Coping Response to Workplace Violence Among Healthcare Workers in the Emergency Department: A Qualitative Study

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Abstract

Background Workplace violence faced in the Emergency Department is well documented. However, there is minimal local data found in the literature. An exploration regarding workplace violence in a local setting is undertaken. This study examined the coping response to the occurrence of workplace violence encountered by an Emergency and Trauma Department healthcare workers.

Method The study was done in one of the Emergency and Trauma Department of a tertiary government hospital in Malaysia. A period of a month was taken for data collection. Inclusion criteria includes healthcare workers who had exposure to work- place violence and agreeable to participate in the study. Incident reports were examined and semi-structured in-depth interview of various level of healthcare staff were conducted.

Results Three final themes were identified in the way healthcare workers response to workplace violence; First, coping in pre-crisis phase to prevent a violent incident from occurring -mental and behavioural preparedness; Two, coping during crisis to prevent escalation of violence- self-restraint, constructive confrontation, seeking instrumental support; Three, coping after crisis to adapt emotionally and improve knowledge in managing workplace violence-seeking emotional support, disengagement, adaptation.

Conclusions The method of coping response employed by participants corresponded to the level of violence exhibited by perpetrator**.** Multicentre study will help to broaden the understanding of WPV in Malaysia

Introduction

Workplace violence (WPV)is a serious occupational hazard, particularly in healthcare settings (1). Since the emergency department is the main point of entry to the hospital, their healthcare workers are often exposed to violence. Several reports have been published to explain the incidence of WPV in the emergency department (2, 3).

Studies in several hospitals in Malaysia have demonstrated that violence in the workplace is common in this region. A study conducted in 2 government hospitals showed that more than 90% of respondents had experienced violence at the workplace, and 78% of them suffered from post-violence (4). Another research done in a public hospital based in Kuala Lumpur found that nurses have the highest incidence of WPV (71.3%), followed by doctors (69.2 %)(5).

WPV has been shown to cause physical, psychological and emotional consequence (6). Subjecting workers to violence in the workplace can lead to a hostile working atmosphere, a poor working attitude, a loss in productivity and a decrease in work performance. The negative effect on the institution includes a lack of competence, a lack of employee morale, a decline in patient care quality and a bad image to the employer (7).

Despite being a rampant phenomenon, the knowledge on how to deal with WPV is still limited. Several studies on WPV coping strategies have been published (8, 9). Problem focus coping and emotion focus coping are among coping methods used by healthcare workers(8, 9). As these few empirical studies were conducted only in certain countries, this field remains largely unexplored in other parts of the world, including in Malaysia. Furthermore, the way people cope varies between countries and communities. To the best of our knowledge,

there is no study in Malaysia on coping with WPV strategies. To fill this knowledge gap, we aimed to study the coping strategies of health care workers in an emergency and trauma department (ETD) in Malaysia.

Methods

Study Design

To better capture the thick description of how healthcare workers made sense of the phenomenon of WPV in ETD, this study was conducted qualitatively. Specifically, thematic content analysis using in-depth interview was employed to explore the coping responses to WPV between different levels of emergency department staff.

Setting

This study was conducted in ETD of one of the tertiary government hospital located at Southern Peninsular of Malaysia. The ETD provided 24-hours service with full resuscitation facilities.

Sampling and data collection

A small-scale pilot study was conducted to have a general idea of the study and to refine the interview questions. Participants are healthcare workers from ETD a tertiary government hospital located at southern peninsula of Malaysia. The researcher used snowballing technique to recruit participants. An initial selection was made through screening of incident reports of healthcare workers who had been exposed to WPV. The participants then recommended the next potential participants. This technique was preferred to ensure both reported, and unreported cases were captured.

