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Joint Programme on
Workplace Violence in the Health Sector

Workplace Violence in the Health Sector

Portuguese Case Studies

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Workplace Violence in the Health Sector
Portuguese Case Studies

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Abbreviations

DHA	District Health Authorities
EU	European Union
HC	Health Centre
MS	Member States
NHS	National Health Service
PPP	Purchasing power parity
RHA	Regional Health Authorities
VAHPITWP	Violence Against Health Professionals in the Workplace

INTRODUCTION

Portugal is a country where the National Health Service (NHS) is a relatively recent institution (early 1980s). As part of the development of the Portuguese NHS, health centres (HC) first made their appearance in the late 1970s, and the family physician in the early 1980s. Until recently Primary Health Care services were managed as a central vertical programme, in parallel with another vertical programme, hospital services. It is only in the last decade that a major effort is being made to merge multiple central-directorates in a single one (the Department of Health), which acts as a central focal point of policies, strategies, norms, and guidelines to be adapted and implemented by decentralised Regional Health Authorities (RHA) – five in total. Since 2001, the central level administration is co-ordinated by a High-Commissioner for Health. The RHA will in future co-ordinate and supervise the activities of the district health care services (*Sistemas Locais de Saúde)*, where HC and district hospital services will be managed by a single district health authority (DHA). The budgets for these DHA and their associated health care services will be negotiated with Region based *Agências de Acompanhamento* (contractualisation boards), according to explicit objectives, criteria and indicators.

The period between 1995 and 1999 was very rich in terms of a new vision of the NHS – more integrated, more entrepeneurial, more responsive to the citizen's of the country, more information-driven and evidence-based. It was as a result of this period of reform (Craveiro et al 2001) that, for the first time, there was in Portugal a concerted effort to write a strategic plan, flowing from explicit policies and with identifiable short to long-term targets (Portugal 1999). This plan was approved by the Cabinet.

An important component of this plan is the development of strategies to ensure greater dignity in professional practice. This last aspect has been re-stated in all yearly action plans of the Ministry of Health, including the most recent one (Portugal 2002).

In Portugal there are 5 health regions divided in sub-regions (1 to 6 per region). The region chosen by convenience for this study includes one of the two largest metropolitan areas in Portugal, with a population of 3 222 200 people (about 30% of the Portuguese population), 22 hospitals (24% of all the hospitals) (2942 beds, corresponding to 12% of all hospital beds) and 84 HC (19% of the national total)[*].

The Portuguese health care system in the European Union context**

Total expenditure on health as a percentage of the GDP

Three country clusters[***] are identifiable for 1997: the two countries in the cluster with the highest percentage are France and Germany; the cluster with the lowest percentage includes 10 countries (Austria, Belgium, Denmark, Finland, Greece, Ireland, Italy, Luxembourg, Spain and the United Kingdom). This suggests a great uniformity across the European Union (EU) member states (MS).

* These exclude mental health facilities.
** Based on Ferrinho & Pereira Miguel 2001.
*** The 15 MS were grouped into three clusters of the best, intermediate and the worst indicators, using a cluster analysis hierarchical method.

Total expenditure on health in PPP$ per capita

In 1997, the highest spending countries are Germany (2325 PPP$) and Luxembourg (2147 PPP$). Portugal (1151 PPP$), Spain (1154 PPP$) and Greece (1157 PPP$) are the lowest spending countries. There are three country clusters. The cluster with the highest *per capita* expenditure includes France, Germany and Luxembourg and the cluster with the lowest per capita expenditure includes Portugal, Spain, United Kingdom, Ireland, Greece and Finland.

Public expenditure on health as a percentage of the total expenditure on health

In the 1970s public expenditure on health increased as a percentage of the total expenditure on health (except for decreases observed for Belgium, Italy and The Netherlands). The 1980s are marked by reductions in this percentual expenditure in 13 countries (France, Denmark, Finland, Germany, Greece, Iceland, Ireland, Italy, Norway, Portugal, Spain, Sweden, The Netherlands and the United Kingdom). These decreases persist into the 1990s, except for the sustained increases observed for Portugal since the 1980s. The MS may be grouped into three clusters. The highest expenditure cluster includes Belgium, Luxembourg, Sweden and the United Kingdom. The lowest expenditure cluster isolates Greece. Portugal includes the intermediary cluster. In Portugal, public expenditure on health is financed by general taxation.

Public expenditure on health in PPP$ per capita

Public expenditure on health in PPP$ per capita shows, for all MS, a sustained increase since 1970 without any indication of abating. In 1997, public expenditure on health is 2 115 PPP$ per capita for Luxembourg and 1 822 PPP$ for Germany. Portugal (689 PPP$), Greece (690 PPP%) and Spain (900 PPP$) are the countries with the lowest values. Luxembourg is the only country in the cluster of the highest public expenditure on health in PPP$. The lowest expenditure cluster includes Finland, Greece, Ireland, Italy, Portugal, Spain and the United Kingdom and the intermediate cluster includes Austria, Belgium, Denmark, France, Germany, The Netherlands and Sweden.

Hospital inpatient expenditure as a percentage of the total expenditure on health

Since 1970 are very variable. Over the last decade most MS (with the exception of Luxembourg) seem to have stabilised this indicator. In most MS, the majority of financial resources are devoted to inpatient care. In 1980, Denmark, Greece, Spain and The Netherlands allocated over 55% of total expenditure to inpatient care, while the Federal Republic of Germany, Belgium, Portugal and Luxembourg only devoted one third of their health resources to inpatient care. In 1997, only Denmark and The Netherlands allocate over 50% of their financial resources to inpatient care. The three country clusters identified include Denmark, Sweden and The Netherlands in the highest expenditure cluster and Austria alone in the lowest expenditure cluster. Portugal is included in the intermediary cluster.

Expenditure on inpatient care in PPP$ per capita

As expected, inpatient health care expenditure in PPP$ per capita shows a sustained increase since 1970 (stabilises in the 1990s for Finland and Norway). The rate of this increase is fastest during the 1990s, except for Italy. The identifiable clusters are Denmark, France and The Netherlands for the highest expenditure cluster and Austria, Finland, Greece, Portugal and Spain in the lowest expenditure cluster[a].

a No data for Ireland.

Public inpatient expenditure as a percentage of the total inpatient expenditure

Public inpatient expenditure for Denmark and Iceland account, since the 1970s, for 100% of all inpatient expenditure. For Belgium this figure increases since 1970. During the 1980s it decreases for Austria and Portugal. During the 1990s this same trend is observed for France and Italy. These trends suggest a stable or growing share of the hospital market by the private sector. Here, Greece is isolated in the lowest expenditure cluster and the highest expenditure cluster includes Denmark, Finland, France, Germany, Italy, Luxembourg, Portugal, Spain, The Netherlands and the United Kingdom.

Human resources

The human resources scenario is that of a health sector that it is increasingly (with the exceptions of Sweden, Ireland and the United Kingdom) employing more and more resources. These resources are characterised by an increasing feminisation, and specialisation (with the exception of Denmark), a slow increase of nurses as a percentage of the health personnel (with the exception of Finland), and a decreasing concentration of the health personnel in hospitals (with the exception of Portugal). Although the number of GP per 1000 population is increasing, its percentage of the total health employment is decreasing (except for Sweden). The number of physicians per 1000 population ranges from 1.7 for the United Kingdom to 5.8 for Italy (3.1 for Portugal); of GP from 0.4 for Ireland to 1.6 for Finland (0.6 for Portugal); of specialised physicians from 0.1 for Denmark to 2.2 for Germany (1.3 for Portugal); of registered nurses from 3.7 for Portugal to 15.3 for Ireland; of pharmacists from 0.2 for The Netherlands and Denmark to 1.4 for Finland (0.7 for Portugal) and of dentists from 0.3 for Portugal to 1.1 for Greece.

A significant aspect of the human resources scenery in Portugal is that most doctors (over 90%) are public servants, and about half of these accumulate their public sector position with work in the non-governmental sector.

Health Care Facilities

Data on health care facilities are limited and of limited comparability. The apparent trends suggest a stable number of PHC units per 100 000 population.

At hospital level the number of inpatient, psychiatric care and acute care beds per 1000 population show a sustained decrease since the 1970s. Nevertheless, the acute care beds as a percentage of the total bed stock are decreasing for The Netherlands and France but increasing or stable for all other MS. These trends reflect the extensive and firm action to close hospitals in the MS, with some exceptions like in Portugal where the trend has been to build more public hospitals.

OBJECTIVES

These studies measure and characterize the problem of violence against health professionals in the workplace (VAHPITWP) in selected settings in Portugal. They answer questions such as: Who are the most affected health professionals? What types of violence are most frequent? In what circumstances do episodes of violence happen? What are the institutional procedures? What are the consequences for the victims, the Institutions and the perpetrators? What is the positioning of the NHS managers, the professional councils the unions and the professional associations about this problem?

POPULATIONS AND METHODS

The Portuguese study is divided in four parts: documentary studies, hospital case study, health centre complex case study, and stakeholders' study.

Documentary studies

The documentary studies include a review of the professional literature and content analysis of institutional documents and of media articles.

a) Literature review

The objective of the literature review is to identify the grey literature and what has been published in Portugal, in professional journals, about violence against health professionals in the workplace (VAHPITWP). The strategy to identify the documents was the following: i) several data bases (the document information centers of Escola Superior de Enfermagem de Francisco Gentil, Centro de estudos Judiciais, Faculdade de Medicina de Lisboa, Departamento de Sociologia da Universidade de Coimbra, Évora, Instituto Superior de Economia e Gestão, Escola Nacional de Saúde Pública, INDICT, Nacional Library) were searched; ii) most stakeholders included in the stakeholders' study were asked about literature on VAHPITWP. The key words used to search for the documents were: stress, occupational stress, health professionals' occupational stress, burnout, professional satisfaction, violence, occupational violence, violence in the health sector, aggression, rape, insult and injuries, hospital, health centre, doctor, nurse. The articles were then scanned for explicit references to violence and only these were included. The articles were also scanned for relevant references that were then retrieved and analysed as the other documents.

b) Institutional documents

The study of institutional reports helps to characterize the VAHPITWP in terms of: The context of the reported violence? Which kind of violence is most frequently reported? Who (professional group) reports it most frequently? What are the institutional responses?

Official Hospitals' and HC's incident as well as accident reports (in which violence was the cause) were analysed. These reports, mostly by the health professionals victimized by the violence, were included only if they occurred within the last 3 years (June 1998 to June 2001).

The institutions included for this part of the study are the same as the institutions selected and included in the hospital, HC and stakeholders studies.

c) National press analysis

This part of the documentary study identifies what leaks out to the public, through the written mass media. All the published newspaper articles on VAHPITWP between June 2000 and May 2001 were analysed. The inclusion criteria were:

- Being part of the "Manchete, Portugal" database of daily and weekly newspaper articles, available at the *Escola Nacional de Saúde Pública* (National School of Public Health, Lisbon, Portugal).
- Being a news article, an editorial, an opinion article or a letter from the reader.
- Having an implicit or explicit reference to VAHPITWP.
- Publication date between June 2000 and May 2001.

The database was searched using key words such as: stress, occupational stress, health professionals' occupational stress, burnout, professional satisfaction, violence, occupational violence, violence in the health sector, aggression, rape, insult and injuries, hospital, health centre, doctor, nurse. The articles were then scanned for explicit references to violence and only these were included.

Hospital case study

This case study entailed the adaptation and the application of the international questionnaire (annex 1) to all the health professionals of the selected district hospital. The hospital was selected on the basis of being a medium sized district hospital, within a fast growing residential village within one of the two of the metropolitan areas of Portugal, but serving also a rural population and having the support of the management board of the hospital for the study.

The study was explained to the hospital management team, who gave us permission to carry it out. They made a nominal list of all personnel available to us. This was the basis to organise the fieldwork. They also issued an internal note asking all personnel to collaborate with the researchers.

The study considered as health workers all those working in the hospital, part-time or full-time, with a permanent or temporary work contract with the hospital administration or even with firms providing services on the premises of the hospital.

The fieldwork took place during the week of the 24th of September and the 25, 26, and 27th of October (to follow-up non-respondents).

The data once collected were entered into a SPSS database, cleaned and analysed using descriptive statistics and the Pearson chisquare test (with the Yates correction when appropriate), or the two sided Fisher exact test, or the likelihood ratio, or the chi-square for trend, or the student t-test, as appropriate. The totals used for the analysis were the number of valid responses for each question.

Health centre case study

The health centre complex was selected on the basis of the support and interest from the health centre director contacted for such purpose.

The study health centre is an urban health centre complex. This complex consists of four primary health care units mostly run by general practitioners and nurses. In one of these units there is a centre for treatment of drug addicts. There is also an associated unit for the treatment of patients with tuberculosis, run by pneumologists and nurses. Lastly, a unit for the ambulatory treatment of psychiatric patients was also included, although not formally part of the HC (it is a community based extension of the psychiatric hospital services). The HC functions from 08.00 am to 22.00 pm, Monday to Saturdays.

