ANNEX

FINDINGS AND RECOMMENDATIONS OF THE TRIPARTITE WORKGROUP FOR THE PREVENTION OF ABUSE AND HARASSMENT OF HEALTHCARE WORKERS

The Tripartite Workgroup for the Prevention of Abuse and Harassment of Healthcare Workers was set up in April 2022 to spearhead a coordinated national effort to prevent the abuse and harassment of healthcare workers in the public, private and community care sectors. The Workgroup was formed in response to an increase in the number of cases of abuse and harassment against healthcare workers, as well as increased public concern for their well-being.

Findings from Engagements

2. Over the second half of 2022, the Workgroup commissioned extensive engagement with more than 3,000 healthcare workers and more than 1,500 members of public, through surveys and focus group discussions.

3. The objectives of the engagement were to gather feedback from healthcare workers and members of public to understand their views on the following:

- Definition of abuse and harassment;
- Extent of abuse and harassment experienced by healthcare workers;
- Root causes of abuse and harassment;
- Avenues to address incidents of abuse and harassment; and
- Additional safeguards that should be put in place.

Experience of abuse and harassment

4. The findings showed that abuse and harassment is prevalent across all healthcare settings. More than two in three healthcare workers said they had witnessed or personally experienced abuse or harassment in the past year, of which half of these healthcare workers (or a third of all healthcare workers) witnessed or personally experienced abuse or harassment at least once a week. Frontline healthcare workers such as pharmacists, patient service associates and nurses were more likely to experience abuse and harassment. For example, 55% of pharmacists witnessed or experienced abuse or harassment at least once a week. This could be attributed to the fact that pharmacists are often the last touchpoint with patients or next-of-kin before discharge from hospital wards or specialist outpatient clinics. About 32% to 40% of healthcare workers in public healthcare institutions (PHIs) responded that they had witnessed or experienced abuse or harassment, compared to 25% of healthcare workers in private healthcare institutions, and 27% in community care organisations.

5. The most common forms of abuse and harassment are shouting, threats by patients and/or caregivers to file complaints or take legal action against the healthcare workers , and demeaning comments. Physical assault was less common. In the past 12 months, 46% of all healthcare workers surveyed said they had witnessed or

experienced shouting, compared to 4% who had witnessed or experienced physical assault.

Perceptions of abuse and harassment

6. According to the survey, many healthcare workers did not consider certain actions as abuse or harassment. For example, about one in three healthcare workers did not consider actions such as physical assault and vulgar or discriminatory comments as abuse or harassment, even though they are clearly so. Table 1 shows a list of actions and the proportion of healthcare workers and members of public surveyed who did not consider these actions as abuse or harassment.

Table 1: Perceptions towards abuse and harassment

Action	**Proportion who did not consider this to be abuse or harassment**	
	Healthcare workers	**Members of public**
Aggressive behaviour from patients with dementia	66%	61%
Repetitive demands / complaints	49%	59%
Unsolicited photo / video / audio recording	44%	38%
Sexual requests and remarks	39%	32%
Molest	38%	29%
Threatening to complain / sue	35%	43%
Demeaning comments	34%	36%
Shouting and threats to cause harm	34%	23%
Physical assault, e.g. slapping	33%	25%
Discriminatory comments, e.g. racism	30%	27%
Verbal abuse, e.g. vulgarities	23%	18%

7. From Table 1, it is observed that a significant proportion of healthcare workers surveyed had discounted actions as not abusive. This suggests that to some extent, healthcare workers have normalised the abuse and harassment that they experience and have rationalised these as being part of their job. Nurses and nursing support staff were less likely than other types of staff to consider actions as abuse or harassment. It is also worth noting that a higher proportion of members of public surveyed did not consider certain actions (such as repetitive demands / complaints, threats to complain/ sue and demeaning comments) as abuse or harassment, compared to healthcare workers.

8. From the focus group discussions, it was found that some members of the public felt certain behaviours should not be deemed as abuse or harassment if healthcare workers had the autonomy to reject or ignore such requests, such as sexual propositions. They also believed that certain acts were not abusive if they felt they were justified or expected of healthcare workers as part of their role (e.g. persistent requests for updates on patient status, recording videos of healthcare workers during care tasks for accountability, doxxing healthcare workers by leaving unfavourable online reviews and pictures of healthcare workers).

9. Generally, there was a lack of a common understanding of what amounted to abuse or harassment. For example, both healthcare workers and members of public felt that some forms of abuse and harassment were subjective depending on how healthcare workers perceived the comments made by patients, which could include potentially demeaning and discriminatory comments.