Interviewing process

Potential participants were briefed on the purpose and procedure of the research. Informed consent was obtained before the interview. Participants were interviewed using a semi-structured questionnaire consisting of (1) demographic data, (2) the experience of the respondent on WPV and (3) their coping strategy. The researcher did not select a group discussion because the participants might not be comfortable addressing those topics in public. During the interview, digital voice recorder was used to capture the exact words of the participants to maintain originality and was performed between 30 and 60 minutes. The researcher took field notes on the participant's reaction to provide a more thorough description of their responses. The interviews were loaded and stored onto the computer using MP3 format. The transcription was performed by the researcher [Noor Hafizah Binti Abdul Salim]. Throughout the transcription process, the participants were de-identified to maintain privacy and confidentiality at all times. Translation of the transcript into English was performed by the researcher [Noor Hafizah Binti Abdul Salim].

Data analysis

The written notes from the interview were in a mixture of Malay and English language, as was the exact transcript of the interviews of the interviewees.

The field notes and the participating demographic data forms were included for analysis. The transcribed data were read and annotated to make a preliminary observation. Subsequently, the available data were initially assigned to specific coding. The coding was conducted by two researchers independently using thematic content analysis. Initial open coding was first performed through iterative readings of the transcripts and identification of themes through labelling of keywords, phrases and quotations from these transcripts. Following the initial open coding, a second axial coding was performed by re-analyzing and categorizing these open codes into broader themes. Discrepancies between the coding by the two coders were resolved through discussion to reach consensus. The software ATLAS.ti 8 was used to analyze and produce thematic analysis. The results of this study were identified as themes.

Results

Demographic Study

Interviews were conducted between February 2014 and March 2014. Thematic saturation was reached with 13 participants. The participants include medical officers (n = 4; 31%), nurses (n = 4, 31%), assistant medical officers (n = 4; 31%) and hospital attendant (n = 1; 7%). Participants had a varying length of experience in working at ETD, ranging from less than a year to 13 years. However, all participants had experience working under government health service for at least two years.

Table 1
Demographic study

Participants	Age	Position	Years of service in ED	Years of Service in Ministry of Health
P1	38	Nurse	7	15
P2	28	Nurse	5	5
P3	36	AMO	6	11
P4	33	MO	4	9
P5	29	MO	2	4.5
P6	24	Nurse	less than 1 year	2
P7	28	Nurse	5	5
P8	38	AMO	13	13
P9	33	MO	4	8
P10	40	MO	6	9
P11	28	AMO	5	5
P12	34	PPK	2	3
P13	34	AMO	8	8

Thematic Analysis Matrix (TAM) (10)

This section will explain about thematic analysis process. Thematic analysis is a systematic method used to analyze data in qualitative research. The steps involved are 1) familiarising with data, 2)generating preliminary codes, 3) search for themes, 4) review themes, 5) define themes, and 6) write-up(11) The thematic analysis matrix for this study is presented in Table 2.

Table 2
Thematic Analysis Matrix

Codings	Categories	Final Themes	Inductive codes
Vigilant of verbal and non-verbal cues	Mental, emotional and behavioural preparedness	**Coping during pre-crisis** -aggressor showed potential violence behaviour -Response aimed at preventing a violent incidence	Coping response change to match the level of aggression displayed by the perpetrator. Coping strategy to violence starts even before the incident of violence occur Self-restraint is frequently use as a coping response Coping with workplace violence does not stop after a crisis ended
Adopt appropriate verbal and behavioural response			
Reducing mismatch between expectation and realities -explain what to be expected -announcement to explain the situation -aware of the limitation			
Mental planning for possible violence event			
Disengagement for fear of losing control	Self-Restraint	**Coping during crisis** -Aggressor had become hostile and displayed verbal or physical violence. -Participant coped by controlling the situation from escalating further	
Self-restraint and not responding to a hostile attitude			
Present calm and professional attitude			
Allow perpetrator to vent and find the root cause - get the perpetrator to explain the source of their frustration -let patient ventilate, ask the patient the reason for their action -let perpetrator cool off by leaving them alone temporarily, then come to clarify	Constructive confrontation		
Clarify situation by explaining, educating or apologizing			

