





Adding injury to insult: Unfair treatment at work and occupational injury among hospital patient-care workers

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Abstract

Background: Hospital patient-care workers have high occupational injury rates. While physical hazards within hospital work environments are established determinants of injury, social exposures may also contribute. This study examined how reports of unfair treatment at work, a dimension of work-related experiences of discrimination, were associated with injury among hospital-based patient-care workers.

Methods: We used data from the Boston Hospital Workers Health Study, a longitudinal cohort of nurses and nursing assistants at two Boston-area hospitals. In 2018, we conducted a worker survey asking about three types of unfair treatment at work and occupational injuries during the past year. We used mixed-effects logistic regression models to evaluate associations between specific types, total load, and high-frequency exposure of unfair treatment with injury, adjusting for age, gender, race and ethnicity, job title, and unit type.

Results: Among 1001 respondents, 21% reported being humiliated in front of others at work, 28% reported being watched more closely than other workers, and 47% reported having to work twice as hard as others for the same treatment. For each type of unfair treatment, we observed a monotonic relationship with occupational injury wherein increasing frequency of exposure was associated with increased odds of injury. We also observed monotonic relationships between total load and high-frequency exposure to unfair treatment and odds of injury.

Conclusions: Work-related unfair treatment is associated with injury among hospital workers. Programs and policies that focus on preventing unfair treatment may lessen injury burden in hospital workers.

KEYWORDS

healthcare workers, hospitals, mistreatment, occupational injury, workplace discrimination

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1 | INTRODUCTION

Nonfatal injury is a substantial occupational health burden for hospital-based healthcare workers.¹ Healthcare workers experience nonfatal injury rates higher than those of industries commonly perceived as physically dangerous, including construction, agriculture, and manufacturing.² The wide range of risks these workers experience on the job—including violence from patients and visitors, patient lifting and repositioning, and sharps exposure—contribute to this burden.^{3–5} Increasingly, occupational psychosocial stressors have also been recognized as risk factors for injury among nurses.⁶ In the present study, we evaluated the extent to which experiences of unfair treatment at work (a dimension of job discrimination) were associated with self-reported injuries among hospital nurses and nursing assistants.

1.1 | Literature review

1.1.1 | Interpersonal mistreatment at work and health

Interpersonal mistreatment at work occurs when an individual is singled out as the target of discrimination, bullying, incivility, or harassment while working.⁷ It is distinct from other forms of workplace stress (e.g., high workload, low control over work) because mistreatment is not considered to be a general feature of the work environment that applies to all workers in a given unit or job type. However, workplaces that are poorly managed or are excessively hierarchical can create conditions in which mistreatment may be more likely to emerge or go unchecked.⁸ Unfair treatment at work, particularly when an individual perceives this treatment is due to their race, sex, sexual orientation, or other individual characteristics, has been linked with a wide range of adverse health outcomes, including poorer self-rated health,⁹ mental health,¹⁰ sleep,¹¹ increased risk of chronic disease,¹² and substance use.¹³

1.1.2 | Mistreatment as a risk factor for occupational injury

In addition to evidence of broad health effects of mistreatment at work, studies have found associations between mistreatment at work (e.g., bullying, sexual harassment, incivility) and occupational injury.^{14–17} Several theoretical models have proposed pathways and mechanisms underlying these associations,^{18–20} suggesting that workplace stressors can increase risk of occupational injury through four primary mechanisms: muscular tension,²¹ fatigue and sleep disruption,²⁰ adrenaline and pain diversion,^{22,23} and cognitive distraction and decreased concentration.²⁴ In addition, excess stress can dampen immune responses, thereby impeding injury healing.²⁵ While interpersonal stress and lower social support at work has been consistently associated with greater risk of occupational injury,^{26,27}

higher levels of social support have been found to increase reporting of injury and critical incidents.²⁸ Therefore, associations between interpersonal stressors at work and occupational injury may be underestimated.

Few studies have investigated whether mistreatment that is perceived to be rooted in discrimination²⁹ is associated with occupational injury.^{30,31} Although two studies found that experiences of discrimination are associated with increasing risk of occupational injury, both have limitations related to exposure assessment. Ibekwe et al. measured general life discrimination rather than work-specific discrimination, while Shannon et al. asked only about race-related discrimination at work and used a single item to measure race-based discrimination. Therefore, more evidence is needed about whether a range of specific experiences of unfair treatment at work, perceived to be related to one's identity or identities, are risk factors for occupational injury.

