


International Labour Office **ILO** International Council of Nurses **ICN**
World Health Organisation **WHO** Public Services International **PSI**

Joint Programme on
Workplace Violence in the Health Sector

Workplace Violence in the Health Sector

LEBANON Country Case Study

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A. Background

1. Concept of Violence

The concept of violence in the Lebanon Study followed the definitions given by the research protocol. No changes were introduced to the definitions proposed in the sample questionnaire.

2. Existing violence measurement mechanisms

There are no defined rules and procedures to prevent violence in the workplace.

3. Existing Knowledge on workplace violence in the health sector

We were not able to find any previous systematic research done on violence in the Health sector. The nursing chapter informed us that they were planning to apply for a grant to investigate the problem among nurses.

The data available comes mainly from newspaper report or hearsay. A sample of an incident reported recently in the news is illustrated by the Newspaper coverage.
(Appendix 1)

B. Country Case Study

1. Methodology

Description of Methods used to collect and analyze data

The field research data collection consisted of two approaches: Qualitative and Quantitative analysis.

First we will report on the qualitative component where the data was gathered through Focus group discussions and in-depth interviews.

Qualitative Part – Field research

Three focus group discussions were undertaken before the quantitative data collection started in order to verify and revise definitions of violence. A summary of the focus group discussions is summarized below.
The first group consisted of 7 nurses and 2 midwives working at different health centers affiliated with the ministry of social Affairs and Health.

The second group consisted of 6 Regular Nurses working in hospitals mainly providing Home care.

The third group consisted of women patients utilizing the Governmental Health Care centers.

The guideline A for focus group discussion with health personnel was used.

Qualitative Survey

Results of Focus Group Discussions with Health Care Personnel:

Responses from discussions with two groups of health care personnel are included in this section. The first group consisted of 7 nurses and 2 midwives working at several health centers affiliated with the Ministry of Social Affairs. The second group consisted of 6 nurses providing home care and working at hospitals as well. The guideline A for questions addressed to health personnel was used during the focus group discussions. The feedback from each one of the participants in both focus groups is considered to be equally critical to the understanding of the problem of workplace violence in the health sector, and their responses will therefore be grouped together.

1- Description of workplace violence in the health sector:

Taken together, the nurses and midwives described violence at the workplace to be both verbal and non-verbal communication and/or behavior that might hurt the victim physically and/or emotionally.
They listed the following examples to be a representation of violence against them coming from different sources:

When the source of violence is a colleague or a supervisor, examples of violence include:

- Tone of voice (authoritarian, degrading, cruel, disrespectful…)
- Insults
- Offensive talk
- Eye contact with disdain
- Slamming the table with the fist
- Hitting
- Abuse of power
- Mistreatment
- Discrimination between employees at the same level
- Lack of appreciation and appraisal
- Low pay
- Work overload
- Hostile unjustified behavior

When the source of violence is a patient or a patient's relative, examples of violence include:

- Lack of trust in the competence of the nurses and midwives
- Lack of compliance
- Breaking the rules (Not waiting for their turn to arrive)
- Offensive and impolite talk

2- Recommended revisions for existing definitions of workplace violence in the health sector:

All nurses and midwives in both focus groups agreed with all the definitions provided by the facilitator and approved the categories under each of the two main forms of violence, the physical and the psychological.
For this reason, the rest of the qualitative survey is based on the definitions provided with the survey questionnaire without any modifications.

3- Worries about workplace violence in the health sector:

All nurses and midwives in both groups expressed their constant fear of being subjected to violence. However, the reasons given for such concerns differed between nurses working in hospitals and health centers and those providing home care.
This shows that although violence is a concern for all healthcare providers, the reasons behind it differ depending on the workplace.
Both groups said that they are now more worried than one year ago not only because there are no solutions or interventions taking place for the problem but also because stress and pressure are constantly increasing, and personal and social problems are accumulating as well for both health care providers and patients.

The following are some of the reasons mentioned about why the nurses and midwives were worried about the problem of violence at the workplace:

For those working at the health center or at the hospital, the reasons were:

- Poor salaries
- Absence of retirement plans
- Lack of job security
- Absence of proper insurance
- Fierce competition among colleagues
- Offensive behavior on behalf of the patients and their relatives determined by their own personal problems
- Increased gossiping in healthcare settings
- Poor management skills of the supervisors and directors

For those providing care at home, the reasons were:

- Being involved in the problems of the family they are working for (sometimes family members fight with each others and use foul language in front of the nurse and she has to continue the treatment till the end)
- The increased knowledge of the patients receiving care at home about their medical condition feeds their tendency to interfere with the nurse’s work and treatment
- The constant presence of the patient’s family members in the room while the nurse is doing her job. They always observe her and compare her work methodology with other nurses they’ve seen before
- Many nurses were wrongfully accused of stealing jewelry and valuables from the homes they worked in

- Many nurses are offended by the way patients look at them and talk to them and are afraid of sexual harassment

4- Mostly encountered types of workplace violence in the health sector:

According to all nurses and midwives in both groups, psychological violence is the type of violence that they are mostly suffering from at the workplace.
Home care providers were much more concerned about psychological violence because they knew that if an incident of physical violence occurred they would have the chance to file lawsuits against the perpetrator whereas it is almost impossible to claim and file lawsuits in cases of psychological violence.

According to all participants psychological violence is represented through:

- Injustice caused by misuse of power and discrimination
- Conflicts due to unclear job descriptions
- Stress caused by fierce competition and the nature of the work
- Mistreatment from patients
- Lack of respect
- Lack of appreciation and appraisal
- Anger of the nurses for having to tolerate unpleasant reactions of the physicians, staff, patients and patients' relatives
- Underestimation and disrespect of the profession of nursing in the society

5- Victims of workplace violence in the health sector:

All participants in both groups strongly agreed that nurses are the people who are most likely to be victimized in healthcare settings.
The group of nurses and midwives working at health centers and not at hospitals or patient's home stated that patients, lower level employees (i.e. janitors), and even sometimes the director are subject to violence and therefore can be considered victims of violence in addition to nurses.

6- Aggressors in the health sector:

According to nurses and midwives in both groups, the aggressors in healthcare settings differed depending on the type of victims in question.
Participants did not separate physical violence from psychological violence, since physical violence is very rare at the workplace and in both cases the aggressor could be any of the following:

When the nurse is the victim, the aggressor can be:
- Colleagues
- Supervisors/directors
- Physicians
- Patients
- Patients' relatives

When the patient is the victim, the aggressor can be:
- Nurses

- Staff in health centers who feel they are more powerful than patients
- Physicians

When lower level employees are the victims, the aggressor can be:
- Higher level employees including nurses and physicians
- Patients
- Patients' relatives

7- Contributing factors to workplace violence in the health sector:

All nurses and midwives in both groups listed similar contributing factors for workplace violence. In most instances, participants were referring to factors contributing to both physical and psychological violence at the same time.