Codings	Categories	Final Themes	Inductive codes
Showing empathy and rapport -make the patient feel they are being prioritized -offer help to solve the problem, facilitate -put the patient in different environment/zone -show empathy and build rapport			
Draw the line -Standing against the perpetrator -Let perpetrator now that they have proof of their violence act			
Disengaged to seek help and for safety reason	Seeking instrumental support		
Get help for an extra hand in handling aggressive visitor or patients			
Get help from superior to become the mediator			
Find a place to cry or calm down	Seeking emotional support	**Coping during post-crisis** -after a violent incident had occurred -response aimed at addressing the emotional impact of violence and learning from their experience to improve in the way they are managing violence	
Deviate attention by engaging in small talk with friends or making jokes			
Venting problem to others			
Temporarily avoid the place where violence just occur	Disengagement		
Reduce unnecessary contact with patients and relative			
Avoid from getting involved in violence incident			

Codings	Categories	Final Themes	Inductive codes
Taking a short time away from work			
Get advice from a more experienced colleague and engage in post violence discussion	Adaptation		
Conduct debriefing session with subordinate			
Looking at the situation from another perspective			

Twenty-four initial codings were derived from participants' quotations, and seven categories were identified from the initial codings. Subsequently, three themes emerged from the data. The themes and categories are

1. **Coping during pre-crisis**: mental and behavioural preparedness.
2. **Coping during a crisis**: self-restraint, constructive confrontation, seeking instrumental support.
3. **Coping during post-crisis**: seeking emotional support, avoidance and positive reinterpretation

Participants cope with workplace violence through three phases. In the pre-crisis phase, the aggressor showed potential violent behaviour, and participants' responses during this phase were aimed at preventing a violent incidence. During the crisis phase, the aggressor had become hostile and displayed verbal or physical violence. Participants coped by controlling the situation from escalating further. In the post-crisis phase, participant responses were aimed at addressing the emotional impact of violence and learning from their experience to improve in the way they were managing violence.

PRE-CRISIS

Mental and behavioural preparedness for a possible violent event

Most participants are conscious that, despite their prior experience, violence may occur at any time. One aspect of being prepared is to consider both verbal and non-verbal hints. They learn from patients or relatives by body language, facial expression and the tone of voice use. Healthcare Assistant 1 reported *"When I saw the face of the patient's family planting anger, I will get prepared. In normal circumstances, I will just keep quiet. I will communicate inappropriate tone, as to how I should communicate with them." Ok, I am going to send this patient to the ward, would you like to follow me?" Sometimes when they are in anger, even our tone of voice can initiate a fight."*

A participant says that they would be careful of the vocabulary and tone of voice they use. Some will limit communication between them while showing sympathy and building a relationship is among the behaviour of some of the participants. *"I learnt from non-verbal cues such as body language of the patients, relatives and the staffs. For example, when dealing with relatives who brought ill-children, sometimes it helps for doctors to show empathy and build rapport, as this could prevent or reduce potentials offensive behaviour from them."*

Some participants are taking prudent behaviour. During all times, they are aware of their acts and words, fearing that they could trigger an incident of violence. A mismatch between the client's expectations and the care offered is one of the triggers of an aggressive event. The staff say that they need to be discreet in describing the patient's need to bridge the gap between expectation and fact. This is so that they can reach a consensus about the most effective care for patients. *"When they anticipate differently, or they think that they are very well-read, and they expect something to be done, but you do not do it, that is when they will create a problem. Another part of it is actually how do we handle them. Sometimes you must be very nice, and sometimes you must be very discreet. They have their expectations before they come to the hospital."* (Medical Officer 2)

DURING CRISIS

Self-restraint

Participants restricted themselves from being impulsive or responding in an equally hostile manner. Some will not respond to the violent remark and remain silent while others disengaged themselves from the scene of the incident for fear of losing control. Assistant Medical Officer 4 reported *"There were those who kept on scolding. But I did not respond and just listen to him. There is nothing I can do since he is already angry. I kept on listening and did not retaliate back. After a while, he will stop on his own".*