1.2 | The present study

The present study aimed to evaluate whether reported work-related unfair treatment was associated with occupational injury in a cohort of hospital-based patient-care workers. We hypothesized that frequent exposure to three specific types of unfair treatment at work, as well as increasing load of experiences, would be positively associated with occupational injury.

1.3 | Conceptual framework

This study draws on a conceptual model for the relationship between work and health that was developed within the framework of Total Worker Health[®].^{32,33} It posits that *conditions of work*, including the psychosocial work environment (here, experiences of unfair treatment at work) are core determinants of worker health and well-being (here, occupational injury). This conceptual model contrasts with traditional biomedical and health promotion models that place responsibility for safety and health at work on individual workers.

While our study does not account for factors outside the workplace, the conceptual model makes explicit that working conditions, such as experiences of discrimination, are shaped by employment and labor market patterns that determine job availability, benefits, pay, and job stability. In this study, relevant employment patterns include shortages of patient-care workers (nurses and nonnurses) that predated the COVID-19 pandemic,³⁴ and were exacerbated in its wake.³⁵

Finally, organizational conditions of work and the labor market are shaped by social, economic, and political factors—ranging from globalization, social inequalities, and the regulatory environment—that affect the ways that people work. Furthermore, those factors at the macro-social level—for example, systemic racism in the United States—shape the types of work that people are trained to do, and the psychosocial exposure profiles of their jobs once they are

employed.^{36–38} Therefore, while the present study examines interpersonal forms of unfair treatment, our framework's inclusion of contextual factors helps us identify that unfair treatment at work occurs within an ecosystem of structural and institutional racism as well as other forms of unfair treatment.³⁹

2 | METHODS

2.1 | Study population

Data were drawn from the Boston Hospital Workers Health Study (BHWHS), a longitudinal cohort study of nurses and nursing assistants at two large hospitals in Boston. Details about the cohort structure and composition are available elsewhere.⁴⁰ Briefly, all nurses and nursing assistants at the hospitals were automatically enrolled in the cohort, and their administrative data (e.g., payroll and occupational health) became part of the project database on an ongoing basis. Periodically, we have surveyed a subset of workers to supplement administrative data. In October 2018, we sent one such worker survey that included questions about work-related unfair treatment, injury, and various other demographic, occupational, and health and well-being related constructs to 2000 workers at their institutional email address, representing 1/3 of all nurses and patient-care associates (PCAs; low-wage nursing assistants) at the two hospitals. Within the eligible job titles, criteria for inclusion were working at least 20 h per week over the 3 months before sampling. After three email reminders and a mailed paper survey that we sent to nonrespondents, 1101 workers responded (response rate 55%). After excluding respondents with data missing on key variables, 1001 workers from 91 distinct hospital work units were included in analyses. The study was approved by Mass General Brigham Institutional Review Board. Survey respondents indicated informed consent electronically before beginning the survey.

2.2 | Measures

2.2.1 | Exposure: Experiences of unfair treatment at work

We used the “treated unfairly on the job” subscale from the short form of the Chronic Work Discrimination and Harassment scale.⁴¹ Although the measure was constructed and validated in a cohort of Black Americans, the questions we used do not ask about race-based discrimination specifically. The subscale includes three questions: “Here are some situations that can arise at work. Please tell me how often you have experienced them during the past 12 months.” (1) *How often do you feel that you have to work twice as hard as others to get the same treatment or evaluation?* (2) *How often are you watched more closely than other workers?* (3) *How often are you unfairly humiliated in front of others at work?* Response options for each question were: “never,” “less than once a year,” “a few times a year,”

“a few times a month,” and “a few times a week.” For each of the three items, for ease of interpretation, we collapsed response options into three categories: never; infrequently (less than once a year, a few times a year); and frequently (a few times a month, a few times a week).

Prior research on interpersonal mistreatment at work (e.g., bullying and harassment) has found that total load of these experiences, in addition to the intensity of each experience, is associated with risk of occupational injury.^{11,16,42} We, therefore, created two summary variables across the three forms of unfair treatment reported. The first summary variable (hereafter, “total load”) counted the different types of unfair treatment that a participant ever reported experiencing (never vs. less than once a year or more; range: 0–3). The second summary variable reflected the number of experiences that were high-frequency (i.e., occurring a few times a month/a few times a week vs. never/less than once a year/a few times a year). The result was a 3-level ordinal variable of high-frequency exposures, where we collapsed the upper categories due to a low number of participants with high-frequency exposure to two types ($n = 35$) or three types ($n = 30$) of work-related unfair treatment (0 = 0 types of high-frequency exposure; 1 = 1 type of high-frequency exposure; 2 = 2 or 3 types of high-frequency exposures).