The population served by this HC complex is mostly urban, including some of the wealthiest neighbourhoods of the country, but it also serves rural and poor urban neighbourhoods.

This case study followed the hospital study. It entailed the further adaptation and the application of the international questionnaire first to the mental health unit (annex 2) and then to the other units mentioned above (annex 3). In all the study units the questionnaire was applied to all the professionals.

The study was explained to the HC director, who gave us permission to carry it out. They made a nominal list of all personnel available to us. This was the basis to organise the fieldwork. They also issued an internal note asking all personnel to collaborate with the researchers.

The study considered as health workers all those working in the HC, part-time or full-time, with a permanent or temporary work contract with the HC administration or even with firms providing services on the premises of the HC.

The study was carried out during two days in October 2001. Non-respondents at the first attempt were contacted two further times. If these repeat contacts failed they were considered as non-respondents.

The data, once collected, were entered into a SPSS database, cleaned and analysed using descriptive statistics and the Pearson chisquare test (with the Yates correction when appropriate), or the two sided Fisher exact test, the likelihood ratio, the student t-test, or the chisquare for trend as appropriate. The totals used for the analysis were the number of valid responses for each question.

Stakeholders' study

Twenty seven hours of taped semi-structured interviews (annex 4) with stakeholders help to understand: What are the institutional policies and procedures to deal with VAHPITWP; What consequences are there for the health services; how do the unions and professional associations stand on this problem and what the solutions might be. The profile of the interviewees is summarised in table 1.

The interviews were transcribed and submitted to a formal content analysis.

Table 1 List of stakeholders selected for the study

STAKEHOLDER	**Number of interviews**	
Union leaders		7
Representatives of Professional Associations and Professional Councils		5
Health managers from the Department of Health of the Ministry of Health and the NHS	Simple random sample of Health Centres in the selected Health Region	9
	Simple random sample of Hospitals in the selected Health Region	9
	Health Department	3
	Department of Human Resources	1
	Regional and Sub-regional Health Authorities	8
	INEM (Institute of Medical Emergencies)	1
	Sub-total	31
Total		**43**

RESULTS OF THE DOCUMENTARY STUDIES

Portuguese literature review

Report prepared by I Fronteira
Comments by Portuguese Steering Committee members
Literature search conducted by I Fronteira
Study financed by the International Labour organization (ILO) and AGO

Following the strategy defined above we identified only one publication with explicit reference to VAHPITWP.

Title: *Risco, Penosidade e Insalubridade - uma realidade na profissão de enfermagem*
Author: *Sindicato dos Enfermeiros Portugueses*
Editor: Sindicato dos Enfermeiros Portugueses
Pages:74
Date: Lisbon, June 2000
ISBN: 972-95420-4-X
Summary: This opinion document, by the Union of Portuguese Nurses, analyses the risk and penosity concept in nursing practice. It makes reference to microbiologic, chemical and radiation hazards as well as equipment, work noise, stress, shifts, age and healthy life styles as risk factors in nursing. It is in this context that violence appears. The chapter dedicated to violence makes a brief reference to the increase of violence in society and underpins factors such as poor security and working hours (open 24h/day) as explaining the high rate of vandalism against professionals' cars.
This document refers that females and nursing directors are the most vulnerable to attacks as well as those working with old age services, at emergency units and in psychiatry.
The second part of this document has 16 real life stories of nurses that have experienced some of the occupational hazard mentioned above, including one on violence. This violence report refers to an incident in a health care centre where a male nurse was brutally attacked by a client. The male nurse was the first and only professional that the client found so he started to complain about everything: the kind of treatment offered to a family member, the deficient service functioning, the waiting time … The male nurse tried to understand what was going on in order to help and to give, if necessary, support. The client, completely out of his mind attacked the male nurse insulting and hitting him. This episode occurred at nigh in an emergency service, in a health care centre without security personnel on duty.

Analysis of institutional documents

Report prepared by P Ferrinho
Comments by Portuguese Steering Committee members
Analysis by P Ferrinho
Document collection conducted by A R Antunes, A Biscaia and I Fronteira
Study financed by ILO and AGO

Twenty two official reports on violence from five health centres and two hospitals were analysed. All the incidents were reported in writing by the victims of violence. The result of this analysis is summarised in table 2.

Some of the highlights of this table 2 include:

- Most reported violence was verbal;
- Reported violence was equally distributed against nurses (n=9), doctors (n=9) and other personnel (n=9);

- Hospital violence was most reported by nurses (in 6/7 reports involving violence against nurses);
- Nurse reported violence was mostly from hospitals (in 6/10 hospital reports);
- HC reported violence was mostly by doctors (in 7/13 HC reports);
- Doctor-reported violence was mostly from HC (in 7/9 reports involving violence against doctors);
- The perpetrators of reported violence were mostly females (in 13/21 reports);
- Most of the reported violence occurred during the summer period (in 13/20 reports);
- Reported violence usually occurred between members of the same sex (in 15/20 reports).

From four of the reports it was clear that the staff involved confronted the aggressor immediately and forcefully, suggesting lack of skills in conflict prevention (cases 4, 5, 10 and 16).

National press analysis

Report prepared by P Ferrinho
Comments by Portuguese Steering Committee members
Analysis by P Ferrinho
Literature search conducted by I Fronteira
Study financed by ILO and AGO

Nine articles on violence were identified and analysed. The results of the analysis are summarised in table 3. The principal highlights of these press reports are as follows:

- Most press reports referred to violence against doctors;
- Most press reports referred to physical violence;
- Most press reported incidents of violence occurred in hospitals;
- The health authorities contacted by the press denied their staff the importance of the incident by downplaying it.

Table 2 Individual incidents reported

Document number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**
Type of aggression	Physical (knife)	Physical	Physical	Verbal	Verbal	Moral pressure	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal	Verbal and physical
The victims	40 years old male nurse	45 years old female doctor	Female doctor and female auxiliary	Female nurse	Female doctor and female auxiliary	Female nurse and 2 female auxiliaries	Female nurse and female auxiliary	Female nurse	Female nurse	Female nurse	Male doctor	Female nurse	Female doctor	Male nurse	Female security (?)	Female administrative	?	Female doctor	Female doctor	Female doctor	Female administrative	2 female doctors security
The agressor	Male bystander	Female patient	Male patient	Female patient	Son of patient	Unknown	Female patient	Daughter of patient	Female patient	Female escort	Husband of patient	Male patient	52 years old female patient	50 years old male patient	Female patient	Female patient	Mother of patient	19 years old female patient	Male patient	Female patient	Son of patient	Mother of child
The type of institution	HC staff during home visit	HC	HC	Hospital ward	Hospital ward	Hospital ward	Hospital ward	Nurses office in hospital ward	Hospital emergency unit	Waiting room of hospital ward	Emergency unit of HC	HC	Consulting room of HC	HC	HC	HC	HC	Consulting room of HC	Consulting room of HC	HC	HC	Paediatric hospital emergency unit
The village or city	Rural HC	Urban HC	Urban HC	Rural hospital	Rural hospital	Rural hospital	Rural hospital	Rural hospital	Rural hospital	Rural hospital	Rural HC	Urban HC	Urban HC	Urban HC	Urban HC	Urban HC	Urban HC	Urban HC	Urban HC	Urban HC	Urban HC	Urban Hospital
Month	June	August	July	May	July	?	?	September	March	May	June	September	July	July	June	August	August	March	August	February	March	February
Reason alleged for the violence	Racism ?	Doctor refused to see patient and referred her to the HC of her residential area	Patient with known criminal record	Drip related worries of patient	?	Delay in opening the ward doors at visit time	?	Bad care provided to the father	?	?	?	Patient wanted to jump the queue of waiting patients	Doctor refused to write an illegal credential for investigation not covered by the NHS	Patient known to have a bad temper	Request for subsidised milk powder refused	Wrong information given on documents needed to register with the HC	?	?	?	?	?	Mother did not want to wait for her turn
Action taken by the victim	Report to the sub-regional health authority and to the police. Court proceedings.	Reported to the police Court proccedings.	Reported to the police.								Reported to the police. Court proceedings.											Police called Reported to the hospital director
Reaction of the authorities		Director of the HC processed the incident as an occupational accident. Given sick leave for psychological reasons.									Given sick leave for psychological reasons		Patient eliminated from the GP list and offered the choice of another GP	Patient written a letter by the director to explain patient duties and rights				Patient eliminated from the GP list and offered the choice of another GP	Patient eliminated from the GP list and offered the choice of another GP	Patient eliminated from the GP list and offered the choice of another GP		

Table 3. Analysis of daily press articles on violence, June 2000 and May 2001

	Individual incidents reported in the daily press						
Document number	**7 & 6**	**8**	**3 & 4**	**2**	**5**	**1**	**9**
Type of aggression	Verbal and physical, involving a knife	Psychological	Verbal and physical (no weapons involved)	Verbal and physical	Verbal and physical (no weapons involved)	Verbal and physical (using an umbrella)	Physical (no weapons involved)
The victims	Two female doctors	175 doctors	One male internist doctor	Doctors in general	One male administrative assistant	One nurse and one gatekeeper	One female doctor, one male nurse, one health auxiliary and one security agent
The aggressor	Male patient escort	Patients, judges and lawyers	Male general practitioner	The patients/public	Male general practitioner	Male patient escort	Male patient
The type of institution	Health centre		Hospital emergency department	Health centre and Hospital emergency department	Health centre	Hospital emergency department	Hospital emergency department
The village or city	Beja (rural)	Guimarães (urban)	Aveiro (urban)		Braga (urban)	Santa Maria da Feira (rural)	Faro (urban)
Month and year of the incident	August 2000	August 2000	October 2000	October 2000	November 2000	December 2000	May 2001
Reason alleged for the violence	Wife of the aggressor told to go to the HC where she is registered	National *laissez faire* culture	Differences of opinion over most adequate patient management	Doctors frequently working alone (in the HC). Lack of civic behaviour by the doctor. Poor working conditions. Media identified as having an important role in encouraging VAHPITWP. Social control role of doctors. Public does not know how the system works. Rising expectations in relation to the possibilities of medical care.	Too many chairs in the consulting room	Parking problems	Patient resisting arrest and investigation for driving under the influence of alcohol
Action taken by the victim	Reported to the police, to the union and to the Regional health authority	Reported to the medical council	Reported to the medical council and to the medical director		Reported to the police, to the health centre director and to the Regional health authority	Reported to the police, to the director	Reported to the police and public prosecutor
Reaction of the authorities	Request for permanent police protection refused by on the basis of deficit of agents Regional health authority downplayed the incident and claimed that it was being overdramatised			This report refers to a meeting of the regional branch of the medical council to discuss the issue of VAHPITWP	Doctor was suspended	Both downplayed the importance of the incidents of VAHPITWP	Court process initiated

RESULTS OF THE HOSPITAL CASE STUDY

Report prepared by I Fronteira and P Ferrinho
Comments by Portuguese Steering Committee members
English translation by P Ferrinho and I Fronteira
Analysis by I Fronteira
Data entered by Vasco Bela
Field work coordinated by I Fronteira and carried out by A R Antunes, A M Bugalho, A R Costa, M C Conceição, I Craveiro, V Bela, M António Gomes, A M Gonçalves
Study financed by the ILO and AGO

The results presented here are just an overview of the principal results.

Study population

Two hundred and seventy seven hospital workers answered the questionnaire (80 % response rate). The response rates by professional groups are presented in table 4.

Table 4 – Response rate by professional group

Professional group	Total	Total questioned	Response rate (%)
Hospital administrators	5	5	100
Nurse	94	71	76
Doctors	49	31	63
Administrative personnel	46	25	54
Clinical auxiliaries	70	69	99
Others	84	76	90
Total	348	277	80

There were 54 males (20,1%) and 214 females (79,9%) and 50,8% of the workers were between 30 and 44 years of age.

The study hospital: health and safety policies and observed changes

If in existence the health and safety policies in force in the hospital are ignored by most personnel (table 5).

Table 5 Perceptions of the existence of policies on health and safety

	yes		no		Do not know	
	Nº	%	Nº	%	Nº	%
They exist	50	19.6	67	26.3	138	54.1
There are policies on physical violence	7	2.9	93	38.0	145	59.2
There are policies on discrimination	4	1.7	93	38.8	143	59.6
There are policies on moral pressure	8	3.3	92	37.7	144	59
There are policies on verbal aggression	8	3.3	89	36.5	147	60.2
There are policies on sexual harassment	1	0.4	89	36.5	154	63.1

In the hospital the last two years were times of change. These changes are not uniformly perceived by all personnel (table 6). Their impact in the health workers' working conditions are more commonly perceived as negative than positive (table 7).