Participants reported that they continue to act courteously and professionally despite being subjected to violence. *"If they give racist or indecent remark, I'll just smile. I can only do that much. So fa,r when I do that, it worked. Those who are angry might become calmer, and it helps to prevent from initiating a fight. At least we will be able to avoid a bigger fight, causing property damage, or physical violence. Try to avoid it. So far, this method is effective".* (Assistant Medical Officer 1)

Understanding the state of mind of the aggressor helps some participants to moderate their emotional reactions and prevent them from acting irrationally. A participant indicated that there was an incident in which he did not react at all to the aggressor despite being exposed to physical aggression because he recognized that the aggressor was not in a good state of mind and could make the situation worse by reciprocating the behaviour. *"Suddenly, the patient came, kicking the door. It was a glass door, and it broke. He came in. He asked, "Who has the highest authority here?". Incidentally, I was in charge of Red Zone at that time, so the others pointed at me. He grabbed me, push me against the wall and he asked, "are you the police? Are you the police?" He was drunk, and he was half-conscious, so I just stayed silent."*

(Medical Officer 4)

Constructive confrontation with the perpetrator to resolve the conflict

Confrontation includes elements in which the participant will find the root of the cause by allowing the offender to ventilate, explore the depth of their understanding and explain the reason for their frustration.

Suppose they can identify the root of the issue. In that case, the participant will clarify the situation by informing the patient on the essence of the disease and its course of care, explaining the general operation and protocol of the emergency department, or clearing up a misunderstanding of the situation. *"For example, if they are shouting at me, assess their understanding. What is it that you understand? What is it that you want from*

me? What is it that you are not happy with? So, I'll tackle one by one. Usually, it works. Because most of the time, people are just anxious, they easily misinterpret your words and your tones as being ignorance, arrogance. That makes them think that we don't empath them and we don't understand what is going on with them".

Nurse 3 explained the process of apologizing. Initially, the victim should be disengaged to allow the aggressor time to cool down, followed by an explanation of the situation and apologies regardless of who is wrong. *"Reply politely to them. During the confrontation, let them be. After some time, return to them and apologize. Just tell them you are sorry, it's not wrong to do that. I have done this before. Return apologize to them for whatever you have done and explain to them the reason for it, for example, if you were tired".*

However, when the above strategies are not successful, or victim feels that the aggression has become overboard, some participants take a stand to draw the line, warn the perpetrator that they have collected evidence of their actions and will submit a report to the authority.

Seeking instrumental support

When a situation has become out of control, getting help from a senior colleague or a higher authority person helps to resolve the problem because they can act as a third person. The third person has typically more experience dealing with violence and can act as a mediator between the participant and the aggressor. Assistant Medical Officer 4 reported that this action will help to calm both parties and will be able to resolve the issue more professionally. *"I observed a disagreement between my colleague and a patient's relative. The conflict eventually became heated and loud. So, the supervisor gathered them in a room for a discussion between my friend and the relative of the patient. Both my friend and the relative was furious at that time. The supervisor asked each of them to explain and then discuss the situation in a calm manner. I saw that in the end, they were shaking hands and laughing with each other. So, I think it helps. Especially when the discussion is appropriately done in a room between the parties involved, it appears more professional.*

Another element of seeking support is to get the involvement of another colleague to attend to the patient when the participant needs time away from the incidence scene. Participant reports that they will get help from others when they need extra help in treating patients who are restless and uncooperative. Patients of this type are typically psychiatric patients or patients who are semi-conscious due to illness. Another reason to seek the support of a colleague is when the situation has become out of control, and the aggressor has the potential to become or has shown physical violence. Participants must separate themselves from the aggressor for their safety when seeking assistance from another colleague. Some ask the security officer or auxiliary police for help *"If I the person become really angry, I will distance myself from them for safety reason. Then I will get help from my supervisor and security guard so they can take over".* (Assistant Medical Officer 1)