The following are factors listed by the participants:
- Verbal fights that could lead to physical contact
- Lack of control over reactions and anger
- Accumulation of previous conflicts
- Working conditions (atmosphere at the health center, physical environment at the health center such as excessive heat or cold, noise, bad furniture [ergonomics], bad condition of the building [walls, windows, doors, and ceiling]…)
- Jealousy and competition among colleagues
- Gender differences
- Financial reasons (poor salary, no benefits, no bonus…)
- Unjust distribution of work (some people are overloaded and others are sitting doing nothing)
- Shortage of nursing staff
- Lack of sufficient knowledge (for both aggressor and victim)
- Lack of confidence (for victim)
- Nature of the work (Stressful)
- The conflict between nurses and nurse aids at the hospital (the nurse aids have many years of experience but no university diploma, the nurses have university diplomas but not much experience and they are superior in the hierarchy to nurse aids who consider themselves to be more important)

Nurses who provided home care stated in addition to the above-mentioned factors the closed system they work in at patient's home. In other words, the nurse is found alone with the patient in his/her own home without any other medical or paramedical staff to assist her and back her up (like in the hospital or health center), so she finds herself obliged to set her own rules and limits with the patient on a one-to-one basis since she is not operating in an institution where established rules and regulations protect her.

8- Triggers of incidents of workplace violence in the health sector:

Nurses and midwives in both groups agreed that a violent incident occurs as a result of several previous conflicts and problems and is triggered off by any tiny accident.

They explained that the following could trigger off a violent incident:
- A word

- A gesture
- A mistake on the job
- A misunderstanding
- One's tone of voice

9- Consequences of workplace violence in the health sector:

All participants in focus group discussions confirmed that the consequences of a violent incident do not only affect the victim but they also harm the aggressor and the people around them.
They also agreed that damage occurs at different levels in the healthcare setting:

On the level of individual workers, the consequences are:
- Resignation of someone from his/her job
- Physical symptoms (injury, pain, crying, shouting…)
- Punishment including firing employees
- Suicide (one participant one such case)
- Isolation
- Pity from friends at work
- Psychological problems (low self-esteem, low self-respect, guilt feeling)
- Feeling of being threatened
- Less devotion and motivation to work (especially if the aggressor was a patient)
- Negative effects on team work and interaction
- Anger, frustration and depression

On the level of the work atmosphere, the consequences are:
- Tension at work
- Chaos at work
- Division of colleagues into two teams (one supporting the aggressor and the other the victim)
- Absence of trust among colleagues

On the level of the provision of services in the healthcare setting, the consequences are:
- Low quality of service
- Reflection of a bad image of the healthcare setting
- Physical damage of the healthcare setting
- More shortage of healthcare professionals (many healthcare professionals shift to other fields in order to avoid being subject to violence at the workplace, they start working in insurance companies, pharmaceutical companies as sales representatives)

10- Existing institutional response mechanisms for workplace violence in the health sector:

The nurses and midwives working in health centers explained that there are no specific rules and regulations that dictate what measures should be taken in case of a violent incident in the health center. They added that what usually happens is, that social workers present in the health center try to help the victim to overcome the problem.
Since policies to deal with incidents of violence are lacking, the supervisor or director in the health center takes the lead and interfere to resolve the conflict; in other cases, one of the

health workers acts as mediator between the victim and the aggressor in order to solve the problem.
Whenever the patients are the source of the violent incident, it is taken for granted that the health worker has to tolerate the patients' behaviors as long as he/she can stand it.

The nurses working at hospitals said that in case of a violent incident they had to fill some papers and complain to the head nurse, who in turn informs the director. Unfortunately, nurses do not go through this because they know that not only it will not help them in anyway but also it might affect them negatively especially when the aggressor is a physician. In fact, a nurse might get fired because of a mistake done by a physician.

The nurses providing home care confirmed that in case of physical violence their institution immediately stops providing the patient with any type of care. In case of psychological violence, if the nurse reports to her supervisor, the latter usually asks someone else to replace her; if the incident occurs again, the institution may end its care to the patient in question.

11- Response of individuals to workplace violence in the health sector:

All participants agreed that every person has his/her own threshold to how much he/she can stand and therefore responses vary from one person to another. According to them, the response depends on the intensity of violence, its frequency, and the nature of the aggressor (i.e. his/her status in the hierarchy, within or out of the institution)
The nurses and midwives in the two groups stated the following as possible responses in case of a violent incident, be it psychological or physical:

For victims:
- Absorbing the problem and not making an issue out of it
- Answering back with violence
- Reconciliation with the aggressor even if the latter did not apologize
- Trying to ruin the aggressor's reputation
- Anger and frustration
- Depression

For Colleagues:
- Avoiding the aggressor and the victim as well
- Trying to help in conflict resolution
- Trying to control the situation
- Losing trust in either the aggressor or the victim
- No reaction, trying to forget about the whole problem
- Do not talk about the truth of the incident unless someone superior to them investigating on the issue asks them about it
- "Thank God it did not happen to me"

12- Existing support for victims of workplace violence in the health sector:

All nurses and midwives working in health centers were not aware of any kind of institutionalized support for victims available in the health centers. They had heard about

NGOs present in the community and who are involved in helping out victims of domestic violence but they have never referred anyone to them.

All nurses working in hospitals consented that the only procedure to deal with workplace violence was to submit a written letter to higher management. They were not aware of institutions in the community involved in supporting victims of violence.