Tabela 6 Perceptions of the changes observed in the hospital over the last two years

	Frequency	Valid Percent
There were changes over the last two years	58	20.9
There were personnel cuts	71	28.5
New personnel was recruited	61	24.4
Resources were constrained	32	12.9
Resources increased	22	8.8
Do not know of any changes	83	32.8

Table 7 Impact of the changes observed in the hospital over the last two years

	Frequency	Valid Percent
No impact	35	23.4
Working conditions worsened	56	35.9
Working conditions improved	42	26.8
Conditions of patient care worsened	45	28.7
Conditions of patient care improved	25	15.9
Does not know	18	11.5
Other	4	2.5

Violence against health professionals

The different patterns of violence observed are summarised in table 8. In none of the cases of physical violence was a weapon used.

Table 8 Patterns of violence observed over the 12 months preceding the survey

Type of violence	**Self was victim**		**Self witnessed**	
	N	**%**	**N**	**%**
Verbal	74	27.4		
Moral pressure	43	16.5		
Discrimination	21	8.0		
Physical violence	7	2.6	21	8,1
Sexual harassment	7	2.7		
Any type	102	36.8		

Violence by professional group

The percentage of any professional group reporting any type of violence is summarized in table 9. Globally violence is most frequently experienced by nurses, although some specific types are most common in other personnel groups.

Table 9 Frequency (and percentage) of any professional group reporting any type of violence

	Hospital administrator/director	**nurse**	**Administrative personnel**	**doctor**	**Clinical auxiliaries**	**Diagnostic paramedics**	**Other with university degree**	**Other auxiliaries**	**other**
Verbal*	1 (20)	29 (41)	3 (12)	**13 (42)**	13 (19)	6 (24)	1 (17)	2 (14)	6 (27)
Moral*	1 (20)	17 (25)	1 (5)	7 (23)	7 ((11)	2 (9)	**2 (33)**	0	6 (29)
Discrimination**	0	9 (13)	1 (4)	1 (3)	5 (8)	1 (4)	0	1 (7)	**3 (15)**
Physical**	0	**5 (7)**	0	0	1 (2)	0	0	0	1 (4)
Sexual harassment**	0	**5 (7)**	0	0	1 (2)	0	0	1 (7)	0
Any type*	2 (40)	**38 (54)**	5 (20)	16 (52)	19 (28)	8 (32)	2 (33)	3 (21)	9 (39)

* likelihood ratio $p<0.05$; ** likelihood ratio $p>0.05$

Frequency of violence experiences

More than half of the victims of physical violence consider it frequent at their workplace (five out of 6 - 83,3%). Over half of the victims of violence have experienced it more than once (table 10).

Tabela 10 Frequência de experiência pessoal por tipo de violência

Type of violence	**frequência com que o respondente tem sido vítima**		
	All the time	**Sometimes**	**once**
verbal	2 (2.8%)	52 (73.2%)	17 (23.9%)
moral	4 (9.3%)	36 (83.7%)	3 (7.0%)
discriminação	7 (35.0%)	12 (60.0%)	1 (5.0%)
sexual	0	4 (57.1%)	3 (42.9%)

Violence by sex of the victims

All types of violence (except for sexual harassment) are most prevalent for male health professionals (never statistically significant) (table 11).

Table 11 Percentage of each sex that suffered a specific type of violence

Type of violence	**sex**	
	male	**female**
Verbal	33	26
discrimination	10	7
Moral pressure	22	15
Physical	6	2
Sexual harassment	2	3
Any type	46	35

Violence by pattern of work

Verbal aggression, moral pressure, sexual harassment and overall violence seem more prevalent among health workers that have contact with female patients (table 12), although not statistically significant. Discrimination and physical violence are most frequent for health workers contacting mostly male patients.

Table 12 Prevalence of violence (%) per predominant sex of patients contacted by health workers

Tipo de violência	**predominant sex of patients contacted by health workers**		
	female	**male**	**both**
Verbal	36.8	32.0	28.6
Moral	31.6	21.7	15.3
Discrimination	5.3	19.0	7.0
Physical	0	8.0	1.6
Sexual	10.5	0	2.7
Any type	57.9	52.0	36.3

Characterisation of the aggressor

For most types of violence patients and/or clients and their relatives are the most frequent aggressors of health workers (table 13). The exceptions are discrimination and moral pressure, that are usually perpetrated by fellow colleagues. All cases of physical aggression were carried out by a male aggressor.

Table 13 Categorisation of the aggressor

Type of violence	**Patient / client**	**Family of patient / client**	**public**	**Co-worker**	**Outside health worker**
verbal	24 (33.3%)	33 (45.8%)	2 (2.8%)	13 (18.1%)	0
moral	5 (11.6%)	5 (11.6%)	1 (2.3%)	30 (69.8%)	2 (4.7%)
discrimination	1 (5.0%)	0	0	19 (95.0%)	0
physical	3 (60.0%)	0	1 (20.0%)	1 (20.0%)	0
sexual	3 (42.9%)	1 (14.3%)	0	3 (42.9%)	0

Where does violence occur

The violence experienced by the health workers interviewed does usually occur in the hospital where they work (table 14).

Table 14 Where does violence occur?

TYPE OF VIOLENCE	**WHERE DOES VIOLENCE OCCUR**	
	In the hospital	**Another place**
Verbal	73 (100%)	0
Moral	42 (97.7%)	1 (2.3%)
Discrimination	20 (100%)	0
Physical	6 (100%)	0
Sexual	6 (100%)	0

Individual impact of violence

The impact of violence on the victim was measured on a scale of 1 to 5 were 1 is never and five always, referring to the experience of the problems listed in table 15. Discrimination seems to be the most disturbing type of violence for health professionals.

Table 15 Impact of violence on the victim

Problems felt by the victims of violence	**Verbal violence**	**Moral pressure**	**Discrimination**	**Physical violence**	**Sexual harassment**
Having repeated disturbed memories, thoughts or images of the incident	1.85±1.01	2.45±1.20	**3.00±1.33**	1.71±1.25	1.86±0.90
Avoiding thinking about or talking about the abuse or avoiding having feelings about it	2.52±1.50	2.84±1.46	**3.40±1.31**	3.00±2.19	3.29±1.70
Being super-alert or watchful and on guard	3.26±1.28	3.74±1.16	**4.00±1.21**	**4.00±1.41**	2.71±1.50
Feeling like everything done is an effort	1.89±1.11	2.35±1.25	**2.42±1.30**	2.00±0.89	1.57±0.98

Institutional reactions to violence

Institutional reactions to the violence are observed only in a minority of cases (table 16). Overall, the balance of the appreciation of the handling of the case of violence by the institution is negative (table 17).

Table 16 Institutional reactions to the violence (absolute numbers)

		Verbal	Moral	Discrimination	Physical	Sexual
Were measures taken to investigate the causes of the incident?	**Yes**	8	6	1	0	2
	No	54	33	4	6	16
	Do not know	1	3	1	0	2
By the boss		6	3	3	0	0
By the professional association		1	2	0	0	0
By the union		1	2	0	0	0
By the police		2	0	0	1	0

Table 17 – Satisfaction with the handling of the incident by the institution (absolute numbers)

		verbal	moral	Discrimination	physical	sexual
Degree of satisfaction	**Very unhappy**	14	14	0	0	11
	unhappy	25	20	3	2	7
	happy	16	2	1	1	0
	Quite happy	3	1	1	1	0
	Very happy	1	3	0	0	0

RESULTS OF THE HEALTH CENTRE CASE STUDY

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Analysis by P Ferrinho
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Study financed by the *Associação Portuguesa dos Médicos de Clínica Geral, Sindicato dos Enfermeiros Portugueses* and *Ordem dos Enfermeiros* and AGO

Study population

In the health centre complex 221 persons answered the questionnaire (overall response rate of 86%) although the response rate varies from question to question. The response rate per unit of the complex is presented in table 18.

Table 18 Response rate (%) per unit of the health centre complex (in brackets is the total expected number of health workers)

	Head office	**Unit 1**	**Unit 2**	**Unit 3**	**Tuberculosis unit**	**Mental health unit**
Response rate	74 (121)	89 (55)	94 (31)	80 (44)	39 (18)	100 (9)

There were 50 males (23%) and 168 females (77%). Their age distribution is summarised in table 19. The bulk of the workers were between 35 and 54 years of age.

Table 19 Age distribution

	Frequency	**Valid Percent**
Less than 20	1	,5
20-24	5	2,3
25-29	15	6,8
30-34	16	7,3
35-39	30	13,6
40-44	36	16,4
45-49	**47**	**21,4**
50-54	40	18,2
55-59	16	7,3
60 or more	14	6,4
Total	220	100,0

Most were married (n= 137, 62%) or cohabiting (n=13, 6%), 33 were single (15%), 32 divorced or separated (15%) and 5 widowed (2%). Only 27 (13%) had moved from another country to Portugal. Eight (4%), 9 (5%) and 11 (6%) felt that in, respectively, the country, their area of residence or the HC, they were part of an ethnic minority group.
The three major professional groups included nurses, administrative personnel and general practitioners (table 20).

One hundred and sixty five (76%) belonged to the staff establishment of the HC, 35 (16%) were contract workers and 16 (7%) were employed on other regimens. One hundred and eighty nine (87%) were full-time workers, 27 (12%) were part-time workers and 1 was a casual worker.

Forty seven (23%) reported working somewhere else as well. Thirty six (17%) worked shifts and 95 (45%) reported working between 20.00 and 08.00 hours.

Table 20 Professional group

	Frequency	Column percent
Nurses	**53**	**24.3**
Administrative personnel	52	23.9
General practitioner	50	22.9
Clinical auxiliary	22	10.1
Cleaning personnel	15	6.9
Other medical speciality	9	4.1
Other professional with an university degree	7	3.2
Security	5	2.3
Diagnostic paramedics	3	1.4
Other	2	.9
Total	218	100.0

One hundred and ninety five (90%) reported contact with patients, 118 (56%) physical contact; 156 (75%) reported contact with children, 163 (79%) reported contact with adolescents, 182 (88%) reported contact with adults and 165 (80%) with the elderly. Most (n=134, 65%) reported equal contact with patients of both sexes, 49 (24%) reported contacts mostly with females patients and 5 (2%) mostly with male patients.

There were 92 (42%) respondents at the head office HC and the others were distributed by the other subsidiary centres: 49 (22%) in one, 35 (16%) in another, 29 (13%) in the next, 9 (4%) in the mental health centre and 7 (3%) in the tuberculosis unit.

The study HC: health and safety policies, observed changes and job satisfaction

If in existence the health and safety policies in force in the HC are ignored by most personnel (table 21).

Table 21 Perceptions of the existence of policies on health and safety

	Frequency	Valid Percent
They exist	47	22.9
Do not know of any policies	**154**	**77.0**
There are policies on physical violence	13	6.3
There are policies on discrimination	1	0.5
There are policies on moral pressure	2	1.0
There are policies on verbal aggression	7	3.4
There are policies on sexual harassment	1	0.5

In the health centre complex the last two years were times of change. These changes are not uniformly perceived by all personnel (table 22). Their impact in the health workers' working conditions are more commonly perceived as negative than positive (table 23).

Table 22 Perceptions of the changes observed in the HC over the last two years

	Frequency	Valid Percent
There were changes over the last two years	**94**	**44.5**
There were personnel cuts	59	28.0
New personnel was recruited	62	29.4
Resources were constrained	52	24.6
Resources increased	26	12.3
Do not know of any changes	43	20.5

Table 23 Impact of the changes observed in the HC over the last two years

	Frequency	Valid Percent
No impact	37	20.2
Working conditions worsened	**58**	**31.5**
Working conditions improved	40	21.7
Conditions of patient care worsened	31	16.8
Conditions of patient care improved	23	12.5
Does not know	33	17.9

Nevertheless, when requested to comment on the statement that working conditions in their health centre unit were adequate for the good performance of their professional duties, the perception of the health workers is that the working conditions are more on the positive than on the negative side (table 24).

Table 24 Level of agreement with the question: "in general do you consider that in the HC, the existing conditions are conducive to a good professional practice?"

	Frequency	Valid Percent
Strongly disagree	15	7.3
disagree	51	24.9
Neither agree nor disagree	37	18.0
agree	**90**	**43.9**
Strongly agree	12	5.9

Violence against health professionals

The different patterns of violence observed are summarised in table 25. In none of the cases of physical violence was a weapon used.

Table 25 Patterns of violence observed over the 12 months preceding the survey

Type of violence	Self was victim of violence	Witnessed violence against other health professionals
Any type	133 (60%)	
Physical	7 (3%)	7 (4%)
Against property	32 (15%)	
Psychological	117 (54%)	
Verbal	111 (51%)	113 (55%)
Moral	50 (23%)	41 (20%)
Discrimination	9 (4%)	11 (5%)
Sexual	2 (1%)	1 (0,5%)

The overlap among different types of violence is summarized in table 26. People that reported moral pressure, or physical violence, or violence against property most frequently reported experiences of verbal violence. The two who reported sexual harassment report also verbal violence and violence against property. All those experiencing discrimination reported also verbal violence and most also reported moral pressure.

