

# Knowledge, attitudes, and practices of violence in hospitals: the case of users of the reception and emergency service of the Ebolowa Regional Hospital.

André Izacar Gaël Bitá<sup>1</sup>, Eddy Thomas Biwolé Omgba<sup>2</sup>, Hermine Ngo Mey Essi<sup>3</sup>, Raquel Perdy Mbom<sup>3</sup>, Agbor Agbornkwai Nyenty<sup>4</sup>

<sup>1</sup>ICT University, Department of public health, Yaounde, Cameroon

<sup>2</sup>University of Yaounde 1, Department of Sociology, Yaounde, Cameroon

<sup>3</sup>Private Training Center of Health Professionals of Enongal, Ebolowa, Cameroon

<sup>4</sup>FHI 360, Catholic University of Central Africa, Yaounde, Cameroon.

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## Abstract

**Introduction:** The phenomena of incivility and violence are increasingly recurrent within health facilities in Cameroon. This study examines the knowledge, attitudes, and practices of violence by users in the reception and emergency departments of the Ebolowa Regional Hospital (ERH). **Methods:** This was a qualitative study of a non-random sample of users encountered in the reception and emergency department at the ERH in southern Cameroon. The principle of saturation was used to determine the sample size. An interview guide was used to collect the data. Demographic data were analyzed by EPI Info 7 and qualitative data by thematic analysis. **Results:** Acts of violence in hospitals are perceived as the use of intense and brutal force that affects the physical and/or moral integrity of others. The forms of violence cited include physical, moral, verbal, and psychological violence. The most frequently cited reasons for the violence were: negligence, the insolence of the nurse, abandonment of the patient without care or information, care not explained and not mentioned in the care booklet, lack of speed in care, insufficient communication about the illness of a relative and ineffective care despite the patient's fatigue. According to the participants, the circumstances that could lead individuals to do violence to nursing staff on duty include theft of medicines, contempt, rudeness, negligence in care, late care, abandonment of patients and poor hospital hygiene, refusal to answer questions, deception or professional incompetence, lack of welcome, attempts to extort or overcharge for prescriptions, and swindling and adultery. The consequences of violence mentioned in the responses mainly included: fighting, injuries, as well as staff reluctance, low hospital attendance, self-medication, and loss of life. Most respondents did not know or had no idea about legal sanctions after an act of violence, but one response mentioned the existence of sanctions such as police custody

and blame. **Conclusion:** Violence in hospitals is a major problem that can have serious consequences for patients, health care staff, and the health care system. The reasons given for the violence highlight the importance of clear and effective communication between patients and healthcare staff, as well as prompt and quality medical care.

## 1. Introduction

Violence is defined by the World Health Organization (WHO) as the deliberate use or threat use of physical force or power against oneself, another person, or a group or community, that results in, or has a high likelihood of resulting in, injury, death, emotional harm, maldevelopment or deprivation [1]. This definition includes interpersonal violence as well as suicidal behavior and armed conflict; it also covers a range of acts that are beyond physical violence, including threats and intimidation. In addition to death and trauma, it encompasses the multiplicity of often less obvious consequences of violent behavior, such as psychological damage or emotional deprivation and development problems that involve individual, family, and community well-being.

Violence can be divided into three main categories according to the WHO: self-inflicted violence, interpersonal violence, and collective violence [2]. Interpersonal violence can be perpetrated by a relative or stranger (known as community violence) and can take many forms such as physical violence, sexual violence, psychological and verbal abuse, deprivation, and neglect [2]. The United Nations Women's Organization (UN Women) defines violence against women as all kinds of physical, sexual, emotional, economic, and psychological acts (or the threat of such acts) that are likely to influence another person. Globally, it is one of the most common forms of violence experienced by women [3].

