the working environment (Al-Turki et al., 2016).

Organizational Factors:

The risk factors that are linked to patient-initiated workplace violence have been further subdivided into three categories: issues pertaining to staff (e.g., poor security and long wait times), issues pertaining to the work environment (e.g., understaffing and working alone), and issues pertaining to patients (e.g., altered mental states or substance abuse). In addition, HCWs react to workplace violence in a variety of ways. One common response is underreporting, which adds to an overall underestimating of the problem's scope. The idea that violence is part of the job, ambiguity over what constitutes violence, the idea that perpetrators lack self-control due to substance abuse or mental illness, the expectation that no corrective action will be taken, and a general lack of knowledge about policies and reporting systems all contribute to this. HCWs believed that long wait times, patients' or families' lack of knowledge, personality and cultural problems, understaffing, congestion, workloads, and a lack of security were the primary causes of violence (Phillips, 2016).

Numerous factors have been linked to the emergency hospital staff's high susceptibility to violence, including low staffing levels, a lack of training for staff to identify and defuse potentially dangerous patients, a lack of violence prevention programs, inadequate security, working in public spaces, and providing services, education, and/or working with mentally ill or unstable individuals. Certain periods of the day, such the late hours of the night or the early hours of the morning, may carry a higher risk of violence. Long patient waits times, patient discomfort; patient and family strain, stress, and rage; and a lack of privacy are other reasons that can lead to violence against emergency room staff. Studies conducted elsewhere in the past attest to the high incidence of workplace violence among emergency medical personnel. Workplace violence may become more aggressive in the future, particularly in the absence of efficient reporting mechanisms and prevention measures (Alharthy et al., 2017).

Significant factors for patients

Mental health conditions include schizophrenia, anxiety, acute stress reaction, dementia, thoughts of suicide, alcohol and drug abuse, older age, male sex, experiencing violence, and possessing firearms (Al-Turki et al., 2016).

The most common causes of violence seemed to be inadequate medical care and a shortage of hospital supplies. Other contributing factors included patients' or their companions' violent behaviour, low educational attainment, and congestion in the medical institution. Patients are growing more demanding and are far more inclined to act aggressively if they are dissatisfied with their medical treatment. According to a study conducted in Jordan, overcrowding, a lack of staff, a lack of resources, and the absence of strong anti-violence

regulations are among the reasons that lead to workplace violence against emergency department employees. Long wait periods have been demonstrated to aggravate and agitate patients and their families even in the absence of an ongoing dispute (Lafta & Falah, 2019).

Factors related to HCWs

Included were long job hours, working alone, understaffed conditions (particularly during mealtimes and visiting hours), and treating erratic patients in mental and emergency departments. Nonetheless, there were contradictory results regarding age, sex, and other demographic traits as well as contradictory results regarding the kind of employment, with nurses probably being at a higher risk (Al-Turki et al., 2016).

Occupational characteristics

Studies found that working night or evening shifts, working several shifts, and lacking a supportive atmosphere for reporting were associated with an increased risk of violence. However, the only other independent predictor linked to violence was working nights or weekends. Numerous research revealed that night and evening shifts were when most workplace violence happened. Working the night shift is typically linked to extended hours spent alone at work, both of which have been linked to an increased risk of workplace violence. Furthermore, operating at night raises the possibility of encountering more erratic patients because of inadequate security. It was advised that in order to lower the danger of workplace violence, staffing patterns that minimize worker alone time and after-hours care should be maintained. Tough punishments should also be imposed on violators (Hinsenkamp, 2013).

Individual factors

For example, working with mentally ill, alcoholic, or drug-abusing patients; being a female healthcare worker; or living and working in a foreign community with distinct customs and traditions (Alshahrani et al., 2021).

The effect of violence on healthcare workers

The healthcare system as a whole as well as the continuity of patient treatment in particular are seriously compromised by these pervasive unethical attacks. Research indicated that workplace violence in the healthcare industry could lead to subpar care, employee turnover, absenteeism, a decline in public health services, hazardous workplaces, inappropriate social behaviour, higher health care costs, and a degradation of healthcare personnel. Workplace violence can result in a variety of psychological and physical effects. The frequency, intensity, and type of violence all influence its effects, which can vary widely. For instance, physical injuries might vary from bruises to fractured bones. Psychologically speaking, the majority of healthcare professionals reported experiencing various emotional disturbances, including persistent fear, rage, despair, anxiety, and sleep disturbances. Furthermore, verbal and physical abuse can have a detrimental impact on a worker's career; regrettably, the majority of victims stated that they intended to quit (Alshahrani et al., 2021).