Table 26 Overlap among different types of violence (absolute numbers)

Type of violence	Verbal	Moral	Against Property	Discrimination	Physical	Sexual
Verbal		44	22	9	5	2
Moral	44		12	7	3	1
Against property	22	12		3	2	2
Discrimination	9	7	3		0	1
Physical	5	3	2	0		0
Sexual	2	1	2	1	0	

Violence by unit of the health centre complex

The percentage of health workers reporting violence is very similar amongst the different units of the HC complex (table 27). The mental health unit stands out because of the very high prevalence of verbal violence and of violence against property.

Table 27 Percentage of health workers reporting violence in the different units of the HC complex

Type of violence	Head office	Unit 1	Unit 2	Unit 3	Tuberculosis unit	Mental health unit
Verbal	50	59	50	37	43	**78**
Moral	15	27	**38**	29	29	11
Against property	18	14	7	9	14	**33**
Discrimination	5	**6**	3	3	0	0
Physical	2	2	7	3	**14**	0
Sexual	0	2	0	0	0	**11**
Any type	55	67	55	46	57	78

Violence by professional group

The percentage of any professional group reporting any type of violence is summarized in table 28. Violence of any sort and physical violence are most frequently experienced by nurses. Verbal violence and moral pressure are most frequently experienced by administrative personnel. Violence against property is most frequently directed against the property of doctors. GP and administrative personnel were the only two groups reporting cases of sexual harassment.

Table 28 Frequency (and percentage) of any professional group reporting any type of violence

Type of violence	Nurses	Administrative	GP	Clinical auxiliaries	Cleaning personnel	Other medical speciality	Other with university degree	Security	Diagnostic paramedics	Other
Verbal	35 (67)	**37 (71)**	22 (44)	5 (24)	3 (20)	2 (25)	5 (71)	1 (20)	1 (33)	0
Moral	12 (23)	**18 (35)**	15 (31)	2 (9)	0	1 (11)	1 (14)	1 (20)	2 (67)	0
Against property	8 (15)	7 (14)	**12 (24)**	0	0	**2 (25)**	1 (14)	0	0	0
Discrimination	3 (6)	3 (6)	2 (4)	0	0	0	**1 (14)**	0	0	0
Physical	**4 (8)**	0	2 (4)	0	0	0	0	0	0	0
Sexual	0	**1 (2)**	**1 (2)**	0	0	0	0	0	0	0
Any type	**36 (74)**	35 (70)	29 (58)	6 (29)	4 (29)	3 (33)	3 (60)	2 (40)	1 (33)	0

Frequency of violence experiences

More than half of the victims of verbal aggression and moral pressure consider it frequent at their workplace (tables 29).

Table 29 Perception of frequency of violence by the victims of that same violence

Type of violence	Is violence considered frequent?	
	yes	no
Verbal	68 (69%)	30 (31%)
Moral	22 (59%)	15 (41%)
Discrimination	3 (60%)	2 (40%)
Physical	1 (33%)	2 (67%)
Sexual	0	1 (100%)

Most report having been victims of violence more than once (table 30).

Table 30 Frequency of personal experience of violence

Type of violence	Average±sd	All the time	Sometimes	Once
Verbal		1 (1%)	75 (76%)	23 (23%)
Moral		4 (10%)	30 (71%)	8 (19%)
Against property	1.60±0.97			
Discrimination		1 (13%)	5 (63%)	2 (25%)
Physical	1.67 ±0.58			
Sexual		0	1 (50%)	1 (50%)

Violence by age group

Victims of violence are most frequent under the age of 45 years (table 31).

Table 31 Prevalence of violence (%) within 5 years age groups

Type of violence	Under 20 years	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60 or more
Verbal	0	25	57	69	60	61	40	43	47	50
Moral	0	50	20	31	20	28	21	15	25	29
Against property	0	25	20	13	10	17	13	18	6	14
Discrimination	0	25	0	6	7	3	7	0	6	0
Physical	0	0	7	6	0	3	4	3	0	0
Sexual	0	0	0	0	50	50	0	0	0	0
Any type	0	50	50	69	61	65	52	53	47	57

Violence by sex

Except for sexual harassment (only two cases, one male and one female), all types of violence are most prevalent among female health professionals (the difference is statistically significant for verbal violence, two sided Fisher exact test p=0.022 and for any type of violence, two sided Fisher exact test p=0.028) (table 32).

Table 32 Percentage of each sex that suffered a specific type of violence

	Male	**Female**
Verbal	35	55
Moral	14	25
Against property	13	15
Discrimination	2	5
Physical	2	3
Sexual	2	0.6
Any type	41	61

Violence by marital group

No significant pattern of association between violence and marital status seems to emerge (table 33).

Table 33 Percentage of each category of marital status that suffered a specific type of violence

Type of violence	**single**	**married**	**Living together**	**Divorced/ separated**	**widowed**
Verbal	45	52	46	**56**	20
Moral	25	21	23	**28**	20
Against property	16	13	0	**26**	20
Discrimination	9	**4**	0	3	0
Physical	0	4	**8**	0	0
Sexual	0	2	0	0	0
Any type	55	57	46	**63**	40

Violence by job security

Violence seems most frequent against health workers belonging to the staff establishment (table 34).

Table 34 Percentage within each type of job security that suffered a specific type of violence

Type of violence	**workers on permanent contracts'**	**Contract worker**	**Other situation**
Verbal	54	46	33
Moral	25	20	6
Against property	15	17	7
Discrimination	5	3	0
Physical	4	0	6
Sexual	1	0	0
Any type	60	43	47

Violence by pattern of work

Violence is most prevalent amongst fulltime health workers (table 35). This difference is statistically significant for verbal violence and any type of violence (likelihood ratios p=0.000 and p=0.015 respectively).

Table 35 Prevalence of violence per hours worked

Type of violence	**Full time**	**Part time**	**Casual workers**
Verbal	56	19	0
Moral	25	12	0
Against property	14	22	0
Discrimination	5	0	0
Physical	2	8	0
Sexual	1	0	0
Any type	60	33	0

The years of experience in the health sector do not seem to differ significantly between those that experienced and those that did not experience violence (table 36).

Table 36 Mean years of experience in the health sector per type of violence suffered

Type of violence	**Mean of years of experience in the health sector±sd**	
	yes	**no**
Verbal	**19.0±10.0**	17.6±10.4
Moral	**18.7±10.0**	18.1±10.3
Against property	**20.2±9.5**	18.0±10.3
Discrimination	16.3±9.3	**18.2±10.3**
Physical	16.0±10.7	**18.1±10.1**
Sexual	15.5±0.7	**18.1±10.3**
Any type	**19.1±9.9**	17.9±10.6

No significant pattern emerges regarding shift work and night work and prevalence of violence, except for moral pressure that it is less frequent among workers that do not work shifts (two sided Fisher exact test p=0,051) (table 37).

Table 37 Prevalence of violence suffered (%) per pattern of work

Type of violence	**Shift work**		**night work (18.00-07.00 hours)**	
	yes	**no**	**yes**	**no**
Verbal	54	51	46	54
Moral	36	20	26	22
Against property	8	16	14	16
Discrimination	6	4	2	6
Physical	3	3	1	5
Sexual	0	1	2	0
Any type	60	56	53	59

With the exception of sexual harassment and moral pressure, other types of violence are most prevalent among health workers that are involved in community work (two sided

Fisher exact test, p=0.022 for any type of violence and p=0.041 for verbal violence) (table 38).

Table 38 Prevalence of violence suffered (%) per work involving or not community work

Type of violence	Community work	
	yes	no
Verbal	70	49
Moral	14	25
Against property	21	14
Discrimination	7	4
Physical	4	3
Sexual	0	1
Any type	78	54

All types of violence are most prevalent among health workers that have contact with patients, particularly physical contact (likelihood ratio p=0.002 for verbal violence in association with contact and physical contact, p=0.017 for physical violence in association with physical contact, p=0.001 and p=0.020 for any type of violence in association respectively with contact and physical contact) (tables 39 and 40).

Table 39 Prevalence of violence suffered (%) per work involving or not contact with patients

Type of violence	Contact with patients	
	yes	no
Verbal	55	21
Moral	25	11
Against property	16	10
Discrimination	5	0
Physical	4	0
Sexual	1	0
Any type	61	26

Table 40 Prevalence of violence suffered (%) per work involving or not physical contact with patients

Type of violence	Physical contact with patients	
	yes	no
Verbal	57	48
Moral	28	16
Against property	19	8
Discrimination	4	5
Physical	6	0
Sexual	2	0
Any type	64	51

The age group of the patients that health workers have contact with does not affect the prevalence of violence (table 41).

Table 41 Prevalence of violence (%) per age group of patients that health workers have contact with

Type of violence	children	adolescents	adults	elderly
Verbal	54	53	53	54
Moral	26	27	26	26
Against property	16	17	16	18
Discrimination	5	6	5	5
Physical	4	4	4	4
Sexual	1	1	1	1
Any type	61	61	60	60

Verbal aggression and overall violence seem more prevalent among health workers that have contact with female patients (table 42), although not statistically significant.

Table 42 Prevalence of violence (%) per predominant sex of patients contacted by health workers

Type of violence	male	female	both
Verbal	40	60	59
Moral	16	20	27
Against property	20	20	13
Discrimination	2	0	6
Physical	2	0	5
Sexual	0	0	2
Any type	48	75	64

Except in two situations, no significant patterns emerge regarding the association of violence with the number of co-workers (table 43). The two exceptions are the apparent concentration of discrimination among workers working isolated and the second relates to the apparent increase of moral violence the higher the number of work-colleagues (chisquare for trend not significant).

Table 43 Prevalence of violence (%) per number of health workers working side by side

Type of violence	none	1-5	6-10	11-15	>15
Verbal	38	55	39	55	52
Moral	19	22	24	27	28
Against property	13	13	10	27	22
Discrimination	13	3	0	0	8
Physical	0	4	5	0	2
Sexual	0	1	0	0	2
Any type	47	57	46	64	62

Characterisation of the aggressor

Patients and/or clients are the most frequent aggressors of health workers (table 44).

Table 44 Categorisation of the aggressor

Type of violence	Patient/client	Family of patient/client	public	Co-worker	Outside health worker	Other
Verbal	65 (64%)	15 (15%)	4 (4%)	17 (17%)	0	0
Moral	21 (54%)	2 (5%)	1 (3%)	1 (3%)	13 (33%)	1 (3%)
Discrimination	3 (50%)	0	1 (17%)	2 (33%)	0	0
Physical	3 (100%)	0	0	0	0	0
Sexual	1 (100%)	0	0	0	0	0

The aggressor is most frequently female for verbal aggressions and moral pressure and male for other types of violence (table 45).

Table 45 Sex of the aggressor per type of violence

Type of violence	Female	Male
Verbal	50 (52%)	47 (48%)
Moral	26 (68%)	12 (32%)
Discrimination	4 (40%)	6 (60%)
Physical	1 (33%)	2 (67%)
Sexual	0	1 (100%)

The aggressors are most frequently adults (table 46).

Table 46 Age group of the aggressor per type of violence

Type of violence	Children < 10	Adolescents 10-18	Adults 19-65	Elderly > 65
Verbal	1 (1%)	8 (8%)	89 (88%)	3 (3%)
Moral	0	2 (5%)	35 (92%)	1 (3%)
Discrimination	0	0	6 (100%)	0
Physical	1 (33%)	0	2 (67%)	0
Sexual	0	0	1 (100%)	0

When and where does violence occur

The violence experienced by the health workers interviewed does usually occur in the health centre unit where they work (table 47).

Table 47 Where does violence occur?

Type of violence	In the HC	In the emergency room of the local hospital[a]	other
Verbal	98 (98%)	1 (1%)	1 (1%)
Moral	37 (97%)	0	1
Discrimination	5 (100%)	0	0
Physical	3 (100%)	0	0
Sexual	1 (100%)	0	0

Small numbers do not allow conclusions other than observe that the few cases of physical violence occurred mostly in the afternoon (1 in the morning and 2 in the afternoon), on Saturdays (1 of 3, the other 2 did not recall the day) and the day before a public holiday (2 of 3).

a This question was only applied to the personnel of the mental health unit.

Observed violence

Although most health workers report witnessing acts of violence over the 12 months preceding the study (table 48), only one did report this observation.

Table 48. Number of times that an act of violence was witnessed over the past 12 months

	Frequency	**Percent**
once	3	1,4
5-10 times	207	97,2
Several times per month	1	0,5
Once a week	1	0,5
daily	1	0,5
Total	213	100,0

Individual reactions to violence

Table 49 summarises the victims' reactions to the different types of violence. Except for sexual harassment and discrimination, supervisors and colleagues seem to be the most frequent support for the violence incident. Victims of discrimination most frequently pretend that nothing happened as well as most frequently confide in relatives rather than colleagues, and most often go for counselling or seek help of professional association. Victims of verbal or moral pressure more frequently seek advice with boss colleagues or relatives, in this order.