13- Recommendations for improvement of support services for victims of both physical and psychological violence:

The nurses and midwives in both groups perceive the following as possible solutions or measures to improve support for victims of workplace physical and psychological violence in the health sector:

- Regular meetings among employees and supervisors to raise awareness about the issue of violence and discuss possible conflicts or problems that may arise
- Involving social workers in active interventions against violence at the workplace
- Formulate procedures to be followed by everybody including patients who want to claim any unpleasant incident

14- Measures for prevention of workplace violence in the health sector:

The following are measures suggested by nurses and midwives in the two groups to prevent violence in the workplace:

- Making available a box for comments and complaints at the healthcare institution for both the employees and the patients
- Developing clear and precise job descriptions and terms of reference for every position at the healthcare institution and communicating those to the people concerned (especially in health centers)
- Defining roles of employees (especially in health centers)
- Creating a family atmosphere at work by involving everyone in social activities and events to strengthen bonds between employees
- Increasing awareness of the public about the importance of nurses and their devotion

Results of Interviews with Healthcare Personnel Working in Organizational or Political Context:

Responses from interviews with five high-ranking healthcare professionals are included in this section. The definition of high-ranking healthcare professional for the sake of the current document is the healthcare professional that is in a position of decision-making in a healthcare institution or body. The people interviewed worked in one of the following institutions or organizations: American University of Beirut-Medical Center, Ministry of Social Affairs, and the Nursing Federation.

The guideline B for questions addressed to target groups working in organizational or political context was used during the interviews.
The feedback from each of the interviewees is considered to be equally critical to the understanding of the problem of workplace violence in the healthcare sector, and their responses will therefore be grouped together.

1- Description of workplace violence in the healthcare sector:

All interviewees stated that violence is any type of harassment, abuse, aggressive behavior or attitude, and mistreatment whether it is physical or psychological/emotional.

2- Recommended revisions for existing definitions of workplace violence in the healthcare sector:

All interviewees agreed with all the definitions provided by the interviewer and approved the categories under each of the two main forms of violence, the physical and the psychological. For this reason, the rest of the qualitative survey is based on the definitions provided with the survey questionnaire without any modifications.

3- Concern about physical and psychological violence targeting health sector personnel:

Responses of interviewees regarding this question varied.
Some of them did admit that violence against health personnel is a concern for them because:

- It causes the departure of many nurses from Lebanon (the attrition rate after the first year of work has reached 40%)
- It negatively affects the motivation of nurses to work
- Nurses in Lebanon do not have a licensed representative body to represent them and fight for their rights
- Nurses are mostly female and are subject to high levels of discrimination

One of the interviewees stated: “Violence should be a concern for decision makers in every institution because it is a potential problem at any given time”.

One person, who occupies a very high position in the Ministry of Social Affairs contradicted the opinions of the other interviewees by saying that violence is not a concern given the nature of the institution where conflict is easily resolved because employees are used to being patient and for most of them it is their job to solve problems.

All interviewees could not confirm whether or not the problem of violence in the health sector has increased since last year because they did not have enough data to assess the problem. However, most of them believe that since there haven’t been any major solutions that were implemented, the problem persisted and may have even increased.

They all agree that the main type of violence existing in the health sector is psychological violence with very rare occurrences of physical violence.

4- Contributing factors to workplace violence in the health sector:

Interviewees listed several contributing factors to both physical and psychological workplace violence in the health sector. The following is a list of all the factors combined:

- Personal factors:
    - Character and temper
    - Low SES

- Organizational factors:
    - Major changes in the organization causing restlessness and insecurity
    - Changes in salary
    - Downgrading of personnel causing decreased motivation
    - Ignorance of physicians regarding the role of nurses
    - Lack of clear job descriptions and clear cut roles for everyone
    - Ignorance of the administration concerning the qualities of a nurse

- Interaction between the individual and the organization:
    - Expectations of individuals can not be met by what the organization is offering
    - Lack of credit for the more educated
    - Lack of award systems (bonuses)
    - Lack of opportunities to progress
    - Misuse of power against those who are vulnerable (from superiors to subordinates)
    - Failure of nurses to set the limits with the physicians and patients and administration
    - Ratio of patients to nurses (very high)

- Other factors:
    - Ignorance of the patients concerning the status of the nurses leading to considering nurses as janitors or orderlies
    - Stress and time constraints
    - Competition
    - Decline in overall economy caused the tremendous reduction in actual value of salaries

Again, the high-ranking officer in the ministry of social affairs clarified that job security and job description (in contrast to what nurses and midwives working at health centers affiliated with this ministry have said) cannot be considered as contributing factors to violence at the workplace in the ministry simply because there are very rigid rules that protect the employee from getting fired.

5- Impact of institutional reforms:

The interviewees agreed that institutional reforms although not directly addressed to the problem of violence, have slightly and indirectly affected the problem of violence. This is due to the positive impact of improved working conditions on the health personnel. Some interviewees, especially those working at the ministry of social affairs expressed their point of view regarding the institutional reform by saying that it can not be successful with all the interference from politicians who try to impose people not suitable for the job. In other words, there need to be a political reform before anything else can work. Moreover, these same interviewees believe that the control systems should improve by shifting from being a tool for

punishment to being a source of support and help through training and continuing education for all employees in the health sector.
One interviewee complained that the only issues dealt with in the reform are the number of employees and not their quality: “they are firing the wrong people. Many health centers have newly appointed drivers without having any car to drive!!!”.

All interviewees agree that if the reform is based on recruiting people according to well-defined criteria and not based on political affiliations, and if roles are clearly described, the quality of work will improve and consequently both physical and psychological violence will decrease.

6- Effects of physical and psychological workplace violence in the health sector:

All interviewees confirmed that workplace violence in the health sector in all its forms has tremendously negative effects at all levels.
These are the combined effects listed by the interviewees:

On the level of employees:
- Decreased motivation leading the employees to do the strict minimum
- Decreased initiative and creativity
- Isolation (avoiding people)
- Lower performance on the job thus leading to decreased service excellence
- Increased sickness
- Increased turnover
- Negative effects on team work and effectiveness
- Wasting time during working hours by chatting and drinking coffee
- Mistreatment of the patients (health personnel become less nice and less patient)
- Departure of health personnel from the country (especially nurses)
- Shifting of health care providers to careers in business, mainly in sales
- Psychological well-being of health personnel is negatively affected

On the level of the health services:
- Deterioration of quality of health services because of the decreased motivation of the personnel
- Increased cost due to increase in mistakes caused by fatigue and stress
- Increased staff fluctuation leading to decreased loyalty to institutions

On the level of the health sector and society:
- Paralysis of the health sector
- Retardation of the society whose health needs cannot be fulfilled anymore
- Absence of efforts for prevention on any level
- Rural areas suffer most because health services in such areas are already very poor

When it came to the issue of absenteeism, points of view among interviewees differed. Some considered that absenteeism would definitely increase due to exposure to violence at the workplace; others believed that absenteeism would not be affected by occurrence of violent incidents.
Those who assumed that absenteeism would not increase gave different reasons for their assumptions.