10. Lastly, there was also uncertainty whether actions should be considered abuse or harassment if they were unintentional, such as physical assault by patients with diminished mental capacity. This finding from the focus group discussions was corroborated with the survey, where 'aggressive behaviour from patients with dementia' was one action that was the least perceived to be abuse or harassment, with a significant proportion of healthcare workers themselves (66%) not considering it as abuse or harassment.

Circumstances of abuse and harassment

11. Table 2 summarises the root causes of abuse and harassment and circumstances under which they occur, based on views obtained from healthcare workers and members of the public in the focus group discussions. While the root causes of abuse and harassment have been broadly divided into three categories below, each incident of abuse or harassment was often multi-faceted with inter-dependent causes.

Table 2: Summary of root causes of abuse and harassment

	Root causes	**Examples**
Patient/caregiver	**Discrimination**	Xenophobic and racist behaviour by patients
	Expectations	Mismatched expectations of healthcare workers' role
		Insufficient trust in healthcare workers' care decisions
	Insufficient self-control or diminished mental capacity	Environmental and psychological stressors
		Medical condition or substance intoxication
HCW	**Perspective on abuse and under-reporting**	Normalisation of abuse and being unable to recognise abuse
		Under-reporting of incidents
Institution level	**Limited manpower and resources**	Limited manpower
		Inadequate security and training
	Inconsistent enforcement and unclear processes	Lack of clarity over reporting; not updated on outcomes of reported cases
		Under-utilised support measures for healthcare workers
		Inconsistent response to negative behaviour

i. Root causes among patients and caregivers

12. Abuse and harassment from patients and caregivers can stem from xenophobia. This includes demeaning comments made to healthcare workers on the basis of their nationality. It also includes unreasonable requests such as asking to be attended to only by healthcare workers of a certain race or nationality, even when spoken language is not a barrier.

13. Patients and caregivers might have mismatched expectations about healthcare workers' role in the delivery of care. For example, caregivers might request frequent updates about the patient's health status, or expect healthcare workers to take on duties outside of their scope of work such as treating them as personal attendants. Some patients and caregivers felt entitled to more efficient and higher quality service than provided. This was the case across the public, community care and private healthcare sectors.

14. These sentiments were exacerbated by the psychological stress of being in a healthcare environment where patients experienced worry, fear or frustration due to uncertainty around their medical conditions, time constraints or financial concerns.

15. Both healthcare workers and members of public encountered cases where patients were abusive because they were unaware or unable to control their actions, due to their medical conditions or substance intoxication.

ii. Root causes among healthcare workers

16. Healthcare workers who encountered abuse and harassment frequently may have normalised or grown accustomed to experiencing it. As a result, abuse and harassment is not always reported, perpetrators do not face consequences, and abusive behaviour is left unchecked. This gives rise to misconceptions among healthcare workers that abuse and harassment are to be tolerated.

iii. Root causes at the institution level

17. Healthcare workers and members of the public said that limited manpower and resources at institutions led to longer waiting times, and inadequate communication between healthcare workers and patients. Patients and caregivers who did not know how to get their concerns addressed would vent their frustration at healthcare workers instead. It was not possible for security personnel to be present in all healthcare settings. Staff also may not have received in-depth training to deal with abusive patients. This was especially the case in community care settings and smaller private clinics.