Table 49 Measures taken by the victim in reaction to the aggression (column percentages; more than one option is possible)

Measures taken by the victim	**Verbal violence**	**Moral pressure**	**Discrimination**	**Physical violence**	**Sexual harassment**
Told the person to stop	38 (37%)	10 (24%)	1 (14%)	2	1
Pretended that nothing occurred	17 (17%)	4 (10%)	2 (29%)	0	1
Physical self-defense				1	
Told family/friends	16 (16%)	12 (29%)	4 (57%)	0	1
Told colleague	28 (28%)	13 (31%)	1 (14%)	1	0
Told my boss	47 (46%)	17 (41%)	0	2	0
Went for counselling	9 (9%)	6 (14%)	2 (29%)	0	0
Asked help from union	2 (2%)	0	0	0	0
Asked help from professional association	3 (3%)	0	1 (14%)	0	0
Changed facility/functions	0	0	0	0	0
Reported the incident in writing	11 (11%)	3 (7%)	1 (14%)	1	0
Initiated court proceedings	2 (2%)	0	0	0	0
Demanded compensation	0	0	0	0	0

Individual impact of violence

The impact of violence on the victim was measured on a scale of 1 to 5 were 1 is never and five always, referring to the experience of the problems listed in table 50. Discrimination seems to be the most disturbing type of violence for health professionals.

Table 50 Impact of violence on the victim

Problems felt by the victims of violence	Verbal violence	Moral pressure	Discrimination	Physical violence	Sexual harassment*
Having repeated disturbed memories, thoughts or images of the incident	2.33±1.16	2.79±1.32	**3.17±0.75**	1.50±1.00	3
Avoiding thinking about or talking about the abuse or avoiding having feelings about it	2.63±1.47	2.89±1.47	**3.00±1.41**	2.75±1.71	3
Being super-alert or watchful and on guard	3.13±1.44	3.49±1.34	**4.14±1.46**	4.0±1.73	---
Feeling like everything done is an effort	2.04±1.25	2.75±1.50	**3.00±0.58**	1.5±1.00	3

* only one reply

Institutional reactions to violence

Institutional reactions to the violence are observed only in a minority of cases (table 51). Overall, the balance of the appreciation of the handling of the case of violence by the institution is negative.

Table 51 Institutional reactions to the reported violence (absolute numbers)

	Verbal violence	Moral pressure	Discrimination	Physical violence	Sexual harassment
Measures were taken to investigate the aggression	29	9	0	1	
By the boss	17	7	0	1	
By the professional association	1	8	0	0	
By the union	2	8	0	0	
By the police	4	1	0	1	
Satisfaction with the handling of the case by the institution	32 happy to very happy 35 unhappy or very unhappy	7 happy to very happy 16 unhappy or very unhappy	1 happy 4 unhappy or very unhappy	1 happy 2 unhappy or very unhappy	No replies

All victims of physical violence considered that it could have been avoided, but only about half of the victims of other types of violence considered them preventable (47/111 verbal, 23/50 moral, 5/9 discrimination).

When questioned about the most important measures that should be taken to ensure a reduction in current violence levels, 60% (n=72) of the victims of violence, independently of the type of violence, came up with suggestions, but only 34% (n=35) of the non-victims did so. These suggestions are summarised in table 52.

Table 52. Measures necessary to reduce levels of violence

Measures necessary to reduce levels of violence	Examples
Physical conditions at the health centre need improvement	Lighting, structure of the building
Work organisation needs improvement	More team work, better plans to correct problems of no respect for working hours
Working conditions need to be improved	More personnel, more resources
Relational quality not up to standards	At reception and even during the consultation
Users are poorly informed	
Agressors need to know that violence has consequences	
The existing level of violence needs to be detected	Better reporting systems
Victims lack skills to deal with the violence episode	
More security	Video systems, security personnel, police on site or on call

Consequences for the aggressor

Only a minority of the aggressors suffers any type of consequences (table 53).

Table 53 Consequences of the violence for the aggressor (absolute numbers)

	Verbal violence	Moral pressure	Discrimination	Physical violence	Sexual harassment
none	28	10	---	---	---
Verbal reprehension	10	2	0	---	---
Care was stopped	5	2	0	---	---
Reported to the police	6	0	0	---	---
Court proceedings	3	0	0	---	---
Don't know	8	5	0	---	---

RESULTS OF THE STAKEHOLDER STUDY

Report prepared by I Craveiro, A R Antunes and P Ferrinho
Comments by Portuguese Steering Committee members and Helge Hoel
Translation by P Ferrinho
Content analysis by I Craveiro and A R Antunes
Field work by A R Antunes, I Fronteira, I Craveiro, I Flores and P Ferrinho during September-November 2001
Study financed by the ILO and AGO

As mentioned previously, the content analysis was geared to obtain answers to the following questions: what are the institutional policies and procedures to deal with workplace violence against health professionals; what consequences are there for the health services; how do respondents´ institutions stand on this problem; and what solutions are possible.

The response rate for the sample described in table 1 is summarised in table 54.

Table 54 Response rate for the stakeholders' study

STAKEHOLDER	Number of interviews		Response rate %	
Union leaders		5 (on 7)	71.4	
Representatives of Professional Associations and Professional Councils		5 (on 5)	100	
Health managers from the Department of Health of the Ministry of Health and of the NHS	Simple random sample of Health Centres in the selected health Region	6* (on 9)	66.6	
	Simple random sample of Hospitals in the selected health Region	6** (on 9)	66.6	
	Health Department	2 (on 3)	66.6	41.6
	Department of Human Resources	0 (on 1)	0	
	Regional and Sub-regional Health Authorities	3 (on 8)	37.5	
	INEM (Department of Medical Emergencies)	1 (on 1)	100	
	Sub-total	18 (on 31)	58.1	
Total		**28 (on 43)**	**65.1**	

* 1 joint interview of medical and nursing directors; ** all interviews were joint interviews of medical and nursing directors

The results are divided into three sections, referring respectively to the opinions of (i) union leaders, (ii) leaders of professional councils and associations and (iii) NHS managers.

Union leaders

We interviewed five Union leaders.

How do the Unions stand on the importance of problem of VAHPITWP?

VAHPITWP was considered as a very important problem by all the interviewees. Verbal aggression was seen as very frequent. The most worrisome type of violence was identified by two of the interviewees as moral pressure, by colleagues and users alike. Physical violence is considered important for doctors and nurses who have to deal directly with patients but not for other health professionals. "Institutional violence" was mentioned by two of the interviewees as resulting from the lack of competence of the managers of health services. Sexual harassment and discrimination was considered infrequent and it is believed that when it happens it is not reported, particularly when the person responsible for the violence is a more senior professional or manager.

One of the reasons why VAHPITWP was considered as important was the growing number of cases being reported, and their increasing severity, particularly of physical violence. This increase in frequency of violence reflects two phenomena of modern society: on the one hand the greater visibility of violence in modern culture and on the other, a growing perception by citizens of their rights, with the corresponding increase in the level of demands. This increased awareness of rights has not been accompanied by a similar increase in civic education

No change has been observed as to the site of occurrence of violence: it is still most common in the hospital emergency departments in ambulatory care services and during home visits.

What are the Unions' policies and procedures to deal with VAHPITWP

Only four of the Union leaders addressed this question. Three Unions document the situation and put pressure in the ministries to improve working conditions, greater security, greater availability of health services for the victims of VAHPITWP. This approach was described as "systematic denouncing". The major limiting factor in taking legal action is the difficulty in obtaining proof that will stand in a court of law.

> *"(...) any action is fraught with complications. The Union does not, as an organisation, have the means to provide (…) support (...) and to face the existing legal constraints, the complicated procedures, the bureaucratic involvement (…) in the end things are left unsolved, and as a result the aggressors stay unpunished" (int. 8: 6).*

The other Union makes a point of listening to the parts involved but seems to have a less active posture.

Regarding the victims of VAHPITWP, four of the Unions provide moral support and make available the legal means available to the Union.

What consequences are there for the health services and victims?

The consequences mentioned are summarised in table 55.

Table 55. The impact of VAHPITWP

VAHPITWP causes problems with non-attendance by professionals, lack of punctuality, work-place aversion and decreased personal and institutional performance, requests for transfers from one service to another or even to another institution. The result is a decrease of productivity and an increase in waiting times.
Repeated violence may result in "burnout", sick leave, early retirement or even in psychosomatic illness.
Violence breeds violence and the victims eventually may themselves adopt aggressive behaviours which further increase the barriers in the relationship between professionals and users.
Violence episodes give a bad public image to the institution.

What the solutions might be.

The range of solutions proposed for the problem of VAHPITWP is summarised in table 56.

Table 56. Measures to reduce the VAHPITWP

SOLUTIONS	COMMENTS
MEASURES MENTIONED *A PRIORI* BY THE INTERVIEWER	
Security measures (security personnel, gate-keepers, alarm systems, portable phones)	Considered important by four of the Unions on its own or as interim measures while the basic problems that lead to violence are addressed.
Improving the physical conditions of the buildings (lighting, noise, temperature, cleanliness, privacy)	Considered important by all of the Unions.
Limiting access by the public	Supported by two of the Unions.
Screening out patients with aggressive behaviours	No Union supported this measure.
Explicit patient protocols (transport, procedures, etc.)	Supported by one of the Unions.
Mix of personnel (ratios of nurses, doctors, administrative and other personnel)	Supported by one of the Unions.
Working hours (excess, shift work, night duty)	Supported by all of the Unions
OTHER	
Improve patient reception by training the health personnel involved in direct patient contact	Measures focusing on the health professionals
Introduce incentives to fix personnel to one workplace	
Improve the efficacy/efficiency of health services	Measures focusing on the services
Improve the quality of the services provided	
Provide civic education to all citizens	Measures focusing on the population
Users must be made accountable	

Leaders of professional councils and associations

How do the professional associations and Professional Councils stand on the problem of VAHPITWP?

All the leaders considered VAHPITWP an important issue.

The President of the Medical Council considered verbal violence as being the most frequent, particularly when doctors work isolated, such as GP in health centres. Nevertheless, the most worrisome form of violence, even if less frequent is physical violence. Moral pressure of patients over doctors, particularly in relation to access to sick

leave certificates, is also quite significant. Doctor-against-doctor violence was acknowledged. There was some recollection of some episodes of xenophobia, particularly against Brazilian colleagues, but no recollection of sexual harassment.

The pattern of violence has evolved. Verbal violence is the type of violence that increased the most. Physical violence increased particularly over the last 13 years. Violence among colleagues is also more frequent now than in the past, mostly because of too much work and overtime. This increase in the level of observed violence must also be seen in the context of a society also more violent now than in the past.

The most violent workplaces are the health centres. The reason is that in the health centres patients feel at home and are very familiar with the health personnel.

For the ***President of the Nursing Council*** there is a need to more in depth understanding of the behaviours that result in aggression. This is important because of the impact of VAHPITWP on the quality of the care provided.

The most frequent and the most worrisome aggressive behaviours are those that lead to verbal aggression. Physical aggression is a minor problem and harassment and discrimination are very infrequent.

Violence, particularly verbal, increased significantly.

Violence is most frequently observed in emergency services, where nurses are most frequently the first-contact professionals.

For the other professional associations different positions emerge. For one of them the objective of the aggressor is to hurt, in a personal context of despair where there is also a lack of competence to react in a more constructive way.

For some, the most worrisome type of violence is the one resulting from institutional harassment ("*perseguição institucional"*) because doctors may interfere with established interests, political and economic. This is particularly true in the case of public health doctors. This type of violence was also acknowledged by one other professional association, particularly in situations of competition for professional leadership positions – the loser is frequently persecuted and repeatedly humiliated by the winner, forcing many professionals to look for alternative workplaces to practice.

Violence among colleagues is also considered very frequent. Verbal aggression, as well as psychological pressure, appear masked as "threats of disciplinary procedures for negligence". Racial discrimination is not acknowledged as being worrisome. Sexual harassment is seen, but infrequent, but "*somewhat worrisome*" as they are usually taken to court. As the proportion of female professionals increase so sexual harassment seem also to increase.

Once again aggression against GP is seen as most worrisome. GP work alone in their consulting rooms. Also, the proportion of women GP is higher than in other medical groups. Violence is particularly frequent against professionals working after normal working hours.

From the perspective of its impact, the most worrisome type of violence is the VAPITWP that recurs daily. Not physical violence that it is infrequent, although with more serious consequences, but rather moral pressure. One of the most frequent consequences of this violence is "burnout".