Some said that health personnel would still come to work just to get paid and without doing any real effort on the job.
Others said that health personnel and especially nurses would still come to work because they have a high sense of responsibility.

One interviewee, in contrast with all others, stated that the quality of the services would not be affected because of the vocational nature of the job.

7- Existing support for victims of workplace violence in the health sector:

All interviewees, except the ones working at the American University of Beirut Medical Center, were not aware of any support mechanisms for victims of both physical and psychological workplace violence available within or outside institutions. They said that this lack of support mechanisms is mainly due to the denial of the problem by authorities and the underreporting of cases of violence.

Interviewees working at the American University of Beirut Medical Center stated that the only mechanism they are aware of within their institution is the "Assault and sexual harassment policy". They add, however, that the effectiveness of such a policy is highly affected by the fear of victims of violence to report in order to avoid being labeled or threatened by their supervisors.

8- Recommendations for improvement of support services for victims of workplace violence in the health sector:

The following are combined recommendations for improvement of support services for victims of workplace violence in the health sector as listed by all interviewees:

- Creating and developing decrees to protect health personnel by giving them the right and authority to complain whenever they feel unjustly treated
- Establishing of a syndicate of nurses who remain the only workforce without an official representative body
- Enforcing already established laws
- Raising awareness among health care professionals about their rights and responsibilities
- Creating a hotline and a special office in every region for questions and complaints
- Establishing a clearly defined system of reporting in all health institutions

9- Implemented measures for response to workplace violence in the health sector:

All interviewees, except the ones working at the American University of Beirut Medical Center, agreed that there are practically no measures implemented as to deal with cases of both physical and psychological violence in health institutions. Health personnel are aware of the possibility to file a complaint in case of occurrence of a violent incident, but no one does so because the system proved to be ineffective and affected by many external forces. It is very rare if not impossible for a victim to reach a satisfying end with the available system.

The other interviewees working at the American University of Beirut Medical Center confirmed that in addition to the "Assault and sexual harassment policy", the proper management to ensure team work, the training of supervisors to care for the well-being of

their employees, optimizing working environments for employees to be enjoying their work are all measures to prevent and respond to cases of violence.

10- Strategies to prevent workplace violence in the health sector:

The following are proposed strategies by the interviewees to prevent all forms of workplace violence in the health sector:

- Creating an effective referral system of victims to counseling and social support services
- Restructuring health institutions and recruiting personnel according to clear selection criteria
- Redefining the role of the control systems of the government making them more helpful and supportive
- Improving the surroundings in the health institutions making them a more pleasant and comfortable place to work at
- Providing more training to employees at all levels
- Fighting corruption at all levels in the system
- Developing campaigns to raise awareness of health professionals, managers, patients and the whole society on the importance of respecting health personnel, their rights and responsibilities, and on the issue of violence at the workplace
- Developing clear and precise job descriptions

11- Barriers for implementation of measures to reduce workplace violence in the health sector:

The interviewees believe that the barriers for implementation of any measure to reduce physical and psychological workplace violence in the health sector are:

- The nature of the society as male-oriented (discrimination against health personnel who are mostly females)
- The absence of laws and the lack of enforcement of existing ones
- Jealousy and competition among health personnel
- Deterred image of health personnel especially nurses in society
- Budget constraints
- Lack of awareness among employers and employees
- Denial of the existence of the problem of workplace violence in the health sector
- Conflicts created by political interests
- Underreporting of violence cases especially when it comes to sexual harassment

Field Research - Quantitative Part
Methodology
Description of method used to collect and analyze data

The English version of the sample questionnaire was translated to Arabic .The Arabic version of the questionnaire was checked and validated through several rounds of pilot testing with respondent and academic specialists. The data was collected through a self–administered questionnaire. The questionnaire was slightly modified mainly for clarity as a result of the pilot testing.

Questionnaire modifications

- It was translated to Arabic. Some meanings were adapted to the Lebanese culture and language. For example:
  - "Union" in PD19 (and other places) was replaced with "syndicate"; because there are syndicates in Lebanon and not unions.
  - "Interact" in PD13 (and other places) was replaced with "deal" (its equivalent in Arabic) because the translation of "interact" caused some confusion.
- The definition of the form of violence to be discussed was added under the title of each relevant section; respondents were asking us over and over about the meaning of the terms. It was apparent that few read the first 2 pages.
- In PD6 "which category best describes your present professional group…"

the category "auxiliary/ ancillary" was omitted because it doesn't have an adequate meaning in Arabic, was covered in the other categories and it doesn't apply in Lebanon.

- PD7 "which category best describes your present position…" was not informative enough. We first added "assistant" to the categories. Then we felt that the difference between senior and line manager will not be apparent in Arabic and that we needed to capture the difference between nurse supervisor, head nurse, registered nurses and practical nurses, nurse aides and orderlies (because the difference in education and status might affect their being subject to violence). So we removed line managers and added 4 categories "nurse supervisor", "head nurse", "registered nurse", "practical /aide /orderly".
- In PD9 "which category of employment sectors represents best your employment for your main job…", we removed "church" from the example, because it's deemed inappropriate in Lebanon, due to the presence of other religions.
- In PD13 (and other questions where it applies), we removed "client", because health care professionals deal with patients not clients.
- In PD13.2 "the patients you most frequently work with are…", we added the ages of the different age groups for infants (1-4 years), children (5-9 years), adolescents (10 –18 years) and elderly (65 and above). This way the difference would be clearer.
- In PV1.12, VA9, BM9, SH9 and RH9 "was any action taken to investigate the causes of the incident…" we changed the skip if the respondent answered "no or don't know". It was "go to question 1.13, VA10… we changed to "go to question 1.14, VA11…". We felt

that it didn't make sense to answer the following question after having said no action was taken.

- The title of the Health Sector Employer section was changed to Measures and Policies by the Health Sector Employer in order to make it clearer.

The Beirut sample included five hospitals: four university referrals hospitals and a private hospital, two nursing home hospital centers for the elderly, four governmental health centers and two NGO's dispensaries. The personnel categories covered included physician, nurses, midwives, managers, administrative personnel, Allied medicine professionals (therapist Radiographers.) and support services (security guards, kitchen, maintenance, reception).

The sampling procedure followed the guidelines of the sample design to insure variability of the sample through random sampling and confidentiality of the respondent.
Approvals to undertake the study was done through several personal visit by the investigator to all the sampled health institutions. First to secure approval of Directors and chief of staff and clearance by the Ethical Institutional research board, then all the departments selected were visited to introduce the study and get lists if employees for sample selection.