POST - CRISIS

Seeking emotional support

Respondents report several elements related to seeking emotional support. There are others who are making jokes and talking to a friend to deviate their attention from the issue at hand. Others seek comfort by weeping or venting their complaints to relatives, a senior colleague and a spouse. Venting is the most common coping technique to be used. Most of those who vent their problems to a colleague prefer to do so with a colleague from a similar line of work. They do that because they feel that their colleague have a better understanding of

the situation faced by the respondents. *"Receiving scolding and offensive words is a common situation. I am already immune to it. It does not give any lasting effect anymore. Normally when it happens, you talk to your friends, just sharing among us, because they understand the situation. Same goes to my colleague. They will come to me saying "I am stress! I am stress! I want to talk" I'll let them talk. That's what we usually do".* (Nurse 4)

The most frequent use of seeking emotional support is among assistant medical officers and nurses. Participants agree that the violent incident culminated in this help to alleviate their rage and frustration. There is a feeling that the occurrence of violence is going to recur, and this is a regular event. Thus, respondents need to vent the incident to help them cope emotionally and psychologically so that they are ready to face subsequent encounters.

A few participants use incidence report to ease their worries. However, most don't record all violence incidence. They will continue to report incidents when the event is significant (e.g. physical violence) or when they think there will be sequelae from the violent incident, as evidence to protect themselves. *"I make incident reporting for peace of mind. But, I don't regularly make incident reporting, because most of the time, the conflict is minor. It resolves with proper explanation. However, even though it is verbal, I'll report on the major conflict. It helps emotionally and mentally because it helps people who think they know your position at the time as to why it happened, what happened and the measures I took".* (Assistant Medical Officer 3)

Disengagement

Some participants will take a short time out after an incident of aggression and will find a place to calm down. They will temporarily avoid the site where the incidence of violence simply occurs or prevent from meeting the aggressor. Others minimize excessive contact with patient and relative. *"For me, when I am feeling down, I will take a short break to relax. I will just sit there without doing anything or talk to my colleagues. 10 to 20 minutes is enough, and after that, I am good. I might temporarily avoid the ward where a violent incident just took place. I will go to other wards first before I send the patient to that ward. I do this is so that my emotion is not affected".* (Healthcare Assistant 1)

Participants benefit from taking time off work. They either stay at home to rest and sleep, take part in outdoor activities, engage with friends or go shopping. They feel that after a brief time out of work, they are more motivated *"I am happy if I can get a leave. After a leave, I fill more spirited when I return to work."* (Medical Officer 3)

Adaptation

Adapting to violence requires participants to deal with its emotional impact and learn the skill to manage violence. Some participants look back into the incident and re-analyze it. Some are actively seeking advice from senior colleagues or conducting a post-violence discussion with them to re-analyze their actions and improve their skills in dealing with such cases. *"I learn how to handle a violent event informally. There is no formal training. So, the way I thought myself was to have a post violent discussion. I will meet with senior supervisors for advice. They will give me input on how I can improve when face with a violent event in the future".* (Medical Officer 1)

Some supervisors conduct a short debriefing session after a violent incident to help the staff ventilate and re-analyze the incident. A managerial post participant reported that he would encourage victims to look from a religious perspective to help them cope with the emotional impact of violence. Looking at the situation from the viewpoint of the patient is one approach often used by the participants. They reassess the conduct of the individual and seek to understand the explanation for their actions. Others can let go of their rage and resentment by recognizing the actions of the victim, *"Initially, I felt angry at him. Why he kicked me? All I wanted was to help him. Then, when I start to think back, he was like that because he was sick, and I wanted to help him. I did not expect it to happen. When faced with a patient like that, I should be prepared to save myself from danger. The patient was already irritable and half-conscious".* (Nurse 2)

Experiencing repeated exposure to violence has made the participants understand that they will have to face them daily and that this has become part of their work. They are desensitized to the emotional effect of violence and have made them more adaptable to handling the situation. A participant reported: *"This is not the first time that it happens. I have faced this many time. Based on my experience facing this situation, this is not something major. Since I have experience handling worse situation than this, I feel, that is the reason this violent event does not affect my work on that day. It also does not make me emotionally unstable or interfere with my work process."* (Medical Officer 1)

Discussion

This study correlates with previous studies demonstrating WPV is a common occurrence in the Emergency Department and occurs to health workers at all levels. (1, 2, 5). Coping is thinking or behaviour that people do while they are in a stressful situation (Hislop & Melby, 2003). Healthcare workers from the Emergency Department are using a variety of coping strategies to mitigate the impact of WPV.