Although VAHPITWP is seen as a very worrisome phenomenon on the increase, it must be seen in the context of a society ever more violent and less tolerant. While in the past violence was most frequent in the emergency services, now it is more generalised. One

factor that contributes to this increase in VAHPITWP is the perception of health as "*a most important value*". Another factor is the increased professional and academic status of the nursing profession. Users are also different: better informed and more sophisticated than in the past, more aware of their rights, they come to the health services with a more demanding attitude. Among the users some ethnic groups are seen as particularly violent as well as the drug abusers.

What are the institutional policies and procedures to deal with VAHPITWP

Once an episode of VAHPITWP affecting doctors is brought to the attention of the ***Medical Council***, a letter is sent to the victim offering legal support and, if necessary, protection is requested from the proper authorities.

The Nursing Council does not have any standard approach to these situations.

Of the three ***professional associations***, one investigates all cases brought to its attention, but the other two do not have any support procedures available to their members. Regarding the one association with a procedure for these situations, the investigation involves talking to all those involved, identifying the reasons for the violence and factors that could help to prevent similar episodes in the future. A report is written and sent to the proper authorities.

What consequences are there for the health services and victims?

The consequences mentioned are summarised in table 57.

Table 57. The impact of VAHPITWP

Adoption by health professionals of a "defensive practice" pattern, with over-prescription of unnecessary procedures, limiting even further the resources available to meet the health needs of the population. As a result medical practice: • becomes more expensive • slower to respond and • of lower quality.
Tendency to develop rules that inadvertently may result in the exclusion of some groups i.e. indirectly limit the access of some users (e.g. drug users, ethnic minorities): "never directly, as that it is not legal, but there are ways of indirectly excluding (them); some of these are so subtle that no one will notice" (int 24:14).
VAHPITWP causes problems with non-attendance by professionals, lack of punctuality, work-place aversion and decreased personal and institutional performance, requests for transfers from one service to another or even to another institution.
VAHPITWP affects the image of the institution: "*(…) even in sporadic cases, what transpires is not helpful (…) and may completely destroy the public image of that unit (…)*" (int. 6: 26). As a result patients will attend that unit with some fear and professionals will avoid it.
As a result of violence doctors may become permissive in writing sick leaves for their patients in order to avoid pressures.
Repeated violence, felt or witnessed may result in "burnout", sick leave or even in psychosomatic illness.

What the solutions might be.

The range of solutions proposed for the problem of VAHPITWP is summarised in table 58.

Table 58. Solutions for the problem of VAHPITWP

SOLUTIONS	COMMENTS
MEASURES MENTIONED *A PRIORI* BY THE INTERVIEWER	
Security measures (security personnel, gate-keepers, alarm systems, portable phones)	4 interviewees considered these measures important but not enough: "*but only these will not solve anything*".
Improving the physical conditions of the buildings (lighting, noise, temperature, cleanliness, privacy)	3 interviewees considered these measures important.
Limiting access by the public	4 interviewees were very much against these type of measures: 1) because things will get worst; 2) violence will tend to increase; 3) access should increase and not decrease; this will avoid the concentration observed at visiting times.
Screening out patients with aggressive behaviours	1 interviewee agrees. 1 interviewee thinks it is important but together with other measures. 1 interviewee disagrees as it may result even in more violence.
Explicit patient protocols (transport, procedures, etc.)	3 interviewees agree.
Mix of personnel	3 interviewees agree.
Working hours	3 interviewees agree.
OTHER	
Political will to explain that the professionals are not responsible for the deficiencies in the system.	Policy measures
To have the courage to focus on the true problems	
Policy of informing the media and the citizens	
To develop a national plan for the prevention of VAHPITWP	
To identify a reference person to deal with the problem, giving him/her the necessary resources	Measures focusing on the health professionals
To give to all personnel the relational skills necessary to deal with patients	
To rethink the organization of the health institutions	Measures focusing on the services
To improve practice management	
To provide support systems for the agressors	Measures focusing on the citizens
To improve the information available to users	
To improve mutual understanding.	

NHS managers

The NHS managers are divided into three groups: health centre managers, hospital managers and managers of regional and central health departments.

HC managers

We interviewed the Medical Directors of six HC. Only one of these interviews was a joint interview with the nursing director.

How do the HC managers stand on the problem of VAHPITWP?

All the interviewees considered VAHPITWP as a very important problem. Five of the HC considered verbal violence as the most important type of violence. It happens daily. It is most frequent against nurses and administrative personnel "(...) *the most frequent type*

of violence is verbal violence (...) it happens everyday. It may become extremely violent (...) we have been through serious episodes of violence" (int. 1: 1). One of the HC managers considers physical violence as the most serious form of violence observed, followed by moral pressure of the users. But all acknowledge all the forms of violence although giving them different priorities. Regarding sexual harassment it is considered infrequent or absent *"the white coat defends us, it is a dissuasive element (...)" (int.16: 3).* Discrimination is also considered very infrequent.

Some said that VAHPITWP is becoming more frequent while others claim that violence is not becoming more frequent but it has changed in its quality, it is more serious.
These changes are attributed to the lack of information by the users and to poor communication skills of the health personnel. VAHPITWP reflects the fact that we *"live in a violent world, people when coming to the HC bring with them a significant amount of stress, they are in a hurry(,,,) people are subjected to a lot of pressure and a visit to the HC is like a safety valve"*. Violence is inbuilt into the national health service in situations such as short term contracts. This reflects violence as part of the general societal culture. The media are an important factor in perpetuating this type of violence. The rights-movement, unlinked to a duties-movement is also an important explanation of the current trend: people claim more and more rights but do not recognise their duties. This is partially associated with the public servant image that users have of health professionals "*I pay a lot of taxes to ensure your income so you better produce the goods"*. Another pattern emerging, particularly during home visits, it is the blaming of the health care services for all social ills.

What are the HC policies and procedures to deal with VAHPITWP

Following official acknowledgement of the episode of VAHPITWP the HC may follow official procedures common to all or, in one case, follow HC-specific procedures.

The one case of HC-specific procedures is the initiative of the management team of the HC. Staff are invited to register complaints, observations, suggestions, episodes of violence, etc in a green book. This book is then regularly "visited" by the HC director. When facing reports of VAHPITWP he/she makes a point of listening to all the people involved in the episode of violence, and of ensuring the adequate follow-up. Some of the cases registered in this green book have been analysed in table 2.

The standard official procedure involves going through official written complaints to be followed by court proceedings, mostly for cases of physical violence, with copies of the documents being sent to the Sub-regional Health Authority.

When the acknowledgement of the episode of VAHPITWP is not official, the approach varies from HC to HC. Only one HC reported some initiative in trying to investigate and address all these cases. Otherwise, violence is so frequent as to being accepted as "banal" or as "small things" not needing all that much attention.

What consequences are there for the health services?

The consequences mentioned are summarised in table 59.

Table 59. The impact of VAHPITWP

Positive impacts or indifferent
VAHPITWP focus our attention and it may help institutions to identify and improve some of their attitudes.
Negative impacts
VAHPITWP conditions professionals to be overcautious, resulting in professional behaviours that consume too many resources unnecessarily.
VAHPITWP induces an ill-feeling, may have physical and psychological sequelae (e.g. fears and feelings of anguish) and may decrease self-esteem.
VAHPITWP may result in discontinuation of treatment to the patient.
VAHPITWP leads to an increase in the number of professionals on sick leave.
Increase in sick leave results in lower productivity, less staff available for overtime and overwork for the personnel remaining on duty.
The cycle described in the previous line results in lower motivation and professional insatisfaction and lower performance levels with reduced access to health care. As a result, professionals are "*less understanding of accessibility problems (...) and will indulge only in minor efforts to overcome these barriers to adequate health care*".
VAHPITWP leads also to increased staff turnover and absenteeism.
VAHPITWP decreases quality of individual care as well as the quality of the overall institutional care.
VAHPITWP is unpleasant because of the negative repercussions on the image of the institution at community level. *"If he (the user) enters into this type of situation (violence), the image he will get of the services is a very disreputable one. This is a totally negative image, he will never again look at a HC in the way we would like him to consider it (...)"* (int.2: 7).

What the solutions might be?

The range of solutions proposed by the HC managers for the problem of VAHPITWP is summarised in table 60.

Hospital managers

In each of the six hospitals we interviewed jointly the Medical and Nursing Directors.

How do the hospital managers stand on the problem of VAHPITWP?

VAHPITWP is a natural expectation in the hospital setting and should not be seen out of this context. It is a "*professional* hazard". It is also seen as a mechanism to try to obtain the attention that the patient feels entitled to. It must be perceived more as a conflict rather than conscious, deliberate and systematic violence. It is important to understand that not all professionals see aggression as aggression against themselves as professionals, they ignore it because the professional tries to understand the reactions of the patients in the context of his or her situation:

> *"This phenomenon of violence against health professionals (...) was very frequent when Leonor Beleza*[a] *was the minister of health. She encouraged campaigns against doctors and patients felt encouraged (to take positions such as) «it is now that I am going to get at them». Otherwise it occurs sporadically ... People protest very easily. They protest very easily and become aggressive against some professionals for any little thing." (int. 22: 5).*

a Minister of health during the 1980s who initiated a campaign to "moralise" public sector professional practice.

Table 60. The range of solutions proposed by the HC managers for the problem of VAHPITWP

SOLUTIONS	COMMENTS	
MEASURES MENTIONED *A PRIORI* BY THE INTERVIEWER		
Security measures (security personnel, gate-keepers, alarm systems, portable phones)	Three HC considered these important measures One HC considered these measures unnecessary if the prevailing working conditions are good	
Improving the physical conditions of the buildings (lighting, noise, temperature, cleanliness, privacy)	Four HC considered these important measures	
Limiting access by the public	Two HC considered this important only in some services, e.g. emergency services, children, the elderly Two HC disagree with these type of measures	
Screening out patients with aggressive behaviour	Three HC considered this important if there is enough staff with the correct skills	
Explicit patient protocols (transport, procedures, etc.)	Three HC considered this important	
Mix of personnel	All HC considered this as an area needing urgent attention	
Working hours	Greater flexibility of the working hours was considered important by two of the HC	
Other		
Mechanisms should be introduced in order to ensure accountability of the aggressors and of the managers responsible for the conditions that lead to the aggressive episode		Measures focusing on policies
To study the phenomenon of aggression focusing on both the victim and the aggressor		
To initiate the humanisation of the most senior personnel in the Ministry of Health, because as things stand now they themselves practice violence against the health professionals		
The services should be staffed with psychologists to support the professionals		Measures focusing on the services
Skilled attendance of the users of the services		
Investigate to what extent the victim of violence is responsible for the violence episode		Measures focusing on the professionals
Personnel should be equiped with conflict resolutions skills		
Improve working conditions		

For one interviewee, physical violence is the most visible type of VAHPITWP, standing side by side with psychological and verbal violence. For all the others, verbal violence is the most frequent type of VAHPITWP and physical violence is considered infrequent. For one, moral pressure is uncommon, while another acknowledges the moral pressure exerted by relatives over the professionals as "*not uncommon*". This type of violence is reflected in the frequent use of expressions such as: *"you guys work here, but we are paying your salaries, so you must do as we wish (...)", "If I catch you outside (...(" (int.3: 3).* Sexual harassment and racial discrimination are infrequent. Sexual harassment, when it happens, has to do with illness in the elderly or in services directed at teenagers or young adults. Infrequent episodes of complains of racial discrimination is presented by some black doctors against patients. This has usually to do with insatisfaction in relation to the care provided which gets mixed with the racial issue. A new type of aggression has to do with attempts to intimidate the professional with threats of denouncing him through the media.

VAHPITWP is most frequent in the hospital emergency department because that is the place where disturbed individuals (drug addicts, alcoholics, mentally disturbed, people in pain …) are most frequently found. Most cases of physical violence occur here.

VAHPITWP has been on the increase for the past 20 years. This has to do with a change of the dependency of patients in relation to professionals, giving rise to situations of violence against patients; this has changed and patients have more rights now. Verbal and

physical violence are on the increase. Violence begets violence, and in a violent society repercussions must be expected in all sectors, including health:

"Violence is increasing in Portuguese society and health suffers from this influence. The battle for audiences promotes a witch hunt for mistakes and negligence in health, resulting in a climate of untrustworthiness and insecurity in relation to health care. (...) promoting in the public's opinion an expectation of better health care, far above the supply capacity. All this primes people for violence as soon as there is a deviation from the expectations, resulting in aggression and animosity. If there is no capacity for attentive listening, persuasion and negotiation, the result is violence." (int. 4: 4).

In terms of the evolution of violence there is one interviewee that says it is becoming less frequent against doctors but all the others acknowledge it as a problem either on the increase or stable (one interviewee) but of similar frequency for all professional groups (more frequent against nurses according to one of the interviewees). This is particularly true for verbal violence. There are also changes in the pattern of verbal violence: while in the past it was more verbal lashing, now it is more verbal threats. Some of the respondents are not sure that physical violence is more frequent but they perceive the physical violence episode as being of "*a different intensity*".