Description of sample

The total sample size was 1016; the age, gender, and marital status distribution are reported on table 1. They were 296 males (31.2%) and 654 females (68.8%). They were equally distributed between single and married and only 3% were separated, divorced or widowed. Table 2 shows that the majority are living in Lebanon, 87% and only 13% have moved from another country but most of them have moved 6 years ago, (60%).

Table 1 – Socio demographic characteristics of respondents, Lebanon

	Frequency (N)	**Percent (%)**
Age distribution		
19 or under	15	1.5
20-24	179	17.8
25-29	234	23.3
30-34	188	18.7
35-39	128	12.7
40-44	104	10.3
45-49	61	6.1
50-54	52	5.2
55-59	29	2.9
60 and above	15	1.5
Total	1005	100.0
		Gender of respondent
Male	296	31.2
Female	654	68.8
Total	950	100.0
Marital status		
Single	499	50.3

Married	460	46.4
Living with partner	3	.3
Separated/ divorced	14	1.4
Widow/ widower	16	1.6
Total	992	100.0

Table 2 – Migration of respondents, Lebanon

	Frequency (N)	**Percent (%)**
Move from another country		
Yes	125	13.1
No	832	86.9
Total	957	100.0
How long ago (years)		
Less than 1	9	7.6
1-5	37	31.6
6 and above	71	60.8
Total	117	100.0

Table 3 shows also that most of the respondent felt they were from a majority within a community (81%) and within a group (70%), and within a job (68.8%).

Table 3 – Identifying as a member of majority or minority within a group, community and job, Lebanon

Member of	**Within a group**		**Within a community**		**Within a job**	
	N	%	N	%	N	%
Majority	598	69.9	667	81.4	564	68.8
Minority	257	30.1	152	18.6	256	31.2
Total	855	100.0	819	100.0	820	100.0

Table 4 and 5 describe the distribution of the respondent by their present job and position as well as how long they have been working and to which employment sector they belong. They were 579 nurses (57 %) 100 physicians (10%) administrative clerical 114 (11%) and 65 support staff (6.4 %) technical staff 50 (4.9%) 24 midwives (2.4 %) and 38 professionals allied to medicine (4%).

Table 4 – Occupation of respondents, Lebanon

	Frequency (N)	Percent (%)
Present job		
Nurse	579	59.0
Administrative/ clerical	114	11.6
Physician	100	10.2
Support staff	65	6.6
Technical staff (lab/sterile)	50	5.1
Midwife	24	2.4
Other	11	1.1
Total	981	100.0
		Present position
Staff	352	36.3
Practical/aid/orderly	187	19.3
Registered nurse	171	17.6
Head nurse	80	8.2
Assistant	48	4.9
Manager/ director	47	4.8
Student/ training	42	4.3
Nurse supervisor	28	2.9
Independent	11	1.1
Other	5	.5
Total	971	100.0

Table 5 – Employment of respondents, Lebanon

	Frequency (N)	Percent (%)
Years in work experience		
Less than 1	65	6.7
1-5	298	30.6
6-10	241	24.7
11-15	149	15.3
16-20	81	8.3
20 and above	141	14.5

Total	975	100.0
Employment sector		
Private- non for profit	689	70.0
Private-for profit	244	24.8
Public/governmental sector	27	2.7
Religious	5	.5
International agency	4	.4
Don't know	13	1.3
Other	2	.2
Total	984	100.0

Table 6 described the characteristic of work patterns among the respondents. The majority work full time and interact with patient while those who work in shift between 6pm and 7am constitute almost half of the sample.

Table 6 – Characteristics of work patterns among respondents, Lebanon

	Frequency (N)	**Percent (%)**
Patterns of work		
Full-time	946	94.6
Part-time	39	3.9
Temporary/casual	15	1.5
Total	1000	100.0
		Work in shifts
Yes	539	57.4
No	400	42.6
Total	939	100.0
Work between 6pm and 7am		
Yes	502	51.7
No	469	48.3
Total	971	100.0
Interact with patients		
Yes	815	83.6
No	160	16.4
Total	975	100.0
Routine physical contact		
Yes	546	68.0
No	257	32.0
Total	803	100.0
Gender of patients		
Female	97	12.0

Male	43	5.2
Male and female	668	82.8
Total	808	100.0

Table 7 describes where health workers spend more than 50% of their time. There was a problem with this question as most respondents ticked a combination of options.

Table 7 – Work setting where you spend more than 50% of your time, Lebanon

	Frequency (N)	**Percent (%)**
Work setting		
Ambulatory	47	4.6
General medicine	68	6.7
General surgery	52	5.1
Psychiatric	21	2.1
Emergency	37	3.6
Operating room	73	7.2
Intensive care	104	10.2
Management	45	4.4
Specialized unit	163	16.0
Technical services	53	5.2
Support services	46	4.5
Other in hospital	2	.2
Health care	28	2.8
Community district	10	1.0
Home for elderly/nursing home	38	3.7
Rehabilitation center/ convalescent home	5	.5
Any combination	163	17.1
Total	955	100.0

Table 8 – Distribution of staff present at work setting during most of work time, Lebanon

	Frequency (N)	**Percent (%)**
Number of staff		
None	24	2.4
1-5	354	35.5
6-10	314	31.5

11-15	92	9.2
Over 15	213	21.4
Total	997	100.0

Limitation of the study / problems

Problems with questionnaire in data collection

- It was too long. Respondents were eager to finish off with it and get back to work.
- PD5 "please identify how you see yourself in each of the different settings…" was unclear due to its format. Research assistants had to explain this question whenever they were present, and many left it blank.
- PD6 "which category best describes your present professional group…" was misunderstood by many, especially those with low education (such as practical nurses, nurse aides and support staff). They thought it meant "which is the best profession among…", so they picked "physician". We controlled for that by correcting the wrong answers; we knew who had answered what.
- In PD7 "which category best describes your present position…", many respondents did not tick a box but gave their exact position in the "other" category. We controlled for that by placing them where they belong in the different categories.
- In PD9 "which category of employment sectors represent best your employment for your main job…", many respondents didn't exactly know to which sector their hospital /dispensary belong to. For example: St George and Makassed Hospitals were seen by many as religious hospitals, although they are private not for profit. We controlled for that by placing each in their appropriate category.
- For PD11 "do you work in shifts?", the equivalent for "shift" was unclear in Arabic to many respondents, although it was the term used.
- PD14 "please indicate if you spend more than 50% of your time working with any of the following specialties…" was confusing to those who worked with normal, regular patients. They didn't know where to tick. They either left it blank or answered "none" or "normal patient" in the "other" category. We controlled for that by placing the "normal patients" in the other. Plus, they were ticking more than one category; we controlled it by putting them in combinations.
- In PD15 "where do you spend most of your time in your main job" and PD 19.1 "if you were encouraged to report, by whom?", some respondents ticked more than one category; we controlled it by putting combinations.
- "Do you consider this to be a typical incident of violence in your workplace?" in PV1.2, VA4, BM4, SH4 and RH4, was not well understood. The research assistants explained it to those they could reach.
- In "How did you respond to the incident?" in PV1.7, VA6, BM6, SH6 and RH6, the respondents who wanted to say that they told the supervisor, did not perceive "senior staff member" as being the supervisor.
- "Listed below are a list of problems and complaints…" in PV1.10, VA7, BM7, SH7 and RH7, was a bulky question in its format. Respondents complained about it and asked for explanation.