Coping response change to match the level of aggression displayed by the perpetrator.

The method of coping response employed by participant corresponded to the level of violence exhibited by the perpetrator. This finding is similar to another study that showed the escalating intensity of the violence could affect the essence of the coping mechanism used by the victim. (8). Furthermore, participants in this study used a combination of coping strategies to stop violence incident, which is consistent with the finding in other studies. (3, 8, 12).

Coping strategy to violence starts even before the incident of violence occur

Managing WPV starts even before the actual crisis occur. The triggering factor might have happened before coming to the Emergency Department. Giesen, in his study, showed the feeling of anxiety, sorrow and pain are associated with a higher incidence of aggression (13). Another study found that confusion, irritability, boisterousness, physical and verbal threats and attacking objects are behaviours predictive of violence risk (14). During the pre-crisis phase, an effort to avoid conflict is essential.

This study found that the identification of potential aggressor by being vigilant and aware of the gap between service offered and the client's expectation will shape appropriate conduct by the healthcare worker. Learning to be mindful of body language and knowing how to de-escalate is a useful skill to be understood by a healthcare

worker (3). In being aware of their weaknesses and shortcomings in their workplaces, the participants in this study have been able to take countervailing steps to remove or reduce the possible risk factor of violence. Among ways to minimize the gap between expectation and the actual service offered are diplomatic and flexible in management of a patient, communicate what to expect beforehand, updating situation in the emergency department to visitors and helping a colleague to expedite patient's management

Self-restraint is frequently used as a coping response

The techniques employed when the participants are guided towards violent behaviour are self-restraint, constructive confrontation and the quest for instrumental support. Self-restraint is used by 10 out of 13 participants, and it is seen in all category of healthcare staff. The element of self-restraint seen in this study are presenting a calm and professional attitude, not matching the threat that they are being subjected to, showing empathy and disengagement from the incident area for fear of losing control. Self-restraint appears to be a common coping mechanism adopted by healthcare staff in Asia (12). In eastern culture, the act of silence is used to preserve harmony (15, 16). Malaysians' values place importance in group interest more than self-interest. Preservation of face and maintaining harmony (17) are among the Malay values. To achieve this, non-confrontational (18) and berbudi-bahasa or courteous (17) conduct are practice. Thus, these embedded cultural values are seen in the way participants response to confrontational behaviour.

Coping with workplace violence does not stop after a crisis ended

The way a person cope with stressor will shape their emotional response. Coping involves resolving a stressful situation by tackling the cause of stress (problem-focused coping) or managing emotion resulted from a stressful situation (emotion-focused coping) (19). The study found that participants seek support to solve the problem at hand when they are dealing with violent incident. However, post-crisis coping is targeted to resolve emotional conflict from violence and improve knowledge in managing violence. Both phases of coping are equally crucial as violence can affect healthcare worker in many levels, including psychological, physical, emotional and work function (6). To reduce its impact, healthcare worker learns to adapt through the various coping mechanism.

Strength and Limitation

The participants are diverse in terms of their professional background, which enables a more comprehensive understanding of all perspectives. However, the research was performed in a single centre study, assumes that the environment here is similar to another hospital in Malaysia. The study assumes that the responses here are universal and reflective of other personnel working in hospitals under the Ministry of Health situation. It cannot account the subtle differences in private hospitals or setting where the patient's characteristics are different. A multicentre analysis would help to build a broad understanding of the coping strategies used by healthcare workers in the ETD.

Conclusion

To sum up, understanding the pattern of the coping mechanism of healthcare workers will provide useful information for intervention aimed at managing WPV. The development of a positive work environment is

critical in supporting WPV workers. Healthcare and administrative personnel training to handle WPV, explicitly to recognize the risk factor for violence and to cope with all forms of violence, including verbal and physical aggression. Proactive engagement at the organizational level will include violence prevention, systematic conflict reduction and post-violence problem management.