In the labor sector, we find violence described as endogenous and exogenous, or internal and external. The endogenous category generally refers to social relations or domination perpetrated at work, and to a lesser degree, the use of violence as a means or instrument of power. It refers to violent behavior committed within the work collective [1]. Exogenous violence is violence suffered by the worker, with the risk of impacting his or her activity at work. This type of violence manifests itself through the worker's confrontation with people outside the company, (customers, users, patients, etc.) [4]. It should be remembered that it is this type of violence that we are interested in in this study.

The hospital is an unusual place of work where the crystallization of anxieties, pain, and suffering can reach strong emotional paroxysms and generate latent violence. There are many incidents of behavior by patients and those accompanying them: the demand for immediate care, unfailing availability of the health care team, personalized listening, and understandable responses, which sometimes lead to impatience, aggression, and even verbal or physical violence. In Cameroon, violence in hospitals is an important occupational health and safety phenomenon whose repercussions can affect staff, users, and the professional environment. And violence in the health sector is poorly explored in Cameroon.

According to a report by the Safeguarding Health in Conflict Coalition (SHCC), there were 17 incidents of violence or obstruction to health care in Cameroon in 2020 [5]. In 2021, 38 serious incidents involving health facilities, staff, and patients were recorded by

health organizations [6]. Violence against health workers is unacceptable and harms their psychological and physical well-being, and their professional motivation and compromises the quality of care [7]. This study examines the determinants of violence by users in the hospital environment in Cameroon, in particular the case of the reception and emergency services of the Ebolowa Regional Hospital (ERH).

## **2. Materials and methods**

### **2.1. Type of Study**

This was a qualitative phenomenological study, the purpose of which was to study human behavior to gain a better understanding and explanation of the issue of violence in hospitals.

### **2.2. Location and study population**

With a capacity of 200 beds, the ERH is a health facility of the Cameroonian health system level, and the second reference in the city of Ebolowa, in Southern Cameroon, and the Mvila division.

The study population was the people attending the ERH and specifically targeted the patients and accompanying persons of the reception and emergency department of the aforementioned hospital.

Patients admitted to the emergency department were those who had stayed at least 48 hours in the emergency department. Patients consulted on an outpatient basis were those who had spent less than 48 hours in the emergency department. And attendants were people with the ability to respond to patients and were responsible for other non-medical care needs of the patients.

### **2.3. Sampling and sample size**

This was non-probability sampling. The sample size was set based on the principle of data saturation. We stopped collecting data when no new information, dimensions, or aspects emerged. This method has already been used in several other studies such as AIG Bitá et al, (2021a, 2021b) [8, 9].

The purposive sampling used to select study participants was based on the maximum variation. It also ensured a diverse sample in terms of age, caregiver status, patient type, and gender. The participants selected for the study were carers or discharged patients who had given informed consent and were interviewed.

### **2.4. Data collection process**

Data were collected mainly through focus group discussions and individual interviews with key informants [10]. The rationale for this method is that it allows unanticipated topics to arise and be explored in depth [11, 12]. Semi-structured discussion and interview guides were developed by a team of experts in multidisciplinary fields, namely an epidemiologist, two nurses, and a sociologist. The guides covered an assessment of endogenous and exogenous factors of violence in hospitals.

The group discussions were held in a spacious area within the health facility and

participants were arranged in a space with at least 1.5 meters of separation, a face mask for each participant, and following government measures to minimize the risk of exposure of participants to COVID-19 during the group discussion. The venue was quiet, with privacy and low ambient noise. The discussions took place in a model seating arrangement where participants could engage face-to-face. For each group discussion, a moderator and two note-takers were assigned. The recorded data was anonymized and entered on a secure computer. Each moderator and group discussion assistant was trained in qualitative research, the objectives of the study, the scope of the study, and the collection tools to be used in the interviews. At the end of each discussion, each participant completed a form to fill in the participants' socio-demographic data.