How to control violence

The concerning results of research conducted both domestically and internationally highlight the critical necessity for preventive measures and stringent policies to stop violent behaviour. By putting these safeguards in place, healthcare professionals will feel secure enough to carry out their jobs and deliver high-quality treatment. Healthcare professionals tend to tolerate aggressive behaviour from patients or family members, even though this is unacceptable unless the violence was unintended. For a very long time, violence against healthcare professionals has been disregarded and undervalued. However, there is a lot of attention being paid to this occupational hazard right now. In July 2018, Saudi Arabia's Ministry of Health (MOH) imposed fines and penalties in an effort to reduce and eliminate workplace violence. According to the MOH, it is illegal to verbally or physically attack medical professionals, and punishment for this offense is up to ten years in jail.

Furthermore, a hotline (937) was established to facilitate prompt reporting and communication on any verbal or physical abuse directed against healthcare professionals (Hogarth, et al., 2016).

The current state of violence prevention training is characterized by general programs that are not customized for the prehospital patient care provider or the particular mobile environment of emergency medical services (EMS). Additionally, self-defence tactics are frequently the main focus of available trainings rather than prevention. Researchers recommend that an EMS violence intervention program take into account the following factors: staff anxiety decompression, environmental considerations, self-assessment, prevention, verbal intervention (calming/defusing techniques), escape and release procedures, control and restraint procedures, and post-incident follow-up. Developing one's communication skills with patients, their families, and bystanders, recognizing high-risk situations, putting safety measures in place efficiently, providing mental health support, and making resources available to professionals who have experienced workplace violence (WPV) are other factors to take into account (Murray et al., 2020).

Even in between contract talks, union activity can influence policy changes and the availability of protective gear at specific workplaces. Unions can influence underreporting by promoting the removal of obstacles to reporting. Including all of these in collective bargaining agreements will enhance them even more. The capacity to develop solutions workplace by workplace from the bottom up and show that they are workable benefits the represented workplaces right away and may eventually result in the adoption of related solutions as best practices, regulations, and/or legally binding standards. There isn't another type of advocacy group that can directly affect individual workplaces to that extent (Murray et al., 2020).

Aim of the study:

To detect factors affecting the behavior of violence against health personnel in the government health sector in the Kingdom of Saudi Arabia.

Methods

Research design:

In the Kingdom of Saudi Arabia, a descriptive analytic cross-sectional research design was conducted with the purpose of detecting factors affecting the behavior of violence against health personnel in the government health sector in the Kingdom of Saudi Arabia. This design is a method that is both systematic and organized, and it is used to gather data from a sample of individuals or entities that are part of a larger population. The major objective of this design is to provide a comprehensive and accurate description of the characteristics, behaviors, perspectives, or attitudes that are present within the target group.

Research Setting:

The study will be conducted in in the government health sector in the Kingdom of Saudi Arabia.

Subject:

Those health cadres who are employed in the government health sector in the Kingdom of Saudi Arabia, both male and female, will be required to meet specific inclusion criteria in order to be considered for inclusion in the sample.

Sample size:

Study sample was 700 of health cadres selected via the systematic random sampling method. When conducting an empirical research with the purpose of drawing conclusions about a population based on a sample, the size of the sample is an essential component to

consider. In actual fact, the sample size that is used in an investigation is established by taking into consideration the cost of data collection as well as the need to have enough statistical power.

Inclusion Criteria:

The inclusion criteria were set as follows:

(1) health cadres who working in the government health sector in the Kingdom of Saudi Arabia.

(2) female and male.

(3) from Saudi Arabia.

Sampling Technique:

Participants submitted data through a survey. Data will be collected by questionnaire.

Tools for data collection:

It will deal with Participants demographic such like age, gender, marital status and educational level. Also issues concerning factors affecting the behavior of violence against health personnel in the government health sector in the Kingdom of Saudi Arabia.

Validity:

The revision of the tools were ascertained by a panel of experts to assess the content validity of the tools and the required modification was done appropriately.

Ethical considerations

Data was submitted by individuals via questionnaires. Participants were notified that participation in the research would be elective and that their anonymity would be preserved. Data will be acquired using a self-reported questionnaire. The ethics committee will offer clearance for this initiative. Before the questionnaire was conducted, each participant supplied signed informed consent.

