VIOLENCE IN HEALTH ORGANIZATIONS IN ROMANIA

Abstract
The issue of violence in health organizations remains profoundly affected by a double dichotomy. That of a radical separation of the victim and the culprit and that between reflection on the victimization of the users and that of the personnel. We propose to interrogate these separations by endeavoring to go beyond the accounting of violent behavior by the apprehension of the phenomenon in the analysis of the situations qualified as violent by the actors themselves in a phenomenological perspective.We argue that the experience of violence of health professionals is linked to the specificities: of the service relationship - which will lead to analyze the relations between users and professionals - and of the organization, which will necessitate studying the social relations of work . The survey system was built on the basis of victimization surveys.This presentation constitutes the Romanian part of a Franco-Romanian comparative survey (Carra, Burlacu and Faggianelli, 2016), the French part being the subject of another presentation (Carra and Ridel, 2017).

***Keywords*:** health sector, violence, comparative analysis

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VIOLENŢA ÎN ORGANIZAŢIILE DE SĂNĂTATE DIN ROMÂNIA

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Rezumat
Experiența violenței profesioniștilor din domeniul sănătății este legată de particularitățile: relației de serviciu - care va conduce la analiza relațiilor dintre utilizatori și profesioniști - și a organizației, ceea ce va necesita studierea relațiilor sociale ale muncii. Sistemul de sondaje folosit în cercetarea noastră a fost construit pe baza studiilor de victimizare. Această prezentare constituie partea românească a unui studiu comparativ franco-românesc (Carra, Burlacu și Faggianelli, 2016), partea franceză fiind subiectul unei alte prezentări (Carra și Ridel, 2017).

Cuvinte cheie: sectorul sanitar, violența, analiză comparativă.

1. INTRODUCTION

Service relations and conflicts of perspectives

The specific methodology that we have proposed, by showing the actors' descriptions of the violent situations they have encountered, allows us to go beyond the census of violent acts, to recontextualize them in the specificities of professional interactions (Carra, Burlacu and Faggianelli, 2016).

The following transcript is significant in this regard: "A special situation is the case of an insured patient upon admission may not receive compensation orders. In this case, appeared tensions and conflicts between the patient and the healthcare professional (...) "(Obs. 3).

The patient's resistance to the administrative logic of care does violence to the professional who is supposed to be the expert on the situation. In this sense, it is a professional event especially as the user may be perceived as seeking to modify the logic of the professional and the institution.

The pro-secular relationship, patient medical staff requires a prior scheme whose main characteristic is to be an ideal type of personalized service repair subject to contingency situations "features pressures still exert preventing achieve fully this ideal and deviations resulting show features no less impact "(Goffman, 1968, p. 377).

These pressures are emerging differences of interests and expectations of each other as to the purpose of the relationship, support, and differences in definitions of situations between professional and layman. Thus, "the beneficiaries and service providers see the situation in a fundamentally different perspective" (Hughes, 1996, p. 96). The answers describing the victimization situations give to see acute face of these different perspectives.

The description of victimization with such issues, the inputs and outputs support, shows different views of how to approach the subject of the relationship and the use of the location of this relationship: "During the winter homeless people come to be hospitalized and patients who are admitted do not want to leave the hospital "(Obs. 93). Are denounced as users "who just seek shelter" or "People of the street (who) do not want to leave the hospital" (obs. 234). It is indeed here to the prior confrontation of two logics: a logic supported by medical personnel face a welfare approach that underlies the demand for these users.

Like the incidents at the door (Barrère, 2002) described in the works on violence in schools, the territory and the control of its good use become the issue of the most lively conflicts and the uncertain outcome. Entering the place or leaving the place can be an opportunity for a confrontation. In social staging the

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hospital, input-output, reveal the difficulties of having a sense of control over their environment for the staff and for the user.

On the side of the user: can he have control of his participation in a support? On the professional side: can he have control of who should participate and who should be excluded. In its traditional form, the space of the hospital is due to my doctor the territory in which is admitted the presence of the patient under certain conditions. Homeless people "who use the hospital as a dwelling during the winter" (obs. 298) tend to symbolize a burst in that territory by their demand for social care. This explains the violent potential of these conflicts of use when it comes to personal, to prevent the presence or expel a person whose action, in itself, can be attributed to a desire perverting the conditions of presence on the site.