## 2.5. Data analysis

Interviews and discussions were transcribed verbatim and identifiable data were removed. A thematic analysis was carried out [13]. First, two authors independently read all transcripts in depth. Categories and themes were identified based on a meticulous and systematic reading and coding of the transcripts [14]. Secondly, a provisional coding tree was created, based on the themes that emerged from the data. Thirdly, the two authors each identified and coded the relevant text passages in a transcript and refined the coding tree. Themes with similar domains were then ranked based on the objective study of the data collected. Particular attention was paid to the number of participants sharing certain ideas in some of the quotes to guide the reliability of the data. Participants' quotes were reported directly as they were spoken, without changing the grammar so as not to lose meaning [15].

Perceived discrepancies between the meanings of the words in the sentences were discussed until a consensus was reached and the coding tree was finalized. Fourth, one author coded the remaining three transcripts using the final code tree and discussed his findings with the second coder.

The study was conducted following the Declaration of Helsinki [16], the International Ethical Guidelines for Epidemiological Studies [17], and the International Ethical Guidelines for Health Research Involving Human Subjects [18].

## 2.6. Ethical considerations

The protocol was submitted to and approved by the HRE health authorities. To ensure the protection and confidentiality of the participant's data, personal information that could identify the participants was not collected. Only people who had freely agreed to participate in the study were enrolled. The collection forms (collection grid) were anonymous. Once the data had been coded, entered, and stored in a computer, access to the database was password-protected and access was limited to those responsible for the research.

## 3. Results

### 3.1. Socio-demographic data of the sample

Between October and December 2021, thirty-six people were interviewed by the survey

team at Ebolowa Regional Hospital (Table 1), with 5.5% (02) in-depth interviews with patients discharged from the hospital and having stayed in the emergency department; 44.4% (16) participants (carers of hospitalized patients) in two focus group discussions; 22.2% (08) interviews with patient carers of patients consulted as outpatients in the emergency department; and 27.7% (10) interviews with companions of patients who had been hospitalized.

Type of interview	Types of participants	Number (%)
In-depth interviews	Patients discharged from the hospital who have stayed in the emergency department	02 (5,56 %) [95%CI 0,68- 18,66]
Patient key informant interviews	Accompanying persons of outpatients	08 (22,22 %) [95%CI 10,12- 39,15]
Key informant interviews	Accompanying persons of patients who were admitted to the emergency department	10 (27,78 %) [95%CI 14,20- 45,19]
Discussion with carers	Accompanying persons of inpatients	16 (44,44 %) [95%CI 27,94- 61,90]

Table 1 Interview methodology and number of participants

Most respondents were male with 66.6% [n=24; 95%CI 49.03-81.44] and females represented 33.3% [n=12; 95%CI 18.56-50.97] but this difference was not statistically significant. The age of the participants ranged from 25-54 years, with a mean of 32.2 years, a median of 29 years, and the 3rd quartile of 34 years. According to the respondents' occupations (Table 2), most of the participants were self-employed, 36% (13), followed by government employees 25% (09), and farmers, 16.6% (06).

Professional	number	%	%CI inf.	%CI sup
Farmers	6	16,67	6,37	32,81
Civil servants	9	25%	12,12	42,20
Self-employment	13	36,11	20,82	53,78
Students	4	11,11	3,11	26,06
Unemployed	4	11,11	3,11	26,06
<b>Level of study</b>				
Secondary	25	69,44	51,89	83,65
Undergraduate university	10	27,78	14,20	45,19
Post Graduate university	01	2,78	0,07	14,53

Table 2 Type of data collection and occupation according to participants

### 3.2. Participants' knowledge and perceptions of violence and its forms

The interviewees' answers to the question of what violence is varied. It emerges that violence is the use of intense and brutal force, often destructive ("It is acting with intense force, brutal and often destructive"), which damages the physical or moral integrity of others ("It is a physical or moral act that damages the physical or moral integrity of others"). It encompasses various forms of aggression, such as physical, moral, and verbal bullying ("It is bullying a person physically, morally and verbally"), physical, verbal, or psychological aggression ("It is physical, verbal or psychological aggression") and disrespect

through words or deeds ("It happens when one has disrespected another person through words or deeds"). Violence can also involve putting pressure on someone physically or psychologically ("Violence is putting pressure on someone physically or psychologically") and using force through actions or words ("When force is used through actions or words"). It can harm the lifestyle of the people concerned, both physically and socially ("It is also to negatively influence physically or socially the lifestyle of the person concerned"). Finally, violence can be triggered by anger or drug use ("When acting out of anger or under the influence of a drug").