Results

Validity and Reliability Tests:

Internal Consistency Reliability Calculation:

After determining the legitimacy of the internal consistency between the statements of each objective and the overall score for the corresponding axis, Pearson's Coefficient Correlation was computed in order to validate the validity of the statement. Following the construction of the research instrument and the establishment of its apparent validity by the presentation of the instrument to a panel of arbitrators who were both knowledgeable and experienced in the area, this step was taken.

For the purpose of determining whether or not the questionnaire has an internal reliability, it was administered to a pilot sample that consisted of thirty members of the healthcare staff. After that, the researchers determined the correlation coefficients in order to assess the internal validity of the research instrument, as the tables that follow demonstrate:

Table (1): Correlation coefficients of items in the first axis with the total score.

Statement number	r	Statement number	r
1	0.496**	7	0.757**
2	0.868**	8	0.456**

3	0.632**	9	0.721**
4	0.646**	10	0.301**
5	0.891**	11	0.759**
6	0.654**		

**: p value <0.001

It is clear from the previous table that all of the statements are significant at the 0.01 level, as the values of the dimensional correlation coefficients ranged between (0.301 - 0.891), which are excellent correlation coefficients, and this offers a hint of strong internal consistency coefficients as well. It provides strong validity indications that may be relied in utilizing the present research technique.

Reliability of the study tool:

As for testing the reliability of the questionnaire, we utilized Cronbach's alpha coefficient, and the accompanying table illustrates the reliability axis of the research instrument as follows:

Table (2): Cronbach's alpha coefficient reliability coefficient for the total score of the questionnaire

	No. of statements	Cronbach's alpha
comprehensive quality standards questionnaire	11	0.856

The table showed that the Cronbach's alpha reliability coefficient for the total score of the questionnaire was (0.856), which is a good reliability coefficient suitable for the study.

Application Method of the Study Tool:

After collecting the study data, the researchers reviewed it in preparation for inputting it into the computer for statistical analysis. Subsequently, they transcribed it onto appropriate tables, provided commentary, and linked it to previous studies. Responses were given five levels: strongly agree (5 points), agree (4 points), neutral (3 points), disagree (2 points), and strongly disagree (1 point). To determine the length of the pentavalent scale cells used in the study Phrases, the range (5-1=4) was calculated and divided by the number of questionnaire cells to obtain the correct cell length (4/5=0.80). This value was then added to the lowest value on the scale (or the beginning of the scale, which is one) to determine the upper limit of the cell. The following table illustrates the method for correcting the Likert pentavalent scale.

Table (3): Method for correcting the scale.

Scale	The weight	The average arithmetic mean value ranges
Strongly Disagree	1	From 1 to less than 1.80
Disagree	2	From 1.81 to less than 2.60
Neutral	3	From 2.61 to less than 3.40
Agree	4	From 3.41 to 4.20
Strongly agree	5	From 4.21 to 5.