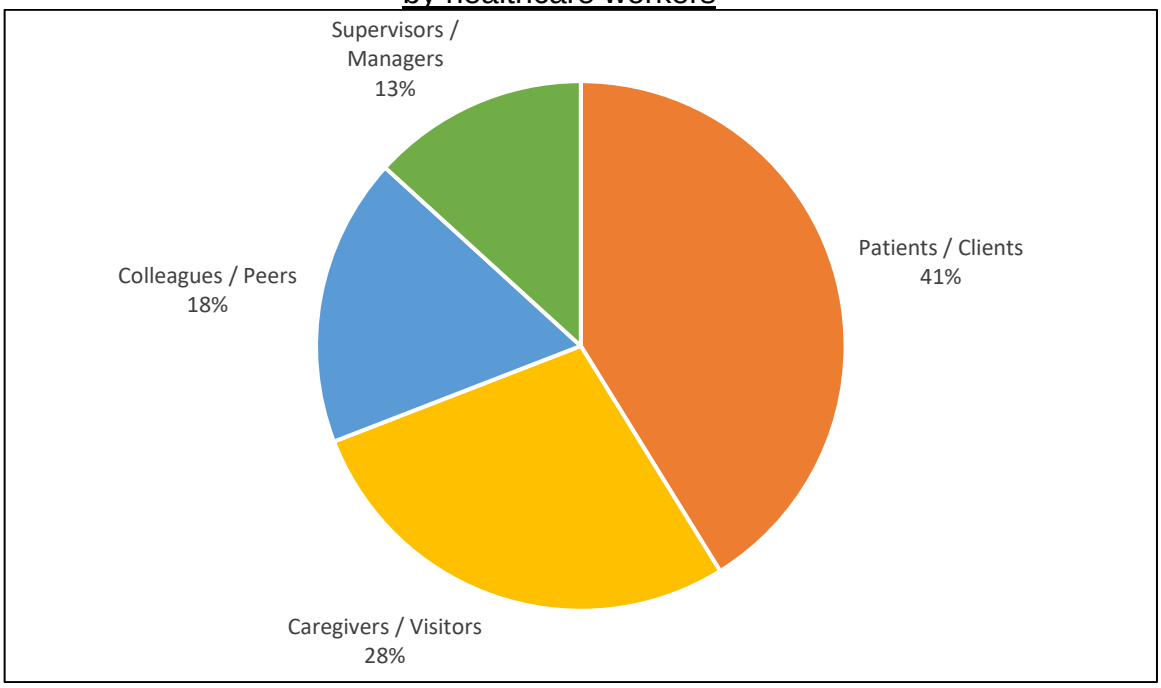
18. While healthcare institutions have varying levels of escalation and reporting processes in place, healthcare workers felt there was room for improvement. For example, healthcare workers were unclear of the criteria or threshold for reporting, and were not always updated on the investigation process and outcome. Healthcare workers said that in some disputes with patients, patients' requests were eventually

acceded to. Such actions inadvertently encouraged negative behaviour by patients. As a result, abuse and harassment is often under-reported.

iv. Source of abuse and harassment

19. On average, healthcare workers reported that abuse or harassment they witnessed or experienced came from patients / clients most of the time (41%), followed by caregivers / visitors (28%), colleagues / peers (18%) and supervisors / managers (13%) (see Chart 1).

Chart 1: Source of abuse or harassment witnessed or experienced by healthcare workers



Under-reporting of abuse and harassment

20. All healthcare institutions have processes in place for reporting and investigating abuse and harassment. However, our survey found that among incidents of abuse and harassment recounted by healthcare workers, only a small proportion were officially reported to the institution (24%) or to the Police (4%) (see Table 3).

Table 3: Actions taken by healthcare workers who experienced abuse or harassment in the last 12 months

Action	Proportion of responses
Informal sharing with colleagues	57%
Informal sharing with supervisor	43%
Shared with family members/friends	33%
Official reporting to institution (by individual or supervisor)	24%
Did not tell anyone	11%
Official reporting to police	4%
Inform union representative	2%
Others	4%

**Does not add up to 100% as respondents can select more than one option*

Healthcare workers attributed the under-reporting of abuse and harassment to the following reasons.

i. Shortcomings in the reporting process and lack of clarity

21. As part of the escalation process, healthcare workers were sometimes made to recount the incident repeatedly to different supervisors and managers, which could be challenging if they were emotionally affected by the event. The filling up of reports was usually done outside of working hours, and this required additional effort and time by healthcare workers. Conversely, staff needed to take time off from work if processes such as interviews at the police station took place during working hours.

22. In addition, healthcare workers said that they were unsure of whether an incident amounted to abuse or harassment. Some recounted instances where they had reported incidents, but were informed by their supervisors that the incident did not constitute abuse or harassment. In the Workgroup's engagement sessions with institutions, supervisors also wanted to be better informed of legal thresholds and advice from relevant authorities.

ii. Perceptions among healthcare workers on reporting abuse and harassment

23. Based on their experience with reporting abuse and harassment, or that of their colleagues, some healthcare workers felt that there was limited action that could be taken against offenders. Some suggested that they could be given more timely updates on the outcome of their reports.

24. In addition, healthcare workers were concerned about how reporting abuse and harassment would be perceived by their supervisors and colleagues. Some were concerned that their supervisors would question if they had inadvertently antagonised patients or failed to meet patients' expectations. In particular, foreign healthcare workers were afraid of reporting abuse and harassment because they were worried about losing their jobs. Some healthcare workers felt that there were too many incidents to report because of the prevalence of abuse and harassment, and they would be seen as over-reacting if they reported all of these incidents. Meanwhile,

supervisors expressed hope for greater clarity and training to better support their teams in knowing when to lodge reports.