The forms of violence cited by the interviewees were: physical, moral, verbal, and psychological violence. Several answers mention physical and verbal violence ("there is physical, verbal violence"), while others mention moral or psychological violence in addition to these two forms ("physical, moral, verbal violence"; "verbal, physical, psychological violence"). Some answers also underline moral and psychological violence as distinct forms ("physical, moral or psychological violence").

### **3.3. Service users' violent attitudes towards unsatisfactory care provision.**

Service users recognized and expressed the forms of violence that could occur if the care received was unsatisfactory. It emerged that acts of violence could result when clients are not satisfied with the care offered. Violence could then manifest itself in different forms, including verbal violence ("verbal violence") and physical violence ("physical violence"). These two types of violence were often mentioned together ("verbal violence, physical violence"; "physical or verbal violence"). The interviewees also recognized that verbal violence can also have psychological repercussions on the persons concerned ("verbal violence that can have psychological repercussions").

### **3.4. The practice of violence by the interviewees**

The users were asked if they had ever committed an act of violence in a care setting and to specify. Most people admitted to having committed an act of violence in a care setting for various reasons (24/26 (92.30%)). The most common reasons given were dissatisfaction with medical care, including reasons such as (1) negligence ("yes, for neglect of care"; "yes, for the negligence of care"); (2) insolence of the nurse ("yes, the insolence of the nurse"); (3) abandonment of the patient without care or information ("yes, for abandoning my patient without care or information"); (4) care not explained and not mentioned in the care booklet ("yes, for care that a nurse wanted to do without explanation and that was not mentioned anywhere within the patient care booklet"); (5) lack of speed in care ("yes, because the staff does not hurry in the care"), (6) insufficient communication about the illness of a relative ("yes, the nurse had not answered one of the questions about my brother's illness") and (7) ineffective care despite the patient's fatigue ("yes, because the care of my son was not effective when he was tired"). However, some people (7.70%) had no problems with their medical care ("not at all").

According to the interviewees, there are several circumstances that could lead individuals to use violence against health care staff on duty (beyond what prompted the interviewees to use violence), including theft of medicines and contempt ("for stealing medicines, for contempt"), rudeness and negligence in care ("rudeness on the part of the staff, negligence in care"; "extortion, rudeness, carelessness"), delayed care ("delayed care"), abandonment of patients and poor hospital hygiene ("abandonment of patients, poor hospital hygiene"),

refusal to answer questions ("when a nurse refuses to answer my questions"), deception or professional incompetence ("if a nurse wants to deceive me, if he/she is doing his/her job badly"), lack of hospitality and quality of care ("when care is not done well, or when the staff is not welcoming"), attempts to extort or overcharge for prescriptions and failure to respect basic hygiene rules ("in the event of an attempt to extort or overcharge for prescriptions, if hygiene rules are not respected") and, finally, swindling and adultery ("in the event of swindling, adultery").

### **3.5. Reactions to acts of violence and knowledge of the consequences.**

According to the users, the consequences of violence mentioned in the answers mainly include fighting, injuries, and death ("fighting, injuries", "fighting, injuries, death", "injuries, fighting, death", "fighting, death, abandonment of patients", "fighting, death, demoralized staff", "fighting, injuries, death", "fighting, injuries, death"). Other consequences highlighted were staff reluctance, low hospital attendance, self-medication, and loss of life ("staff reluctance, low hospital attendance, self-medication, loss of life"), reduced quality of care and psychosis among patients ("reduced quality of care, low hospital attendance, fighting, injuries, psychosis among patients") and staff unemployment ("death, staff unemployment, low hospital attendance").