- In PV1.15, VA12, BM12, SH12 and RH12 "if you did not report the incident…", if respondents did report it, they had no place to answer it, and left it blank. It was coded as inapplicable. Another category should have been added.
- In HE2 "what measures to deal with workplace violence exist in your workplace…", some of the options were confusing to the respondents, such as "restrict public access", "patient protocols", "restrict exchange of money", and "check in procedures for staff", although explanation was given after each point. So we don't know whether leaving them blank meant that they didn't exist at the their workplace or that they were not understood.
- HE3 "to what extent do you think these measures would be helpful…" was repetitive to HE2 in its length and content; respondents were bothered by it.
- In HE4 and HE5, many respondents gave more than 1 answer. We controlled it by putting them in combinations.
- As for the opinion section, it was left blank most of the time. Respondents were too tired, bored or needed to go by the time they reached this open-ended section at the end of the questionnaire. It required more effort.

Results of the quantitative survey

2- Magnitude, characteristics and scope of workplace violence in the health sector

The dimension of the workplace violence showed that the prevalence of verbal abuse was the highest (41 %) followed by bullied /mobbed (22.4%), then physically attacked (6 %), racially harassed (4.9%) and sexually harassed (2.4%).

Table 10. Prevalence of Physical and Verbal Violence, Bullying/ Mobbing, Sexual and Racial Harassment, LEBANON

	Physical		Verbal		Bullying		Sexual		Racial	
	N	%	N	%	N	%	N	%	N	%
Attacked										
Yes	59	5.8	412	40.9	220	22.1	23	2.3	46	4.7
No	950	94.2	596	59.1	777	77.9	960	97.7	935	95.3
Total	1009	100.0	1008	100.0	997	100	983	100.0	981	100.0
Typical Incident										
Yes	36	65.4	295	75.0	171	82.6	15	65.2	32	72.7
No	19	34.6	98	25.0	36	17.4	8	34.8	12	27.3
Total	55	100.0	393	100.0	207	100.0	23	100.0	44	100.0
Who Attacked										
Patient	34	62.9	73	18.4	16	7.5	4	17.5	4	9.0
Relative	14	25.9	66	16.6	16	7.5	2	8.7	3	6.8
Staff member	2	3.7	89	22.4	84	39.6	6	26.0	21	47.7
Management	2	3.7	70	17.6	43	20.3	3	13.0	2	4.7
Colleague	1	1.9	15	3.8	9	4.2	5	21.8	5	11.4
General Public	1	1.9	13	3.2	11	5.2	3	13.0	4	9.0
Any Combination	0	0.0	72	18.0	33	15.7	0	0.0	5	11.4
Total	54	100.0	398	100.0	212	100.0	23	100.0	44	100.0
Where										
Health Institution										
Inside	53	90.0	381	96.0	196	93.0	18	82.0	38	90.0
Outside	3	5.0	13	3.0	13	6.0	4	18.0	4	10.0
Patient Home	3	5.0	3	1.0	1	1.0	0	0.0	0	0.0
Total	59	100.0	397	100.0	210	100.0	22	100.0	42	100.0

Table 10 shows that violence was perceived as a typical incident by the victims in most of the cases.

Perpetrator and victim
For physical violence, the patient or a relative was the main perpetrator, while for bullying and verbal abuse, sexual and racial harassment, it was mainly either a staff member or a colleague or a manager. (Table 10)

Where it concentrates
It happens most of the time for all types of violence inside the institution. (Table 10)

Response of the victim to the violence
Table 11 shows that the majority took a combination of measures. It is worth noting that for bullying, verbal abuse and sexual harassment, one forth of the victims took no action.

Table 11 – Distribution (%) of response of victims of violence in workplace, Lebanon

	Abuse			**Harassment**	
	Physical	Verbal	Bullying	Sexual	Racial
Number of victims	56	401	220	23	46
					Victim reaction
Took no action	7	20	23	9	20
Pretend it never happened	2	3	3	4	4
Told the person to stop	5	11	15	17	22
Told friends/family	4	2	1	4	7
Told a colleague	5	6	7	5	0
Report to snr staff	13	10	9	9	4
Sought counseling	2	1	1	0	0
Help from the syndicate	7	1	0	0	0
Help from association	0	3	5	4	4
Transferred	2	1	2	5	1
Completed incident form	2	0	0	0	2
Pursued prosecution	0	0	0	0	1
Tried to defend myself	1	0	0	0	0
Any combination	50	42	34	43	35

Measures taken in response to an act of violence by the victim are displayed in table 12. It shows that no action was taken most of the time, and in case something was done, the manager was the main person who took action. (Table 12)

Table 12 – Distribution (%) of measures taken in response to any act of violence as reported by the victims, Lebanon

	Abuse			Harassment	
	Physical	Verbal	Bullying	Sexual	Racial
Number of victims	59	412	220	23	46
Employer action					
Yes	37	21	16	100	18
No	60	61	67	0	73
Don't know	3	18	17	0	9
Who took action?					
Management/ employer	85	89	83	100	50
Syndicate	0	2	0	0	12
Community group	5	5	17	0	0
Police	5	2	0	0	0
Other	5	2	0	0	0
Consequences to perpetrator/ abuser					
None	59	51	38	0	25
Verbal warning issued	27	38	44	0	38
Care discontinued	0	3	2	0	12
Reported to police	5	1	0	0	13
Aggressor persecuted	0	0	0	0	12
Other	0	0	0	0	0
Do not know	9	7	13	100	0
Incident could have been prevented					
Yes	25	26	46	45	47
No	75	74	54	55	53
Total	100.0	100.0	100.0	100.0	100.0

Support given to the victims is reported in table 13. The most common type of support given by the employer was the opportunity to speak, except for racial harassment. In general, the

victims were dissatisfied with the way the incident was handled in the work place. And the reason for not reporting, the option ‘useless’ or ‘it was not important’ had the highest frequency.