Table (4): Socio demographic characteristics of the studied participants

| Sociodemographic variables	Cases (n=700)	
	No.	%
Age category (years)		
Less than 25 years	150	21.4%
From 26 to 35 years	130	18.57%
From 36 to 47 years	260	37.1%
More than 47 years	160	22.8%
Gander		
Male	400	57.1%
Female	300	42.85%
Marital status		
single	250	35.7%
married	180	25.7%
absolute	270	38.57%
Job		
doctor	90	12.85%
pharmaceutical	60	8.57%
specialist	220	31.4%
Technical	230	32.85%
nurse	65	9.3%
Administrative	35	5%
Educational status		
Diploma or less	250	35.7%
Bachelor's	160	22.85%
Postgraduate studies (PhD - Master)	290	41.4%
Years of experience		
1 – 5 years	180	25.7%
6 – 10 years	160	22.85%
11 - 15 years	140	22%
16 – 25 years	220	31.4%
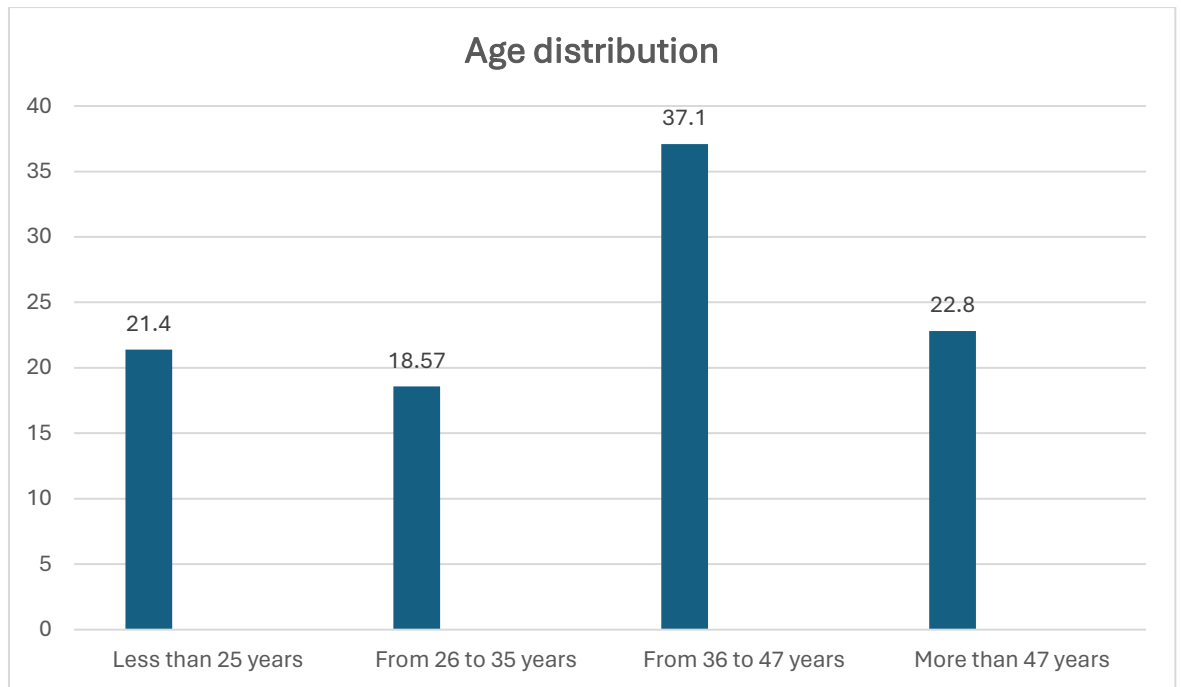
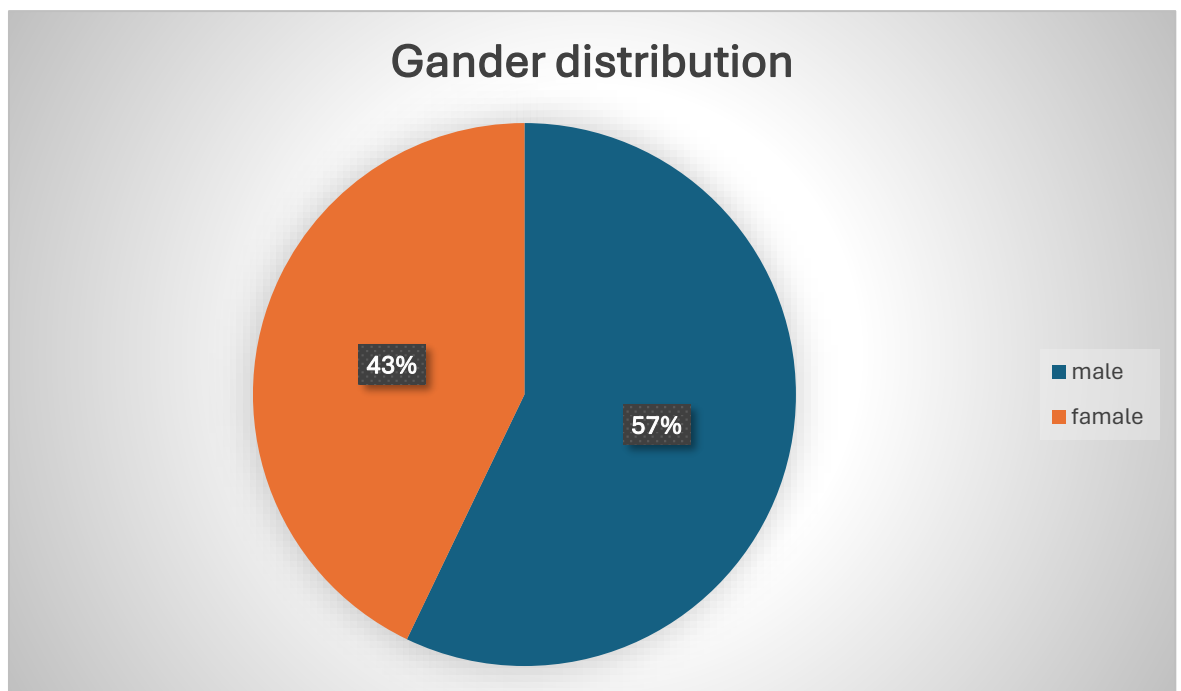Fig (1): Age distribution among the studied participants