Adequacy of existing measures against abuse and harassment

25. Healthcare workers were generally aware of support measures available to them (e.g. counselling services, peer support, resources for self-care and mental wellbeing, whistle-blowing hotline). However, the utilisation of such support measures was low. Fewer than one in ten tapped on counselling services and mental health resources, and fewer than one in five tapped on peer support. Nonetheless, more than seven in ten of those who had utilised such support measures reported that they were effective. More can be done to encourage healthcare workers who experience abuse or harassment to utilise these support measures. Notably, there is low awareness of the Protection from Harassment Act (POHA) among both healthcare workers and members of the public.

26. When asked what measures were needed, healthcare workers suggested more institutional support for staff who had been abused, such as affirming a zero-tolerance policy against abuse and harassment, as well as strengthening public education. Healthcare workers were also supportive of preventive measures such as training for staff to manage difficult situations, and protective measures such as the use of CCTVs and increased security.

27. Members of the public were supportive of public education as well, through measures such as requiring that patients undertake to treat healthcare workers with respect at the point of admission.

Workplace bullying and harassment

28. In the survey, workplace bullying and harassment by colleagues and supervisors made up 31% of all cases of abuse or harassment witnessed or personally experienced, and this happened more than twice a month on average. This was more commonly experienced by younger or junior staff. While this was usually in the form of verbal abuse, there were also instances of physical abuse and sexual harassment.

Summary of findings and implications

29. There is high prevalence of abuse and harassment across all healthcare settings, including verbal, physical, sexual, and online abuse. There was also a lack of a common understanding of what constitutes abuse and harassment, particularly in terms of whether the perpetrator had intended it as abuse. Notably, healthcare workers often normalised abuse and harassment as part of their job, which resulted in them not recognising certain behaviours as abusive or not taking follow up action. The negative perceptions the reporting process among healthcare workers also result in significant under-reporting.

Recommendations from Workgroup

30. In response to these findings, the Workgroup has three broad recommendations that can be summarised into **Protect, Prevent,** and **Promote**.

These recommendations will be implemented through a standardised zero-tolerance policy across PHIs and a national public education campaign. The details will be developed in the next phase of the Workgroup this year.

Protect	Prevent	Promote
Protect healthcare workers who face abuse and harassment	**Prevent situations that lead to abuse and harassment**	**Promote positive relationships between healthcare workers and patients/caregivers**
• Develop a zero-tolerance policy with effective protocols for handling abuse and harassment. This includes: ○ A common definition of abuse and harassment ○ An effective reporting and escalation protocol ○ A supportive culture of reporting ○ Clear consequences that are implemented and enforced	• Equip healthcare workers to avoid potential abusive situations • Deter potential offenders with the zero-tolerance policy	• Align expectations of healthcare workers' roles and promote respect towards them
Standardised zero-tolerance policy across institutions		National public education campaign

Protecting healthcare workers who face abuse and harassment

31. The Workgroup recommends the development and implementation of a standardised zero-tolerance policy against abuse and harassment, with effective protocols for handling abuse and harassment. Generally, this should include:

- A common definition of abuse and harassment to support the zero-tolerance approach.
- Effective reporting and escalation protocols, and support structures to give healthcare workers the confidence and assurance to report abuse and harassment.
- Clear consequences for offenders that are implemented and enforced.

i. Definition of abuse and harassment to support the zero-tolerance approach

32. The Workgroup proposes the following definition of abuse and harassment:

Abuse and harassment are defined as any threatening, abusive or insulting words, behaviour or communication, that may cause a healthcare worker to experience distress, harassment, threat or discrimination; even if the individual did not intend to do so.

33. The definition covers

- Zero tolerance towards abuse and harassment of any form.
- Repeated incidents or behaviour that may have a cumulative impact on healthcare workers' emotional or psychological well-being.
- Abuse and harassment that has taken place regardless of the intention of the perpetrator, including by those with cognitive impairment, confused, or with dementia.
- Any abuse or harassment by colleagues/other healthcare workers.
- Including but not limited to:
    - Any threatening, discriminatory, abusive or insulting words, behaviour or any form of communication.
    - Publishing any identity information of the target person or a related person of the target person (such as online doxxing).
    - Threats that may include reputational, financial or physical harm.
    - Discrimination that may be due to race, religion, gender, nationality, language or any other factors.

ii. Reporting and escalation protocol, and support structures to give healthcare workers the confidence and assurance to report abuse and harassment

34. All behaviour or any form of communication that falls within the definition above should be considered abuse or harassment and should not be left unreported. Healthcare workers should be provided with a direct and straightforward reporting process, and an escalation protocol and response plan that is commensurate with the severity of the incident.