Table 13 – Distribution (%) of support given to the victims and reason for not reporting the act of violence in the workplace, Lebanon

	Abuse		Harassment		
	Physical	Verbal	Bullying	Sexual	Racial
Number of victims	59	412	220	23	46
Support by employer					
Counseling offered	41	33	40	0	63
Opportunity to speak	76	85	76	100	13
Other	24	25	8	0	38
Victim satisfaction with handling of incident					
1 Very dissatisfied	27	39	49	27	49
2	13	20	16	18	23
3	33	21	19	14	12
4	12	9	6	18	3
5 Very satisfied	15	11	10	23	13
Reasons for underreporting					
It was not important	44	26	19	18	20
Felt ashamed	3	2	4	23	2
Felt guilty	3	1	1	5	7
Afraid	2	10	12	5	10
Who to report to?	0	2	2	4	7
Useless	41	45	50	23	37
Other	7	3	0	0	0
Any combination	0	11	12	22	17

Frequency of the violence at the workplace

The victims of violence reported on how frequent the incident was. The victims of racial harassment reported the highest frequency among all types of violence, which was happening all the time (41%). (Table 14)

Table 14 – Among those who reported being victims of violence, what was the frequency? Lebanon

	How often							
	All the time		**Sometimes**		**Once**		**Total**	
	N	%	N	%	N	%	N	%
Type of violence								
Verbal abuse	61	15.2	265	66.0	76	18.8	402	100
Bullying	51	24.4	139	66.5	19	9.1	209	100
Racial	19	41.0	22	48.0	5	11.0	46	100
Sexual	4	17.4	9	39.0	10	43.6	23	100

Emotional reaction to a physical violence is described in table 15.

Table 15 – Physical violence reaction, Lebanon

Since you were physically attacked, how bothered have you been by:

	Not at all		**A little bit**		**Moderately**		**Quite a bit**		**Extremely**	
	N	%	N	%	N	%	N	%	N	%
Repeated memories	15	30.0	10	20.0	15	30.0	4	8.0	6	12.0
Avoiding thinking	12	26.0	11	24.0	12	26.0	6	13.0	5	11.0
Being “super-alert”	2	4.1	0	0.0	17	35.4	19	39.5	10	21.0

Feeling like everything you did was an effort.	5	11.0	5	11.0	10	22.0	20	43.0	6	13.0

Emotional reaction to a verbal violence is described in table 16.

Table 16 – Verbal abuse reaction, Lebanon

Since you were verbally abused, how bothered have you been by:

	Not at all		**A little bit**		**Moderately**		**Quite a bit**		**Extremely**	
	N	%	N	%	N	%	N	%	N	%
Repeated memories	92	25	93	26	65	18	63	18	48	13
Avoiding thinking	90	26	71	21	101	30	44	13	35	10
Being “super-alert”	46	13	47	13	67	18	109	30	98	26
Feeling like everything you did was an effort.	66	19	48	14	68	20	91	26	73	21

Emotional reaction to a bullying/ mobbing violence is described in table 17.

Table 17 – Bullying/ mobbing reaction, Lebanon

Since the bullying/ mobbing incident(s), how bothered have you been by:

	Not at all		**A little bit**		**Moderately**		**Quite a bit**		**Extremely**	
	N	%	N	%	N	%	N	%	N	%
Repeated memories	41	22	42	22	42	22	42	22	23	12
Avoiding thinking	43	24	37	21	57	32	28	16	13	7
Being “super-alert”	23	11	20	10	44	23	56	29	52	27
Feeling like everything										

you did was an effort.									
29	16	20	11	40	22	46	26	45	25

Emotional reaction to sexual harassment is described in table 18.

Table 18 – Sexual harassment reaction

Since the sexual harassment, how bothered have you been by:

	Not at all		**A little bit**		**Moderately**		**Quite a bit**		**Extremely**	
	N	%	N	%	N	%	N	%	N	%
Repeated memories	7	32	2	9	4	18	3	14	6	27
Avoiding thinking	7	32	2	9	4	18	4	18	5	23
Being “super-alert”	1	5	2	9	1	5	6	27	12	54
Feeling like everything you did was an effort.	4	19	2	10	5	24	4	18	6	29

Emotional reaction to racial harassment is described in table 19.

Table 19 – Racial harassment reaction, Lebanon

Since the racial harassment, how bothered have you been by:

	Not at all		**A little bit**		**Moderately**		**Quite a bit**		**Extremely**	
	N	%	N	%	N	%	N	%	N	%
Repeated memories	9	22	4	10	5	13	9	22	13	33
Avoiding thinking	6	15	6	15	12	30	8	20	8	20
Being “super-alert”	3	11	6	30	5	18	7	18	18	46
Feeling like everything										

you did was an effort.

8	21	4	11	6	15	6	15	15	38

Anti-violence strategies

All respondents were asked whether they were aware of the development of a specific policy by their employer. Table 20 reports on policies related to health and safety, physical workplace violence, verbal abuse, sexual and racial harassment, bullying and mobbing.

Table 20

Has your employer developed specific policies on:

	Yes		No		Don't Know	
	N	%	N	%	N	%
Health and Safety	659	75.7	115	13.2	96	11.0
Physical workplace violence	315	40.1	255	32.4	216	27.5
Verbal Abuse	322	40.6	292	36.8	180	22.7
Sexual Harassment	284	37.8	237	31.5	231	30.7
Racial Harassment	244	32.4	254	33.8	254	33.8
Bullying/ Mobbing	272	34.9	285	36.5	223	28.6
Threat	262	34.3	268	35.1	234	30.6

Table 21 describes all the existing measures that may minimize violence in the workplace, as reported by all respondents.