What are the hospital policies and procedures to deal with VAHPITWP

Two hospitals do not have any procedures, two hospitals distinguish between procedures for official or unofficial acknowledgement of episodes of violence (box 1), two hospitals describe registers to record these episodes (box 2) and one hospital did not give us any information regarding this question.

Box 1. Different procedures for violence acknowledged officially or unofficially

Hospital 1: when VAHPITWP is reported officially there are two possibilities: 1) a written report to the board of management that decides on what to do; 2) a written report is prepared internally but the thrust of the initiative is judicial. When the episode is not reported officially, but gets to be known, there is follow up at the level of the service unit to try to solve the problem.

Hospital 2: when VAHPITWP is reported officially there are two possibilities: 1) following the written participation there is a formal internal inquiry to understand what happened and to solve the problem; 2) if the process is communicated outside the institution, the most common outcome is a court proceeding, but there are also inquiries conducted by other institutions, namely the Medical Council in cases where doctors are involved; or the General Health Inspectorate of the Ministry of Health. When the episode is not reported officially, but gets to be known, the Service Director is asked to investigate and report on what happened.

Box 2 Systems to register episodes of violence

Registers are used only for cases where the consequences of the user-associated-violence are considered serious, when there is premeditation or the aggression is not associated with an illness situation. If the consequences are serious and the violence is associated with an illness situation, then the violence episode is dealt with as a professional accident. When the violence episode involves relatives of patients, the episode is communicated immediately to the immediate supervisor to deal with the issue.

Besides the above procedures, four of the hospitals acknowledged mechanisms to support the victims of violence. These include supporting any, medical or otherwise, treatment that is necessary and transferring people from one service to another if requested or appropriate.

What consequences are there for the health services?

The consequences mentioned are summarised in table 61.

Table 61. The impact of VAHPITWP

Positive impacts or indifferent
Not everything is negative about VAHPITWP. It may help institutions to identify and improve some of their attitudes.
VAHPITWP itself does not have any repercussions on the health system, but civilized complaints may have a positive impact on the services, as they demand investigations and corrective measures.
Each professional has his or her own coping mechanisms and "*there is a technical profile for each professional, that gives him or her some stability, ensuring that (...) the aggression by patients or their relatives will have little or no impact on this professional attitude.*" (int.22: 11).
Negative impacts
VAHPITWP conditions professionals to be overcautious, resulting in professional behaviours that consume too many resources unnecessarily.
Continuous violence induces unavailability, an ill-feeling, may have physical and psychological sequelae (e.g. fears and feelings of anguish) and may decrease self-esteem.
VAHPITWP may result in discontinuation of treatment to the patient.
VAHPITWP leads to an increase in the number of professionals on sick leave.
Increase in sick leave results in lower productivity, less staff available for overtime and overwork for the personnel remaining on duty.
The cycle described in the previous line results in lower quality of care and professional insatisfaction.
VAHPITWP increase expenses with security.
It is unpleasant because of the negative repercussions on the image of the institution at community level.

What the solutions might be?

The range of solutions proposed by the hospital managers for the problem of VAHPITWP is summarised in table 64. Regarding the measures proposed *a* priori by the interviewers it is worth highlighting the concern with the need to improve the physical environmental conditions in the hospital (lighting, noise, temperature, cleanliness and privacy), as well as the need to reduce the excessive working hours of staff. The table presents some results separately for psychiatric hospitals. This is justified by the very specific nature of the measures proposed by the managers of these institutions.

The managers of the regional health authorities and of central departments of the ministry of health

We interviewed 6 public sector health managers at central and regional level.

How do central and regional level managers stand on the problem of VAHPITWP?

All the interviewees considered VAHPITWP as an important problem. As to the most important form of VAHPITWP, the opinions varied from four that considered psychological violence, including verbal violence (one) and moral pressure (one) as the most important. One of the interviewees considers that physical violence is not very relevant and another one considers it worrisome, reflecting a lack of mechanisms to ensure the security of the health professionals, particularly in situations when health professionals meet their clients behind closed doors. Physical violence is also considered very important for emergency care crews called to provide emergency non-institutional care. Verbal aggression is also identified as frequent against health professionals manning emergency telephone lines and against administrative health personnel. Sexual harassment is considered infrequent, not visible or unknown. Physical violence is considered, if not the most important, the most worrisome, the most visible and the one that most frequently leads to court cases.

Table 62. The range of solutions proposed for the problem of VAHPITWP

SOLUTIONS	COMMENTS	
MEASURES MENTIONED *A PRIORI* BY THE INTERVIEWER		
Security measures (security personnel, gate-keepers, alarm systems, portable phones)	1 hospital does not consider this an important measure. 2 hospitals consider it an important measure.	
Improving the physical conditions of the buildings (lighting, noise, temperature, cleanliness, privacy)	4 hospitals consider it an important measure. An improved environment "*it is pacifying*". "*When the hospital is clean, well looked after, anyone dumping a cigarette butt, or anything, on the floor will be embarrassed. Or even spitting on the floor! If everything is dirty he or she will do it. A good environment is dissuasive of violence as (…) it does not fit with the humanising environment (…)*" (int.22:16).	
Limiting access by the public	1 hospital considers this an important measure because sometimes there is a need for barriers to allow for better performance. 2 do not consider this an important measure, unless unavoidable because of space restrictions.	
Explicit patient protocols (transport, procedures, etc.)	1 hospital considers this an important measure.	
Mix of personnel	3 hospitals consider it an important measure.	
Working hours	2 hospitals consider it an important measure, namely the need to reduce the workload on the staff.	
OTHER		
Emergency services: • to formalise the status of companion, a relative that may go with the patient anywhere; • to improve the referral within the emergency department to expedite patient flow; • to humanise these services; • to have more social workers on duty.		Measures focusing on the services
To establish a formal information service for patients and relatives.		
To improve accessibility.		
To reduce the "social cases" within the hospital, by improving the first line health and welfare services.		
To train the health professionals in relational, communication and conflict resolution skills, in self-knowledge and ethics.		Measures focusing on the professionals
To heighten awareness of all personnel that violence is a real possibility.		
To improve remuneration to levels that reduce the need for second and third employments, which engenders tiredness, reduced patience and overreaction of the professionals.		
To establish a formal information service for patients and relatives.		Measures focusing on the citizens
To educate citizens to respect the referral line to access hospitals.		
Hospital services must meet needs and expectations of citizens.		
To evaluate patient satisfaction regularly.		
Psychiatric hospitals		
There is a need for staff capable of containing violent patients, particularly in an emergency department.		
Professionals have to be prepared to understand and to deal with violence assuming a neutral position.		
The team has to assume a very important guidance and support role for members to be able to cope with violence.		
Patient access has to be restricted to some areas.		
Psychiatry professionals should be entitled to risk pay.		

One of the interviewees considered that racial discrimination is most frequent against the users of the health services but not so much towards the professionals. Another one

states that racial discrimination against health professionals happens and that it may amplify other forms of violence.

Regarding the observed trends in the evolution of VAHPITWP, most interviewees consider that VAHPITWP in general is on the increase. The current level of VAHPITWP is partly attributed to the eternal disorganisation of the health services and to the lack of management skills.

> *"Some people have too much power (...) they misunderstand their role (...) and these leads to the creation of barriers to the personnel working under them. This is particulalry visible (...) in hospitals" (int. 11:5).*

One other interviewee considers that current violence trends reflect the level of violence in society. A third attributes it to a greater media visibility, and because people more frequently now than in the past dare to challenge professional opinions. One considers that we may not be seeing an increase in the incidence of violence but rather a greater visibility because of the role of the media or even, according to another, due to intensity of the violence observed today. A new form of violence, violence against property, is associated with the emergence of drug addicts.

Violence is considered most frequent in health centre consultation rooms and reception desks and in hospital emergency care departments. In hospitals violence by patients escorts is more frequent that in HC.

What are the policies and procedures to deal with VAHPITWP

The impression that emerges is that there are no clearly thought through policies and procedures regarding VAHPITWP, and the initiative to deal with the problem is left with operational managers. The feeling is that, whenever relevant, the victims should be encouraged to take their complaints to the courts of the country.

Equally, there are no specific recommendations regarding support to the victims of VAHPITWP. Emergency crews are encouraged to report any episodes of VAHPITWP in the report that has to be written at the end of each shift. What is done regarding episodes of violence is not formally spelt out.

What consequences are there for the health services?

The consequences mentioned are summarised in table 63.

Table 63. The impact of VAHPITWP

Positive impacts or indifferent
VAHPITWP may have a positive impact on the services, as they demand investigations and corrective measures.
Negative impacts
VAHPITWP induces lack of motivation, leads to more absenteeism, may have psychological sequelae (e.g. feelings of anguish, fear) and may decrease professional and institutional performance as well as professional satisfaction.
VAHPITWP leads to professionals changing from profession.
VAHPITWP results in defensive patterns of professional practice.
It is unpleasant because of the negative repercussions on the image of the health care system.

What the solutions might be?

The range of solutions proposed by central and regional level managers for the problem of VAHPITWP is summarised in table 64.

Table 64. The range of solutions proposed for the problem of VAHPITWP

SOLUTIONS	**COMMENTS**	
MEASURES MENTIONED *A PRIORI* BY THE INTERVIEWER		
Security measures (security personnel, gate-keepers, alarm systems, portable phones)	Two interviewees consider these measures important. Three as not important and may actually give a false sense of security by hiding the problem.	
Improving the physical conditions of the buildings (lighting, noise, temperature, cleanliness, privacy)	Three interviewees consider these measures important. Two as not important.	
Limiting access by the public	One interviewee considers these measures important.	
Explicit patient protocols (transport, procedures, etc.)	Four interviewees consider these measures important.	
Mix of personnel	Two interviewees consider these measures important.	
Working hours	Three interviewees consider the reduction of the working hours as an important preventive measure.	
Other		
Improve the organisational culture. This improvement should include structural and legal components.		Policy measures
Greater focus on management tools to ensure adequate management of people.		
Training health personnel: 1) in order to be able to deal with conflict situations; 2) to improve reception at the front desk.		Measures focusing on the professionals
Clear job descriptions and explicit hierarchies.		
Introduce mechanisms for the reporting of violence.		
Give the frontline reception to the younger professionals.		
Improve working conditions.		Measures focusing on the services
Improve human resources management.		
Reorganise the services keeping the user and the professional in mind.		
Ensure that internal service communications are coherent.		
Create mechanisms to ensure accountability.		
Prepare parents to deal with the illness situation of their children.		Measures focusing on the population
Treat people as people.		

CONCLUSIONS

On the methods

The methodology chosen for the present study has provided a large amount of very useful information about workplace violence in the Portuguese health sector, which is likely to be valuable to the further progression of the present project and of great importance for further development of the issue in Portugal. The fact that the information, by and large, comes from people in positions of power at different levels of the health sector (including union leaders) is also likely to increase commitment at a senior management level for the implementation of future strategies with regard to violence prevention.

However, the stakeholder focus on people in managerial or representative positions, the voice of the health sector employees has not fully been heard. For this reason, we cannot be fully reassured that the report correctly reflects definitional issues, problem description and that possible solutions are fully covered.

The study also neglects the non-governmental sector, a minor partner in health care provision, but growing.

The study describes a phenomenon, but does not contribute to clarify why the phenomenon happened when it happened, although the stakeholders's study tries to shed some light on this.

Lastly, the most rare types of violence, such as physical violence and sexual harassment, need a different approach even to achieve a better characterisation.

Despite these limitations, this remains the only formal Portuguese study on VAHPITWP.

On the patterns of violence

Measured violence

Violence seems much more frequent in the HC than in the hospital.

In order of most frequent reporting, verbal violence is the most frequent, followed by moral pressure, discrimination, physical violence and sexual harassment. The HC data on violence against personal property suggest that it is very prevalent but, we have no data on this for the hospital study.

It appears that in the ambulatory setting, mental health workers and those doing community based work are more prone than others to any of the types of violence studied.

All types of violence, in the HC are also most frequently directed against female health workers and int the Hospital against male workers.

Verbal violence is most frequent against HC nurses and administrative personnel.

Physical violence seems most frequent against nurses in both the HC and the hospital.

Sexual harassment seems a particularly frequent problem of hospital nurses.

Moral pressure is most frequent against HC GP and administrative personnell.

Discrimination seems a phenomenon felt mostly in the hospital by nurses, other professionals with a university degreeand the other category.

An important aspect is that, in both health facilties where the study was conducted, the whole range of the different types of violence were identified. This suggests that **all** HC and hospitals need guidelines on how to handle the whole range of them.

It becomes also clear that some sorts of violence seem to go together. This suggests the possibility of a "at risk worker" on the one end and/or of a sequence of phenomena that may result in the most severe forms of violence. Clarifying this issue is important to allow for the definition of the adequate interventions.