35. Each report should be followed up with independent investigation and transparent feedback on the outcome of the report, from the institution and the police if relevant.

36. Throughout the reporting and escalation process, healthcare workers should feel assured, supported and protected by the institution. Institutions should ensure that healthcare workers have a psychologically safe environment that supports reporting.

iii. Consequences for offenders that are implemented and enforced

37. We should ensure that healthcare workers have confidence in the reporting and escalation process and make the consequences clear. The threshold for actions to be reported to the police and/or handled by institution and the relevant consequences should be clearly spelt out.

38. In cases where legal recourse is available (e.g. under the Penal Code or the POHA), the threshold and process should be made clear to staff and supervisors. Institutions should support staff in making police reports if necessary.

39. Regardless of whether legal recourse is available, institutions should develop a suite of internal actions that can be taken independently. This may include issuing a warning to the perpetrator; disengaging by refusing unreasonable requests or

discharging abusive patients who are assessed to not require urgent medical care; and disengaging from abusive caregivers or visitors by preventing them from entering the premises. Among and within institutions, healthcare workers may also flag out the recalcitrant perpetrators to allow fellow healthcare workers to take appropriate precautions when interacting with them and prevent repeated abuse or harassment. There will be a need for further work on guidelines to help institutions carefully balance the considerations of protecting staff from abuse and harassment without neglecting duty of care for patients in need of treatment.

Preventing situations that lead to abuse and harassment

40. The zero-tolerance policy towards abuse and harassment, and stern consequences, will act as a deterrent to potential offenders. In addition, some situations that lead to abuse and harassment can be prevented through the avoidance or better management of potentially volatile situations.

41. Healthcare workers should be equipped to avoid potential abusive situations. Staff should have basic knowledge on how to identify and handle abuse and harassment, and be ready to call out such behaviour when they or their colleagues encounter it. They should also be trained in effective communication, how to de-escalate tense situations with patients, as well as the appropriate response to adopt in high-risk situations. Institutions may also look into implementing physical protection measures like portable panic buttons to alert security to escalating situations.

42. Where relevant, healthcare institutions could also provide relevant staff with specialised training on care and management techniques to better handle patients with specific conditions such as dementia.

Promoting positive relationships between healthcare workers and patients/caregivers

43. The Workgroup will work with MOH Holdings to implement a national public education campaign to promote positive relationships between healthcare workers and patients. The objective of the campaign will be to align expectations of healthcare workers' roles and promote respect for healthcare workers.

44. The national public education campaign should be complemented by further efforts at the institution level. For instance, institutions should correct any mismatched expectations that patients might have, through providing more information on the processes to expect, role of healthcare workers, patient conduct, and the appropriate channels to raise concerns about care delivery. These may be presented to and acknowledged by patients at suitable junctures, such as at the point of registration or admission.

Conclusion

45. As healthcare workers shared their experiences of abuse and harassment from patients and caregivers, many were also empathetic to their patients and caregivers, acknowledging the stress and uncertainty that they faced. However, healthcare workers also voiced that repeated incidents of abuse and harassment were wearying

and affected them psychologically over time, much as they accepted these experiences as part of their duty of care.

46. More needs to be done to stop abuse and harassment so that consequences can act as a deterrent and healthcare workers feel protected by a strong anti-abuse and harassment policy. We should ensure that healthcare workers have confidence in the reporting and escalation process and make the consequences clear to both perpetrators and healthcare workers. Given the high awareness and effectiveness of support measures, it would be important to understand and tackle the barriers to seeking these support measures among healthcare workers. Healthcare institutions must also take a strong stand against internal bullying and harassment by colleagues and supervisors.

47. The Workgroup takes a firm stand that there should be no tolerance for abuse or harassment of healthcare workers, regardless of the intention and circumstance. However, we also want to strike a balance to ensure that a positive relationship of trust and respect is maintained between healthcare workers and their patients.

48. In the next phase of the Workgroup's term in the second half of 2023, MOH will work with public healthcare clusters to develop and implement the zero-tolerance policy described above. The policy will be standardised across all PHIs. Private healthcare institutions and community care organisations will be encouraged to refer to the parameters of this zero-tolerance policy when designing or updating their internal processes. MOH Holdings will also launch the national public education campaign to promote positive relationships between healthcare workers and patients.

49. The Workgroup will continue to engage all stakeholders and encourage members of the public to partner us to create a safe and conducive working environment for our healthcare workers to carry out their duties effectively.