### **3.6. Knowledge of legal sanctions after an act of violence**

Concerning the users' knowledge of the sanctions provided by the law, the majority of the answers indicate that the respondents do not know or have no idea about the legal sanctions after an act of violence ("No I don't know", "sorry I don't know", "no I don't know at all", "I don't know", "sincerely no idea about it", "I don't know", "I don't have any idea", "no, no idea", "no, no I don't know"). However, one response mentions the existence of sanctions such as custody and reprimand ("yes custody, reprimand").

## **4. Discussion**

This study aimed to understand the determinants of violence among health personnel by users in the emergency department of the Ebolowa Regional Hospital. Also, to describe the knowledge and attitudes of hospital users on violence. The demographics of our sample showed the majority participation of men, with women in the minority, thus demonstrating that violence is gender and sex-specific. This topic then includes gender-based violence because both sexes are involved in the interactions of violence; neither leniency in treatment nor gender equality is spared in the expression of hospital violence.

Subject to examinations and treatments, patients are not sufficiently addressed in this context because of their fragile health. Weakened, it is not easy to disrupt their convalescence, even if those who have recovered have taken the precaution of resting as recommended by the doctor. In this sense, the High Authority for Health has as its credo the policy of securing the medicinal treatment of the patient, as well as the interaction with the latter, which nevertheless provokes violence. Patients seeking health and social ties are exposed to forms of brutality that affect them as much as those accompanying them. The latter assists the patient in his or her temporary or permanent incapacity [19], for whom the multifaceted support of a third party is necessary. Constantly conscious and privileged witnesses, these companions, in the inability of the patients, testify to the

practices of violence in the hospital because they are not spared from violence, their age guarantees maturity. The age range of the actors oscillates between 25 and 54 years, which implies that they are all of age and above all adults, capable of discerning the quietude and then the ataraxia against violence in the hospital. Their level of education, at least secondary and at higher, also contributes to this lucidity because the level of education increases their intuition about the characteristics of violence and their understanding. The informants, who are mainly professionally active, and who have the status of patients and companions, undoubtedly have latent social positions as well as prestige which is beneficial to health. It is these positions that favor access to health since life has no price, but care relationships because they are based on the organization of knowledge, and work must be financed [20]. This illustration attracts the covetousness manifested by economic deviance (overcharging, theft of medicines, etc.). The status of the patient and carer predisposes knowledge and perceptions of violence in the ERH.

Violence is a known practice for the informants. Culturally, they develop knowledge and perceptions about it. In terms of knowledge, violence is part of the shared and available knowledge (at the ERH). The description of the latter by the informants is basically like the documentary and interactive description of the WHO at the beginning of this work [21]. The article is informed by common sense knowledge where violence by nature involves the use of force, which illustrates their perception. Which force deploys an objective and subjective dimension. Violence is applied to the social, the individual, and the physical, to release bodily/social harm. The use of physical force is characterized by brutality, of which brutal and destructive actions are illustrations, to paraphrase the data. This atrocity does not entirely define violence insofar as mental force is another component. This other aspect is subjective. It is the individual feeling of the offended person, in this case, the patient/carer. It raises the imbalance of the internal quietude where the mind, from its moral and psychological form, feels harassed by the proliferation of outrageous words. This approach of knowing violence where the physical and the moral are put together is also defended by Yves Alpes et al [22]. The violence experienced by the informants is mainly directed at people to easily reach their property. It is then a form of the constraint of individual will against another. From this point of view, as knowledge is linked to interest, Karl Mannheim considers that it can serve as an ideology [23]. The sources in their consideration of violence, if they characterize it as a linear process where anger and drug use can initiate a socio-psychological brutality, which reflects the negative impact on the person according to their expressions. However, the sources did not explicitly introduce the provocative actors. This knowledge and perception of violence can be distinguished from theory, occupying the middle ground between theory and practice.