Declarations

Study consent and ethical consideration

Ethics approval was obtained from the Research Ethics Committee, UKMMC and the Medical Research & Ethics Committee of the Ministry of Health of Malaysia (NMRR-15-1569-2518 (IIR)). Potential participants were briefed on the purpose and procedure of the research. Informed consent was obtained before the interview. All methods were performed in accordance with the relevant guidelines and regulations.

Availibility of data and materials

The datasets used and analysed during the current study are available from the corresponding author on reasonable request.

Consent for publication

NA

Competing Interest

We confirm that this work is original and has not been published elsewhere, nor is it currently under consideration for publication elsewhere. All authors mentioned above have read and approved the manuscript for submission. There were no issues relating to the journal policies. The authors declared to have no competing interest otherwise.

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References

1. Spector P, Zhou Z, Che X. Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. Int J Nurs Stud [Internet]. 2014;51(1):72–84.
2. Taylor JL, Rew L. A systematic review of the literature: workplace violence in the emergency department. J Clin Nurs. 2011;20:1072–85.
3. Morken T, Johansen IH, Alsaker K. Dealing with workplace violence in emergency primary health care: A focus group study. BMC Family Practice 2015;16(1)
4. M.S. Geshina Ayu, K. Mohammad Rahim*, M.S. Nadiah Syariai, M. Nurul Hazrina, M.I. Zaihairul HNH, Universiti Sains Malaysia M. Workplace violence prevention in healthcare governance. 1992;38.
5. Zainal N, Rasdi I, Saliluddin SM. The Risk Factors of Workplace Violence among Healthcare Workers in Public Hospital. Malaysian J Med Heal Sci. 2018;14(SP2):2636–9346.
6. LanctÔt N, Guay S. The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. Aggression Violent Behaviour 2014;19(5):492–501.
7. American College of Emergency Physicians (ACEP). Crowding. Policy statement. Annals Emergency Medicine. 2013;61(6):726–7.
8. Karatuna I. Targets' coping with workplace bullying: a qualitative study. Qual Res Organ Manag An Int J. 2015;10(1):21–37.
9. Rasero L, Ramacciati N. Coping methods used by emergency department nurses after a workplace violence experience could influence their intention to leave the hospital. Evidence Based Nursing. 2018;21(4):113.
10. Bin Mohd Noor MZ. FlexZhouse: New business model for affordable housing in Malaysia. A+BE Architecture and the Built Environment. 2017.

11. Clarke V, Braun V, Hayfield N. Thematic analysis. Qualitative Psychology A Practical Guide to Research Methods. 2015;222–48.
12. Gholamzadeh S, Sharif F, Rad FD. Sources of occupational stress and coping strategies among nurses who work in Admission and Emergency Departments of Hospitals related to Shiraz University of Medical Sciences. Iran J Nurs Midwifery Res [Internet]. 2011;16(1):41–6. Available from: http://www.ncbi.nlm.nih.gov/pubmed/22039378%0Ahttp://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC3203298
13. Giesen P, Mokkink H, Hensing M, van den Bosch W, Grol R. Rude or aggressive patient behaviour during out-of-hours GP care: Challenges in communication with patients. Patient Educ Couns. 2008;73(2):205–8.
14. Almvik R, Woods P. Short-term risk prediction: The Bröset Violence Checklist. J Psychiatr Ment Health Nurs. 2003;10(2):236–8.
15. Nakane I. Silence in intercultural communication. Perceptions performance John Benjamin's Publ Co. 2007;
16. Kuang Ching Hei WNL, David and MK. The Perceived Value of Silence and Spoken Words in Malaysian Interactions. J South East Asia Res Cent Commun Humanit. 2015;7(1):53–70.
17. Abdullah A. The influence of ethnic values on managerial practices in Malaysia. 1992.
18. Asrul Z. The Ideal Malays. PJ Golden Vis Publ. 2003;
19. Krohne HW. Stress and Coping Theories. Stress Int J Biol Stress. 2002;22:15163–70.