At the side of the conflicts of use can arise conflicts of temporalities? It is less a question here of a comparison of the definitions of the contents of the professional activity than of those of the time of the action. It is first the urgency of the patient who has to confront those of others: "People who do not take into account emergencies" (obs 327) and the organization of work. The patient is one of the others and the perception of his urgency has to accommodate the institutional and professional temporalities of management: "In most cases, people do not understand the concept of waiting and that everyone has problems and we, in turn, are human beings "(obs 465). As this last verbatim underlines, behind the confrontation of the definitions of temporalities, the reification of the other in the interactions takes shape. The patient risks being transformed into an object of care when the professional risks being summed up in instrument of a medical treatment and some try to resist it. In this context, professionals may fear "contact with users who are often nervous because they have to wait" (obs 298). A fear tinged with regret when one knows that one does not have "enough time to listen to each patient" (obs 352).

It is also the demand of the users which is evoked like cause of the degradation of the interactions:

"It happens in the emergency room that a patient requests a non-existent hospital service and then becomes angry because he absolutely wants to be admitted to this hospital" (obs 81). What is denounced is a service relationship that seems to take the form of a relationship of servitude (Jeantet, 2003) with respect to a patient demanding perfection of service rendered and the absence of hazards: "The frustration of a patient who when I took the blood sample was stung many times" (obs 286). These demands of the patient become for some what they like the least in their profession which is reflected in a denunciation of "unjustified complaints". "Sometimes exaggerated demands" (obs 39) are all the more difficult to bear because they return to the feeling of a lack of consideration: "The result of my work is not always considered" (obs 161).

The emotional burden related to the specificities of the professional activity also intervenes in the conflict: "It is impossible to save the life of a 78-year-old person seriously ill with cancer. His family blamed us for his death and from there began a long series of threats and insults against all personnel "(obs 468). The situation engages on the one hand the exceptional, the pain and the intimacy, and on the other hand, the daily life and the professional activity, the public relation. If the situation of the patient is constituted for him in break of the daily order of things (Berger and Luckmann, 1986), it is constituted in routine for the staff of which it represents the daily life of the activity. The integration of the routine breakdown of the user charged with affects in the daily life of the professional who tries to push back these affects, thus sometimes engages on conflicts and reactions of the user or his relatives who victimize the staff.

Thus the reported victimization give to see the perspective of differences between users and professionals. These can be divided into three categories declining attitudes of users and nature of the conflict:

- Illegitimate users and conflicts of use referring to incidents linking user requests and disqualification by staff.
- Demanding users and service conflicts referring to incidents that link a gap between user expectations and professional practices.
- Proven users and emotional conflicts between a user struggling with a break in the daily order of things and a staff engaged in daily activities.

Whether violence is read as belonging to uses considered illegitimate or as a result of misunderstanding of care or attributed to the demands of users, the analysis of situations reveals these conflicts of perspective (Freidson, 1984) and interests. Divergent in a logic that is confronting each other.

These differences, falling within the scope of the service relationship, can be duplicated by social and ethnic differences. Ethnicity or the social category of the patient will thus be mentioned in several accounts of victimization.

Thus a staff says in its preamble victimization narrative: "The most common situations of violence occur in hospitalized patients who are part of social assistance" or appropriate for other specify "I was verbally and physically assaulted by a patient of another ethnic origin."This is both the cultural shift that will be mentioned as an explanatory factor".

Patients with culture and education frustrated with offensive and threatening behaviour" (481 obs.). And a diversion of socially situated use:" the street people no longer want to leave the hospital "(234 obs.).

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These conflicting perspectives are exacerbated or appeased depending on the organization - service, unit, institution - and how it works.

2. ORGANIZATIONS, CONFLICTS AT WORK AND VICTIM EXPRESSION

The Romanian health system has embarked on a transition since the change of political regime in 1989, and the accession, in 2007, to the European Union. Before 1989, the Romanian health care system was organized according to a Soviet model, centralized, with public funding and free access for nationals. The staffs are civil servants and the establishments are integrated into the state apparatus. The reforms after the revolution led to the denationalization sector in a liberal direction.