Table 21

Existing Measures to deal with violence:

	Yes		No		Total	
	N	%	N	%	N	%
Security measures	657	76.5	202	23.5	859	100
Improve surroundings	428	50.2	425	49.8	853	100
Restrict public access	304	35.5	552	64.5	856	100
Patient screening	261	30.4	597	69.6	858	100
Patient protocols	346	40.5	509	59.5	855	100
Restrict exchange of money	229	26.9	622	73.1	851	100
Increased staff numbers	169	19.8	683	80.2	852	100
Check-in procedures for staff	152	17.9	695	82.1	847	100
Special equipment or clothing	323	37.8	531	62.2	854	100
Changed shifts or rotas	261	30.7	590	69.3	851	100
Reduced periods or working alone	117	13.8	730	86.2	847	100
Training	177	20.8	673	79.2	850	100
Investment in HR dvpt	235	27.7	614	72.3	849	100
None of these	66	7.8	778	92.2	844	100
Other	13	1.5	831	98.5	844	100

Table 22 reports on whether the respondents thought the measures described in table 21 were helpful in improving the work setting.

Table 22
To what extent do you think these measures would be helpful in your work setting?

	Very		Moderate		Little		Not at all	
	N	%	N	%	N	%	N	%
Security measures	589	73.5	135	16.9	55	6.9	22	2.7
Improve surroundings	451	61.6	200	27.3	64	8.7	17	2.3
Restrict public access	334	48.5	203	29.5	101	14.7	51	7.4
Patient screening	343	50.4	186	27.4	94	13.8	57	8.4
Patient protocols	334	50.7	190	28.8	78	11.8	57	8.6
Restrict exchange of money	265	41.7	125	19.7	116	18.3	129	20.3
Increased staff numbers	377	54.1	161	23.1	84	12.1	74	10.6
Check-in procedures for staff	340	50.7	180	26.9	91	13.6	58	8.7
Special equipment or clothing	324	50.1	146	22.6	108	16.7	67	10.4
Changed shifts or rotas	274	43.2	176	27.8	95	15	88	13.9
Reduced periods or working alone	338	52.5	136	21.1	82	12.7	87	13.5
Training	414	62.7	136	20.6	70	10.6	39	5.9
Investment in HR dvpt	401	64.2	132	21.1	53	8.5	37	5.9
Other	31	48.4	14	21.9	6	9.4	7	10.9

Impact of changes in the workplace to prevent violence is described in table 23.

Table 23
Which changes have occurred in the last 2 years?

	N	%
None	158	20.5
Restructuring/ reorganization	117	15.2
Staff cuts	75	9.7
Increased staff numbers	48	6.2
Restriction of resources	10	1.3
Additional resources	5	0.6
Don't know	172	22.3
Other	3	0.4
Any Combination	184	23.8
Total	772	100.0

Impacts of changes on daily work:

	N	%
None	142	19.1
Work situation worsened	110	14.8
Work situation improved	101	13.6
Situation for patients worsened	10	1.3
Situation for patients improved	67	9

Don't know	165	22.1
Other	4	0.5
Any Combination	146	19.6
Total	745	100

Table 24 reports on the perception of respondent in general about workplace violence in the health sector.

Table 24 – How worried are you about violence in your current workplace? Lebanon

	Frequency (N)	**Percent (%)**
Worried about violence		
1 not at all	490	49.9
2	202	20.6
3	199	20.3
4	41	4.2
5 very	49	5.0
Total	981	100.0
Procedure for reporting violence		
Yes	536	56.4
No	414	43.6
Total	950	100.0
If yes, knowledge of how to use procedure		
Yes	431	89.2
No	52	10.8
Total	483	100.0
Is there encouragement to report violence?		
Yes	624	67.2
No	304	32.8
Total	928	100.0

Conclusion

The present report highlights the need to do further research on the violence in the workplace and to start to implement new policies to combat all kinds of violence specially the psychological one in the context of the healthcare system.

Appendix 1

North MP throws punches at doctor

An argument between a resident doctor at the American University of Beirut and a north Lebanon politician developed into fistfight at the emergency ward on Monday.
Doctors at the American University Hospital on Tuesday condemned what they described as an unjustified "physical assault" by Jihad Samad on an unidentified physician, who was attending to the Minyeh-Dinnieh MP's nephew. Medical sources said that the MP and the doctor got into a shouting match, prompting Samad to punch the physician, who responded in kind.
The sources said that the MP was furious when the doctor refused to show him and his brother, who is a physician, x-ray results of his nephew's broken leg, insisting that an orthopedic surgeon must first examine them.
"Samad and his brother became upset for a trivial reason that had nothing to do with the emergency room treatment or the patient's condition and attacked a resident doctor," AUH doctors said in their statement.
Samad, the statement added, refused to apologize to the emergency room's team. The MP was not available for comment when contacted by The Daily Star.
"The administration requested the MP to apologize, but he refused," said the statement. "The administration condemns such behavior, especially when it comes from a person in a position of responsibility. Samad should have practices self-restraint and acted more wisely while dealing with others," the statement said.

16/2/2000
Daily Star
AUH medics take silent action

The medical team at the American University of Beirut's Medical Center announced on Thursday that it will hold a silent protest outside the hospital's main building at 11 a.m. on Friday.

A statement issued by the medical team said the action was organized to highlight "the insult and assault inflicted on some members of the medical team while they were on duty."

On Tuesday, American University Hospital said Minyeh-Dinnieh MP Jihad Samad lost his temper and punched a resident doctor for dialing to show the MP X-ray results of his nephew. Samad denied the accusation, saying that he was assaulted.

16/2/2000

AUH staff demonstrate against MP's 'violence'

The medical staff at the American University Hospital held a silent demonstration on Friday to protest a recent brawl between an MP and a resident doctor in the emergency ward.

The protesters described Monday's violent argument between Minyeh-Dinnieh legislator Jihad Samad and a resident doctor a violation of their "sacred workplace".

For almost half an hour, an estimated 100 resident doctors, nurses and other staff members held a demonstration outside the hospital's main building, hampering the flow of traffic in the surrounding area.

The action was organized to protest against the incident at the emergency room, where Samad is said to have lost his temper and punched resident doctor Hisham Mokaddam.

Ghattas Khoury, who heads the Order of Physicians, participated in the sit-in, along with Mounir Obeid, head of medical staff at AUH, and other senior staff members.

"Hospitals and clinics are not centers for violence and the exchange of expletives," said Khoury. "People should respect these institutions in order for us to do our job right. Our workplace is a sacred place."

Samad has denied the allegations, claiming that the AUH and the Order of Physicians have "falsified the facts."

Khoury denied that the confrontation was caused by a lack of communication between the patient's family and the doctor, insisting that "indefinite test results are not disclosed."

Asked whether doctors were considering filing a lawsuit against the legislator, Khoury said that "this is up to the hospital to decide."

Participants at the demonstrations declined to answer questions, saying that they had been asked not to disclose information to the media.