Violence is an attitude that can appear latent in users. Its discretion is justified by the type of character and senses that interactions mobilize. If everything seems normal to the users, no reaction is envisaged. It is the relative frustration [24]. of the care that arouses the deviant reaction. If the medical care, including negligence, overcharging, misappropriation of medication, and discourteous expressions by the nursing staff, thus formulating physical, moral, psychological, and verbal abuse, then the user could retaliate. Health is therefore at the Centre of social interests at the ERH. Solicited (health) by the users, then in principle rendered by the service of the health personnel who instead, manifest deviant behavior, then germinates the emergence of violence. This assertion is



opposed to the thesis of the reduction of inter-individual violence, postulated by Norbert Elias in Western societies [25]. Psychologically omnipresent, violence is an intention that is transformed.

In this research, almost all the informants admit to having committed violence as a reaction to a previous deviant act by the health personnel. The cause of the violence is psychosocial. It emerges from the relative frustration that expresses the achievement of objectives by unconventional means. There is a hospital ethic that fosters cohesion between patients and those who care for them. The ethical ideal of nursing, places respect for the dignity and autonomy of the patient, and the care and commitment of the carers at the heart of the values. [26]. As soon as any intrusion of behavior, characterized by social attitudes of the health care staff arises, so soon the violent retaliation of the patients/caregivers is encouraged. The relative frustration is at the nerve points, the nodes of exchange between carers and users. From the social dimension, speed, fantasy, inefficiency, and frail communication in the care circuit are the dimensions that give rise to brutality. These are dispositions that put the physical social relationship at odds in that the inter-individual bond is in crisis. Communication, speed, and many others, instead of harmonizing the link, modify it earlier. Since communication is the essence of the links in the hospital because it reveals situations and decisions, frail communication is the source of mistrust and suspicion. Once communication is vulnerable, sharing information no longer fosters solidarity. Yet all societies are familiar with the phenomenon of communication. All societies are based on communication. Society is a community, i.e., a sharing of signs, and an exchange of messages. [27]. Lack of speed and fantasy (not explained by the nursing staff), which can lead to ineffective care, are also social attitudes that offend users when it is known that these characteristics do not contribute to physical recovery, on the contrary.

From a mental point of view, the inattention, disrespect, and renunciation expressed by the nursing staff towards the patients and their companions deteriorate the self-esteem of the second actors, who therefore feel offended by the lack of respect, as they say in their local expression. Therapeutic patient education addresses the psychological aspect, as Elsevier Masson SAS reminds us. [28]. The informants develop a psychosociological argument framing the causes of violence. A social condition can lead to a mental one, just as the reverse is possible. Mental extortion leads to the theft of patients' medicines, just as the latter can lead to the former. There is a predisposition of mind where users have been socialized into hospital malpractice. To foresee an attitude of violence as sometimes observed among users is to be aware of the prevalence of certain violent practices inherent within the HRE. Nevertheless, what attitudes do users use to deal with these deviant practices?

Users develop an individual attitude of immediate retaliation. The actors introduce the theory of violence against violence. It consists of replying to an attitude, a practice of brutality with another equally violent one. These are reactions that do not always correspond exactly to the physiognomy of the initial deviance. From direct observation, each user reacts according to a deliberate choice. Thus, tooting, cursing, not answering, staring are benign responses, and in a very restricted social setting (face to face). They are responses that are circumscribed to a small radius and then have their full meaning of influence on the medical staff. These reactions may be gentle, but they limit the actions of the caregiver who knows that these gestures are not appreciated.

Another form of user reaction is verbal violence. Here, there are outbursts, insults, threats, degrading names, and dishonorable questions (who are you? I don't care, watch out, thief, incompetent, poor...). This form of agitation is average and goes beyond the restricted framework. It attracts a lot of attention because of the noise that spreads in a quiet space. Within the hospital, another reaction is interpreted from the stormy reports of fights with or without injuries, attempted fights, tearing and crumpling of medical gowns, throwing away of health personnel's equipment, voluntary and unauthorized departures of users, as well as quarrels. These reactions denounce and sanction the deviations of the healthcare staff. This final phase generates enough noise to have an impact beyond the department concerned.