This denationalization was first recorded in a double sense: private funding to replace public funding and privatization of the sector to first focus on the medical and dental exercise, and medication. The policy priority has yet been given to the rehabilitation of the installations, which in the early 1990s were not ready to receive patients. This emergency policy was accompanied by a heavy reliance on foreign aid (Letourmy, 1998), humanitarian aid still play a role today. Since joining the European Union, the reform of the Romanian health system must continue according to the National Strategy for Health 2014-2020 and the multi-annual plan for the strategic development of human resources for health 2017-2020, condition for access to European funding. These changes are a source of tension facing a liberal system, which not only did not end in a parallel economy, even if it fell or significantly improved working conditions, but also exacerbated the inequalities of access to care. Despite an increase, funding for health remains the lowest in the EU and the emigration of health professionals is massive (French Embassy in Romania, 2017). For the professionals who stayed in Romania, these changes are a source of new competition, between professionals, between departments and between institutions. The professionalization of health personnel has also been transformed by European and international professional standards (Popovici, 2013), leading also to changes in care work. These changes are conducive to role conflicts in a system of recomposition, especially in the case of care requiring coordination between several professionals, statutes, specialties and different services. This "work of articulation" (Strauss, 1985), when it is not satisfactory, appears favourable to the development of conflicts at work. The following verbatim response to the question of expectations that professionals have towards their establishment to accomplish their work suggests such difficulties: the respondent wishes and the direction helps to create "a better relationship between services" (obs 118).

This professional activity takes multiple forms, actualizing itself by more or less valued tasks, ranging from tasks leading to the manipulation of advanced techniques to cleaning patients, this differentiation of tasks and their valorisation being closely associated with the status of professionals: doctors, nursing assistants

and nurses. The social valuation is also realized according to the differentiations made with the users and the social groups to which they are identified: from the users of social milieus raised to the stigmatized groups (the "homeless", the "social cases" or the "Roms"); depending on the pathologies involved: from the "good case" to stigmatized diseases such as alcoholism, or perceived as dangerous, such as AIDS; depending on the type of service: advanced services (surgery, medicine) to psychiatry, geriatrics or emergencies; also depending on the exercise facility and its reputation. Hughes (1984) shows that the prestige of professionals is the result of a "moral division of labor", each seeking both to be more self-reliant and to delegate "dirty work" to others. Especially to junior employees. This "moral division of labor" is not done smoothly in a health system in profound transformation. His clashes appear in the declarations of violence: more than one in five takes the form of conflict at work. Some of them look to see voltage lines of authority. A doctor evokes a "hierarchical nature of Conflict" (236 obs.) By explaining: "People who arrive in positions that do not have the skills". However unlike situations involving users, responses to open-ended questions when they relate to labor relations and practices are rare and usually suggestive, not to indicate on what specific aspects of the profession are grafted conflict. The role of the organization and conflicts at work on the users was identified very early in the scientific literature. Stanton and Schwartz (1954), studying the psychiatric hospital, thus make the link between disorders in the medical social environment, more precisely latent disagreements between members of the hospital team and certain pathological manifestations. The contradictory instructions on their treatment, or the conflicts they crystallize, disrupt the patients. In addition, an environment marked by conflict at work, and more generally by labor relations deteriorated due to poor working conditions, does not appear conducive to the development of good relations with users. Moreover, this context favors a victim expression. The principal components analysis (see figure 2) makes it possible to visualize, by the greater or lesser proximity of the variables, the determining role of the organization, not only in the declaration of victimizations but also in the relation with the users. Axes 1 and 2 explain 76% of the variance. Axis 1 brings up another element that has not yet been mentioned: recognition, a recognition that is the opposite of the professional feeling of the organization's inability to manage internal conflicts. These two dimensions draw different career paths (figure 1). Professionals who feel recognized want to evolve in the profession, while others say they want to change service or even change jobs. Verbatim shows a demand for recognition of "efforts" or "merit". As evidenced by the answers to the open questions, it must focus particularly on changes in working conditions, the demand for equipment being first, followed by additional staff and an increase in wages. The situation engages on the one hand the exceptional, the pain and the intimacy, and on the other hand, the daily life and the professional activity, the public relation. If the situation of the patient is constituted for him in break of the daily order of things (Berger and Luckmann, 1986), it is constituted in

