Workplace violence casts a long shadow

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"*Workplace violence is consequential*" is the understated observation of Strawbridge et al. in their paper "Reluctant victims: healthcare workers and workplace violence",[1] in this issue of the *New Zealand Medical Journal*. There is a lot known about workplace violence in healthcare and the authors emphasise much of this, including that it is common and under-reported, and that we are not meeting our duty of care towards staff as well as we should. Significantly, they present two engaging and shocking, personal "lived experiences" of violence and describe the consequences for them, which include much more than the physical and persist well beyond the moment of the violent act.

It is common

Violence occurs throughout our health system workplaces but, unsurprisingly, its prevalence in emergency departments (EDs) is particularly high. In a recent survey of clinical directors of EDs in Aotearoa New Zealand,[2] 11 of 13 reported an incident, or multiple incidents, of violence by a patient or accompanying person in their ED within the past week. The majority of these included physical violence, and most reported verbal violence occurring daily or frequently. In a survey of New Zealand emergency nurses' exposure to violence over the 2025 Christmas and 2026 New Year period, 84% of respondents reported unacceptable behaviour, with 77% of those feeling threatened.[3]

It is under-reported

Unfortunately, some of the decision makers in health only perceive reality if they see it in a spreadsheet, quantified and with cost analyses provided. Violence in health workplaces is under-reported, underappreciated and inadequately responded to. The stories, injuries and struggles of those experiencing this violence are too often ignored. Added to inaction, failure of existing systems and inadequate response options simply add to the injury. Studies from Christchurch Hospital ED,[4,5] with exhaustive recording of events of violence for 1 month a year, show that for the rest of the year the reporting is a fraction of what it should be. This significant under-reporting is consistently described in the international literature.[6–9]

The reasons for under-reporting are postulated to include staff considering that violence "is just part of the job" or its presence becoming normalised, or that individuals are desensitised to it because of its ubiquity. Process barriers are recognised, and staff are known to forgo reporting because they consider it will achieve nothing.[1,6–9] A consequent negative self-fulfilment occurs—under-reporting because of a perception nothing will be done contributes to nothing being done, a cycle that must be broken. But there are more factors to consider. For example, failure to acknowledge the impact of verbal abuse—too often minimised, yet it allows a culture that further normalises violence. In addition, a common failure is upholding "zero-tolerance policies" in a meaningful way, with caution expressed towards taking action involving external reporting (through police) or legal methods (such as trespass actions).[7] The lack of concrete consequences can be demoralising for staff directly affected.

We know what we should be doing

We have a useful and authoritative volume of advice about how to address workplace violence in healthcare. As an example, Richardson et al.[10] published an evidence base and guide to non-pharmacological management of the aggressive ED patient, and there is much guidance about the pharmacological management of such patients. There is less robust evidence of guidance, protocol and policy for expected support, ongoing rehabilitation and recognition of the continued psychological stresses associated with both physical and verbal assault. Constant exposure to a traumatic environment—one where the expectation, if not always the reality, of violence is present—inevitably leads to higher levels of hypervigilance, mental exhaustion and the potential to impact cognition, compassion and critical thinking. Consequently, and taking a more global approach

to both prevention and management of workplace violence in EDs, both the Australasian College for Emergency Medicine (ACEM)[11] and the College of Emergency Nurses New Zealand (CENNZ)[12] have published statements.

The ACEM policy document on workplace violence[11] states:

> *"Jurisdictional health system managers and hospitals have a legal responsibility to ensure that the ED is a safe workplace for all employees, while at the same time providing community access to safe, high quality, equitable emergency medical care. Hospital administrators must ensure that policies, procedures, staffing models, preventative training and education, verbal de-escalation and safe restraint training and education, ED design and incident reporting systems contribute to the prevention, minimisation and effective management of violence in the ED."*

The authors of this editorial question whether "*jurisdictional health system managers and hospitals*" in New Zealand can confidently claim that they have fulfilled this responsibility. Violence towards healthcare staff does not arise in a vacuum. Contributing factors need to be acknowledged, whether they are short staffing, inadequate environments (for example, a crowded ED or long waiting times) or communication failures. This does not excuse violence, but acknowledgement and attention to these contributors is necessary if any meaningful response is to occur.

The ACEM policy document goes on to detail expected solution implementations. The detail of the recommendations is beyond the scope of this editorial but, in summary, they describe preventative interventions, including providing an ED environment that is less conducive to violence, interventions for the violent event itself and post-incident interventions, including addressing comprehensive reporting and ongoing support for the victims of the violence.

A similarly broad list of recommendations is presented in the CENNZ document, emphasising the importance of a national approach, ED nurses' rights, education and the role of regulatory frameworks. ED reporting, and the need for global responses to contributing issues such as social factors, are also identified.[12] While the context of this advice (and this editorial) is the ED, it is universally applicable no matter what the health context.

In their paper Strawbridge et al. present two cases of personal "lived experiences" of violence. They reinforce all of the things we know and are not attending to adequately. In addition, they starkly remind us that workplace violence can cast a dark and long shadow. We must do better.

COMPETING INTERESTS
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