The violent reaction is a response to deviance that can be seen consequently. Of the effects listed, on the internal level of the hospital, fighting, injuries, and death are among them. This reasoning seems logical in placing the mechanism of the result of the consequence in sequence. If direct observation attests more to fights and injuries as effects of violence, the death of either the user or the health staff remains unreal. Similarly, no rational legal decision by the forensic pathologist or other competent services has been presented by the users in the sense that the death of a patient is directly related to the negligence or ineptitude of the health care staff. Without entirely refuting this argument, it remains unconvincing but intuitive. These internal consequences, contrary to health ethics, demonstrate how violence is rooted in the hospital environment, calling into question the nature and virtue of this social framework. Going to the hospital becomes problematic when one can determine the type of treatment in use for most users. From the quest for health to its depravity, the hospital space is wrongly de-socialized because of the social representation that its staff, sometimes inclined to rational violence, give to prevail. This influence of the ERH goes beyond the internal framework.

The violent deviant reputation of the ERH's health staff is externalized. The aggregation of violent behaviors within the hospital and the various manifestations generated have initiated deviant socialization, which the socialized (users) propagate during or at the end of their hospitalization. Like the infodemic [29], which merges information and epidemic and spreads rapidly in social spaces, the violence is illustrated in a psychosociological infection that sets the external environment of the hospital on fire. Whether founded or not, both news and violent rumors describe the hospital atmosphere by inspiring fears, anxieties, withdrawal, and self-care. It is to this extent that ugly memories combined with deviant relationships lead to self-medication, withdrawal from the hospital, psychosis, and the vile image of a profession. This vile representation of the nursing staff can negatively influence the return of many former users who feel that violence is a cycle, it repeats itself at the ERH. Apart from self-punishment by the users, there are legal measures.

It is through abuse that users respond to violence with a response proportionate to the act of the health staff. In most cases, patients and their careers are unaware of their rights as patients, of the quality of care that precisely fuels the relative frustration, and of the sanctions associated with deviations. From this point of view, the facts show that ignorance can lead to the use of inappropriate means. Similarly, since the only victim was aware of the existence of the normative framework, his knowledge did not spare him from violence. We can only say that ignorance is often enough to provoke hostility and that knowledge is not always enough to avoid it. [30]. When sources are aware of these legal sanctions, there should be demonstrable fault and liability on the part of the staff in

question. Negligence in the care of the patient, for example, is prohibited. The health professional must therefore not refuse to treat [31]. The negligence of the patient, the theft of medicines, etc. must not remain mere statements, these acts should be combined with careful testimony and alleviating the need for a request for a sanction such as a reprimand, or police custody to obtain information. It is held that violence emerges from a relative frustration between the user and the care staff. This practice becomes even more entrenched in the ERH when it is also transformed into a sanction in a space where the law is scorned. Violence at the ERH has transformed the hospital space by disintegrating cohesion.

## 5. Conclusion

Violence in healthcare settings is a major problem that can have serious consequences for patients, healthcare workers, and the entire healthcare system. The reasons given for the violence underline the importance of clear and effective communication between patients and healthcare staff, as well as quality medical care. We recommend that preventive measures be put in place to reduce the risk of violence in the health care setting. This could include training for healthcare staff on how to handle difficult situations and communicate with patients, as well as raising patients' awareness of their rights and responsibilities concerning their medical care. It would also be important to put in place clear procedures for reporting and dealing with cases of violence, including appropriate sanctions for perpetrators.

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## Conflicts of interest

The authors declare no conflicts of interest.

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### Corresponding Author

André Izacar Gaël BITA,  
The ICT University, Yaounde, Cameroun  
**Email:** bitagael@gmail.com