Fig (2): gander distribution among the studied participants

Table (1) & Figure (1-3) showed that 37.1% and 18.75% of the studied participants were aged 36 -47 years and 26-35 years respectively. Regarding to the gander, more than half (57%) were males and 43% were females. 33.4% of the studied participants were specialist while only %32.85 was Technical. As regard to years of experience, 22.85% of the studied participants worked from 6 – 10 years.

Secondly: Results Related to the Axes of the Questionnaire:

Table (5): response of the studied participants regarding to the first axe (Violence Experience) of Questionnaire

No.		Cases (n=700)			
		Mean	SD	Category	Rank
1-	Have you ever experienced violence (verbal or physical) in the workplace?	4.23	0.865	Strongly agree	3
2-	How frequently do you encounter violent incidents in your workplace?	3.58	0.824	Agree	7
3-	Lack of security measures is the primary reasons behind violence against health personnel in the government health sector.	3.75	0.722	Agree	6
4-	Long waiting times and overcrowding are the primary reasons behind violence against health personnel in the government health sector	4.11	0.67	Agree	5
5-	High expectations from patients are the primary reasons behind violence against health personnel in the government health sector	4.52	0.865	Strongly agree	1
6-	Communication barriers are the primary reasons behind violence against health personnel in the government health sector	4.26	0.758	Strongly agree	2
7-	Staff shortages are the primary reasons behind violence against health personnel in the government health sector	4.22	0.657	Strongly agree	4
8-	Lack of awareness among patients about the healthcare system contribute to escalating violent incidents.	3.42	0.642	Agree	8
Total score		3.93	0.788	Agree	

From the results shown in Table (5), it is evident that there is variation in the agreement among the study participants regarding the comprehensive quality standards and the productivity of health personnel in the government health sector in the Kingdom of Saudi Arabia. The participants' agreement averages ranged from (3.42 to 4.52), falling into the fourth and fifth category of the Likert scale, indicating agreement to strongly agreement with the study tool. This demonstrates consistency in agreement among the study participants regarding factors affecting the behavior of violence against health personnel in the government health sector in the Kingdom of Saudi Arabia.

Phrase (5): High expectations from patients are the primary reasons behind violence against health personnel in the government health sector. ranked first with an average agreement of (4.52)

Phrase (6): Communication barriers are the primary reasons behind violence against health personnel in the government health sector. ranked second with an average agreement of (4.26)

Phrase (1): Have you ever experienced violence (verbal or physical) in the workplace. Ranked third with an average agreement of (4.23)

Table (6): response of the studied participants regarding to the second axe (Preventive Measures) of Questionnaire

No.		Cases (n=700)			
		Mean	SD	Category	Rank
1-	Improved communication strategies with patients prevent violence against health personnel in the government health sector.	4.132	0.699	Agree	2
2-	Have you received any training or support related to handling violent situations in the workplace?	3.735	0.741	Agree	3
3-	Comprehensive staff training in conflict resolution prevent violence against health personnel in the government health sector.	4.612	0.831	Strongly Agree	1
Total score		4.31	0.821	Strongly agree	

Phrase (3): Comprehensive staff training in conflict resolution prevent violence against health personnel in the government health sector. ranked first with an average agreement of (4.612)

Phrase (1): Improved communication strategies with patients prevent violence against health personnel in the government health sector. ranked second with an average agreement of (4.132)

Phrase (2): Have you received any training or support related to handling violent situations in the workplace? Ranked third with an average agreement of (3.735)

Discussion

The conduct of violence against health staff in the government health sector in the Kingdom of Saudi Arabia is influenced by a number of different elements. The high levels of stress and irritation that patients feel as a result of lengthy wait times and congested facilities are a crucial aspect that contributes towards the problem. Because of these settings, tensions might become even more heightened, which can then escalate to instances of verbal or physical abuse directed against healthcare personnel (Al-Turki et al., 2016).