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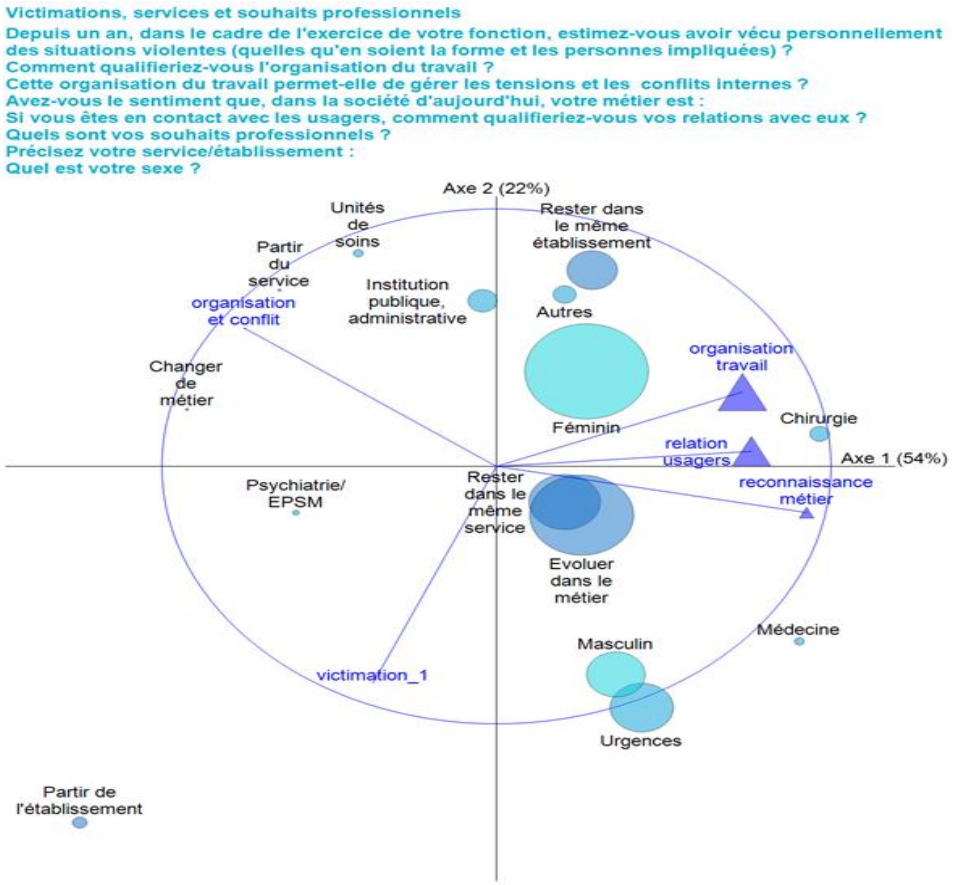

FIGURE 1 - VICTIMIZATION AND ORGANIZATIONS
Source - Own work in the Sphinx Survey software

Thus, reported victimizations reveal divergences of perspective between users and professionals. These can be divided into three categories declining user attitudes and nature of the conflict:

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These differences, falling within the scope of the service relationship, can be duplicated by social and ethnic differences. Ethnicity or the social category of the patient will thus be mentioned in several accounts of victimization. Thus, a staff member states in the preamble to his victimization story: "The most frequent situations of violence occur in hospitalized patients who are on social assistance" or that it is appropriate for others to specify "I was verbally and physically assaulted by a patient of another ethnicity". It is at the same time the cultural shift that will be mentioned as an explanatory factor: "Patients with a culture and education that are frustrated with offensive and threatening behavior" (obs 481) and a misuse of socially situated people in the street do not want to leave the hospital anymore "(obs 234).

These conflicting perspectives are exacerbated or appeased depending on the organization - service, unit, institution - and how it works.

CONCLUSION

In order to identify the root causes and to find solutions later, some researchers recommend the implementation of a system of reporting cases of violence in hospitals in Romania and the collection of data in Romania, to transmit incident reports, but also to create databases relevant to support the needs of the current medical system (Pricop et al, 2016).

But there are also voices who believe that the sensitivity and vulnerability of European countries during the crisis could help decision-makers identify effective measures to strengthen their states' capacities to protect themselves in the event of a future economic and social crisis, including in the fight against violence in the healthcare sector (Alonso et al, 2016).

In appearance, a first solution could come from the private sector. Recent research in hospitals in Romania shows that more than 77% of patients are satisfied with the services provided by private clinics (Androniceanu, 2017). But does not this have the effect of accelerating and increasing the constraints on the public sector? Constraints to adapt to this new economic situation with a scope of missions broader than the private sector and missions appearing to professionals more distant from their core business? A situation that would exacerbate the tensions related to the conflicts of outlook that our research reveals.

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