Reported violence

On the type of violence that health workers feel necessary to report upon, we have three sources of data: the hospital, the HC and the institutional documents studies.
Twenty two official reports on violence from five health centres and two hospitals were analysed. Most reported violence was verbal, reflecting the results of the hospital and the HC study. But, in HC, administrative personnel and nurses seem to underreport when compared to doctors.

It seems that some forms of violence such as discrimination, moral pressure and sexual harassment will not be properly addressed by the current system of written report books which are open to all colleagues.

This under-reporting, is also reflected in the results of the hospital and HC studies, as less than 15% of the episodes of violence are reported in writing, although a more sizable proportion is reported verbally to the supervisor.

Violence acted upon by management

Even after being reported upon not all violence is acted upon by management. Managers seem more likely to react to reports of verbal violence than on reports of moral pressure. And when acted upon the action taken is not felt as adequate and satisfactory by the victims.

Violence as seen by the media

The media reports on violence do not reflect the true dimensions of the problem. The media reflects violence as being physical and against hospital doctors when in reality it is a much more serious problem, with dimensions other than the physical dimension, in HC and against nurses and administrative staff. This points to the need to clearly brief the media professionals on the results of this study.

Violence as seen by different stakeholders

All stakeholders considered VAHPITWP as an important problem. They clearly identified verbal violence as the most frequent and physical as the most serious and worrisome, reflecting a reliable empathy with the reality as measure by the hospital and HC studies and serving as a measure of external validity of their results.

On a framework to approach violence in the workplace

From the stakeholders study, it became also apparent that, although knowing about the problem, little has been done about it. This is a classical situation in a normative institutional public sector culture like the Portuguese culture where, what is not addressed in official policies, strategies or norms is only infrequently addressed by public sector administrators (Conceição et al 2001). Why little action has been taken by the non-public sector stakeholders (professional associations and unions) is less clear.

What emerges from all the different studies here presented is that the problem of VAHPITWP is a widespread and very prevalent problem. It should not be approached as

a simple security problem, but as a multifactorial subject with cultural, political, social, economic, managerial and individual determinants.

VAHPITWP has to be assumed explicitly, by all stakeholders, as an important issue. An issue where rights and duties must be clearly apportioned, while respecting the right to indignation and to protest, and ensuring a ZERO TOLERANCE for any type of violence.

On the basis of the above results we propose the following framework to approach the phenomenon of VAHPITWP (figure 1). This allows us to focus on what must be done immediately for immediate impact, without forgetting other issues that have to be addressed, may be even on the short term, but where the impact will be felt only in some years time.

The approach considers several levels of intervention.

At a more preventive level, we identify what we call the macro level interventions. These focus on the general conditions of our society (cultural aspects, civism, schooling, level of information, behaviour of the mass media, etc) and on the legal framework, and general policies and strategies for the issue of violence in general. The impact horizon for interventions at this level is probably of 10 years and more.

At a meso-level the focus should be on the normative side: guidelines on VAHPITWP available for managers, health workers, patients, occupational health doctors, union representatives, etc. But also on the more general issues related to management competencies and general working conditions and conditions of access to health care. The impact horizon for interventions at this level is probably of 3-10 years.

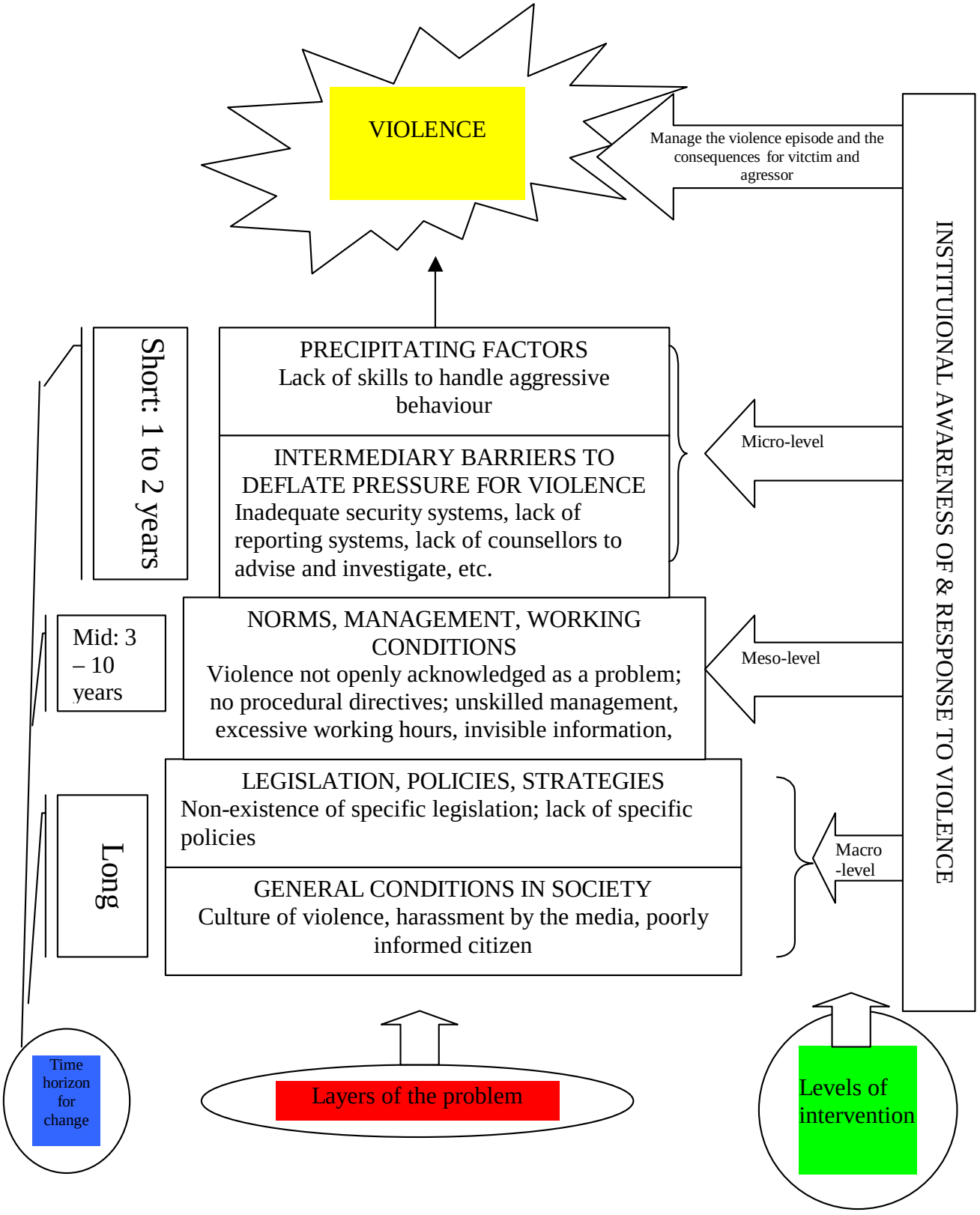
At a more micro level the purpose is to try to change what can be changed on a short term basis, 1-2 years. Interventions at this level would focus on issues such as security systems, reporting mechanisms, communication training, training in conflict management, existence of counsellors/mediators, etc.

When all the above levels of prevention fail, and violence takes place, then there must be in place the mechanisms to deal with the violence episode and its consequences: security alert systems, self-defense, and systems to support the victims, to investigate the violence and to deal with the aggressor.

On the ongoing follow up of this study

The Portuguese Steering Committee embarked on this study committed to act on the results of this study. This has been done, and continues to be done, according to criteria of right to know (this applies particularly to all those who gave some of their time to answer our questions, but also the public in general), relevance, capacity to intervene and taking into account opportunities as they arise. In this context we briefly report on some of the feed-back and follow up already achieved.

Figure 1. A framework to approach the phenomenon of violence against health workers in the their workplace.



Report back to the Department of Health

The Department of Health is the National Health Authority with the capacity to issue national guidelines on this subject. As such we presented our results to them in February 2002: The meeting counted with the presence of the Director General, one of the Deputy Director Generals, the Director of Health Care Services and other officials (a total of 20 participants, excluding the members of the Steering Committee). The presentation was well received. Two suggestions came out of the meeting: the Department of Health will sponsor a national workshop on this topic during the current year; the Department of Health will issue guidelines on how to address this subject in the NHS facilities. Further action will depend on the outcome of the national workshop.

Another result of this input is that, in his annual report of March 2002 (Portugal 2002), the Director General of the Department of Health clearly identifies VAHPITWP as a significant problem that will receive his attention during the current year.

In May the Director General nominated a group to act upon the findings of our study with recomendations on what official action should be taken by the Department of Health to address this problem. This working group includes two members of the steering committee, André Biscaia and Isabel Craveiro.

Report back to the collaborating institutions, stakeholders, national funders and to the international Steering Committee

The feedback sessions started in April and should be completed by June 2002.

Report back to specific professional groups in Portugal

The results of the study were presented at the 19th Family Doctors National Meeting (13th to 16th March 2002) that joined 1600 doctors. Two presentations were made:

- one in a plenary session about the Family Doctor's Working Context with the presence of the President of Medical Council and the General Health Inspector of the Ministry of Health. The attendance of this session included 1400 doctors. The study was very well received and generated a lot of expectations about the consequences of the study;
- and another in a seminar with an attendance of 120 doctors. This seminar was run like a large focus-group, with a structured input and discussion, prepared jointly by the researchers of the Portuguese Steering Committee and a facilitator. We validated a lot of our conclusions and got the perception that VAHPITWP is really a very prevalent problem. The seminar was taped and we looking for funds to conduct a formal content analysis.

Reporting back to other professional groups will be through presentations to professional associations, conferences, papers to local professional journals and personal contact with key stakeholders.

Media reactions to the Portuguese study

There were a lot of mass media professionals at the 19th Family Doctors National Meeting and all were very interested on this subject. Our presentation made headlines in five national newspapers – "Correio da Manhã", "Diário de Notícias", "Público", "A Capital" and "Jornal de Notícias" and one regional one "Comércio do Porto". In three of them we had a title in the front page, and these inserted a full page article with the results of the study. We had, also, a reference in two national TV channels (SIC and RTP) and in a National Radio Station (TSF).

This highlights the importance of a careful preparation of a press conference in future presentations.

It also attracted the attention of all three portugueese medical newspapers.

What further research is needed?

Further research on the topic will be unlikely because of the lack of interest of national funders. If funds become available this will be approached from six perspectives.

Complete analysis of the current information obtained during the stakeholder study

In the short time available to carry out this study it has not been possible to complete the formal content analysis of the all the material transcribed from the stakeholder interviews. This remains our priority.

Formal content analysis of the discussion with General Practitioners at their national Conference

The seminar with an attendance of 120 general practitioners, mentioned above, was taped. As mentioned, this seminar was run like a large focus-group, with a structured input and discussion. We are looking for funds to conduct a formal content analysis. We are considering the possibility of conducting similar seminars with other health professionals.

Improve in-depth understanding of the processes associated with violence

In depth understanding of the phenomenon of violence will require a different approach. We propose to focus on victims and agressors and try to understand the violence episode. This could be done though focus groups, as already done by other countries collaborating in the international study.

Improve NHS representativeness of the data base on VAHPITWP

A formal study, using epidemiological sampling methods to achieve a nationally representative sample of health professionals is not considered viable. The alternative being considered is the development of a simplified standardized questionnaire for hospitals and another one for HC, to characterize the problem. This could be then offered to the Department of Health, to issue it as the normative tool to measure the problem in the NHS. This could then be applied, by interested occupational health professionals in the different institutions of the NHS, inviting them to share the results into a national database.

Expand into the non-governmental sector

The private for profit sector is growing in Portugal. The Church sector is a significant provider of health care. Health care provider cooperatives are emerging. These sectors, particularly the well established ones, should be approached, not only to characterize their patterns of violence, but also to learn what is done about it.

Conduct intervention studies to identify cost-effective interventions

This is a clear need, but not addressed in the discussions of the Portuguese Steering Committee up to now.

Bibliography

Conceição C, Gonçalves A, Craveiro I, Blaise P, Van Lerberghe W, Ferrinho P. Managing the performance of family physicians in the Portuguese National Health System. Human Resources for Health Development Journal 2000; 4 (3): 184-193.

Craveiro I, Ferrinho P. Planear estratégicamente: a prática no SNS. Revista Portuguesa de Saúde Pública 2001; 2: 27-37.

Ferrinho P, Pereira Miguel J (editors). The Health Status in The EU. Narrowing the Health Gap. Unpublished Report to the European Commission. Lisbon, 2001.

Portugal. Ministério da Saúde. Saúde um compromisso – uma estratégia de saúde para o virar do século 1998-2002. Lisboa, 1999.

Portugal. Direcção Geral da Saúde. Ganhos de Saúde em Portugal. Ponto de situação. Lisboa, 2002.

Sindicato dos Enfermeiros Portugueses (2000). Risco, Penosidade e Insalubridade - uma realidade na profissão de enfermagem. Lisboa: Sindicato dos Enfermeiros Portugueses, p 74.