As an additional point of interest, cultural norms and expectations play a part in the formation of attitudes on the provision of healthcare. The reality of resource restrictions and process limitations in healthcare settings may not always coincide with the expectations that patients have for rapid and individualized treatment. Patients may have heightened expectations regarding these aspects of care. A mismatch like this might give rise to feelings of discontent and hostility toward healthcare practitioners (Alshahrani et al., 2021).

Conclusion

Violent attacks, primarily verbal, perpetrated by the patient's friends or family in a medical setting are a serious problem. Because they believe it is part of their job and there is a lack of system privacy, the majority of victims choose not to disclose the events. The majority of healthcare professionals' ignorance of the formal reporting system can be attributed to their lack of reporting system training. Healthcare workers are pleased with the MOH's program and sanctions for reducing workplace violence, which have led to a notable decrease in the incidence of violence. Furthermore, more research is advised in this area as

the mechanism for reporting violence may reduce the frequency of violent incidents. Lastly, study participants proposed that creating a strong reporting system and raising public knowledge of violence-related concerns could help to lessen the risk associated with this line of work.

References:

Zainal, N., Rasdi, I., & Saliluddin, S. M. (2018). The Risk Factors of Workplace Violence among Healthcare Workers in Public Hospital. Malaysian Journal of Medicine & Health Sciences, 14.

Alshehri, F. A. (2017). Workplace violence against nurses working in emergency departments in Saudi Arabia: a cross-sectional study (Doctoral dissertation).

Sun, J., Liu, S., Liu, Q., Wang, Z., Wang, J., Hu, C. J., ... & Liu, Y. (2018). Impact of adverse media reporting on public perceptions of the doctor–patient relationship in China: an analysis with propensity score matching method. BMJ open, 8(8), e022455.

Tonso, M. A., Prematunga, R. K., Norris, S. J., Williams, L., Sands, N., & Elsom, S. J. (2016). Workplace violence in mental health: A Victorian mental health workforce survey. International journal of mental health nursing, 25(5), 444-451.

Al Ubaidi, B. (2018). Workplace Violence in Healthcare-An Emerging Occupational Hazard. Bahrain Medical Bulletin, 40(1).

Edward, K. L., Ousey, K., Warelow, P., & Lui, S. (2014). Nursing and aggression in the workplace: a systematic review. British journal of nursing, 23(12), 653-659.

Vezyridis, P., Samoutis, A., & Mavrikiou, P. M. (2015). Workplace violence against clinicians in Cypriot emergency departments: a national questionnaire survey. Journal of clinical nursing, 24(9-10), 1210-1222.

Al-Turki, N., Afify, A. A., & AlAteeq, M. (2016). Violence against health workers in Family Medicine Centers. Journal of multidisciplinary healthcare, 257-266.

Phillips, J. P. (2016). Workplace violence against health care workers in the United States. New England journal of medicine, 374(17), 1661-1669.

Alharthy, N., Mutairi, M. A., Alsahli, A., Alshehri, A., Almatrafi, A., Mahah, A., ... & Qureshi, S. (2017). Workplace violence among emergency medical services workers in Riyadh, Saudi Arabia. Journal of Hospital Administration, 6(3), 26-32.

Lafta, R. K., & Falah, N. (2019). Violence against health-care workers in a conflict affected city. Medicine, conflict and survival, 35(1), 65-79.

Hinsenkamp, M. (2013). Violence against healthcare workers. International Orthopaedics, 37, 2321-2322.

Alshahrani, M., Alfaisal, R., Alshahrani, K., Alotaibi, L., Alghoraibi, H., Alghamdi, E., ... & Aljumaan, M. (2021). Incidence and prevalence of violence toward health care workers in emergency departments: a multicenter cross-sectional survey. International journal of emergency medicine, 14, 1-8.

Hogarth, K. M., Beattie, J., & Morphet, J. (2016). Nurses' attitudes towards the reporting of violence in the emergency department. Australasian emergency nursing journal, 19(2), 75-81.

Murray, R. M., Davis, A. L., Shepler, L. J., Moore-Merrell, L., Troup, W. J., Allen, J. A., & Taylor, J. A. (2020). A systematic review of workplace violence against emergency medical services responders. New solutions: a journal of environmental and occupational health policy, 29(4), 487-503.