2.2.2 | Outcome: Occupational injury

We measured occupational injury with two survey questions: “Have you had a sharps injury in the past 12 months?” and “During the past 12 months, excluding sharps injuries, were you injured seriously enough while performing your job that you got medical advice or treatment or lost time from work?” These questions align with the definition of an OSHA-recordable injury,⁴³ and have been used in previous studies.⁴⁴ If participants responded “yes” to either question, they were coded as having an injury.

Given that our primary exposure was experiences of unfair treatment at work, and that feelings of being unsupported at work may result in unwillingness to formally report an injury to the employer,²⁸ we opted to use self-reported injury as our primary outcome instead of administratively-reported injury. In sensitivity analyses, we used administrative data on injury reports from the hospitals' occupational injury database, matched to individuals' survey responses using secure study ID numbers. To capture a parallel injury construct to the question asked on the survey, and given that the survey was fielded over a 4-month period, our administrative injury measure reflected whether a survey respondent had filed a report for an OSHA-recordable injury in the year before the date they completed the survey.

2.3 | Covariates

We selected covariates that were potentially associated with both occupational injury and unfair treatment, and that were not

hypothesized to occur along a potential causal pathway from unfair treatment to injury. We included age (<30, 30–39, 40–49, ≥50 years), gender (woman vs. man), race and ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic or Latinx, Asian or Pacific Islander, mixed race or other), job title (staff nurse, PCA, and other), and unit type. All covariates were self-reported on the worker survey.

2.4 | Statistical analysis

We used mixed-effects logistic regression models to estimate odds ratios (OR) and 95% confidence intervals (CI) for associations between reported work-related unfair treatment and self-reported injury in the past 12 months. We modeled each type of unfair treatment separately, then modeled (a) the total load ever experienced and (b) the number of experiences at high-frequency, both unadjusted and adjusted for covariates. Hospital units in which people worked were specified as random effects in all models given potential nonindependence of observations due to a shared work environment.

2.5 | Sensitivity analyses

We repeated all analyses, replacing self-reported injury with individuals' administratively-reported injuries from the hospital database in the year before the survey as the outcome (see Measures: Outcome above).

3 | RESULTS

The analytic sample included 1001 participants, evenly distributed across age groups (Table 1). Most of the sample self-identified as women (92%) and non-Hispanic White (79%). Ten percent identified their race and ethnicity as non-Hispanic Black, 4% as Hispanic or Latinx, and 3% as Asian American or Pacific Islander. The sample was predominately nurses (83%), followed by PCAs, a low-wage worker group (12%) and those with other titles, such as clinical nurse specialist (5%).

Frequency of occupational injury varied across social and demographic characteristics. Across the sample, 9% ($n = 86$) of participants self-reported that they had an injury in the year before the survey. The injured proportion was higher for workers aged 50 and older (10% injured) compared with those aged 30–39 (6% injured); for men (13% injured) compared with women (8% injured); for non-Hispanic Black workers (11% injured) and Asian or Pacific Islander workers (13% injured) compared with non-Hispanic White workers (8% injured).

When we examined the distribution of experiences of unfair treatment, the most frequently endorsed item was “How often do you feel that you have to work twice as hard as others to get the same treatment or evaluation?” (Figure 1A). Twenty-seven percent reported that this occurred infrequently (less than once a year, a few

TABLE 1 Social and demographic characteristics of total sample ($N = 1001$) and proportion self-reporting an injury.

	<i>n</i>	Percent	<i>N</i> injured	Percent injured
Age				
Younger than 30	269	27	24	9
30–39	284	28	18	6
40–49	175	17	16	9
50 or older	260	26	26	10
Missing	13	1		
Gender				
Woman	919	92	76	8
Man	69	7	9	13
Missing	13	1		
Race and ethnicity				
Non-Hispanic White	791	79	65	8
Non-Hispanic Black	99	10	11	11
Hispanic/Latinx	39	4	3	8
Asian/Pacific Islander	31	3	4	13
Mixed race/other	16	2	3	19
Missing	25	3		
Job title				
Staff Nurse	833	83	70	8
Patient Care Associate	119	12	11	9
Other	47	5	5	10
Missing	2	0		

Note: Of the total sample of 1001 workers, 86 (9%) self-reported that they had an injury the year before the survey.

times a year) and 20% reported that it occurred frequently (a few times a month, a few times a week). On the item “How often are you watched more closely than other workers?,” 19% of participants reported infrequent exposure and 9% reported frequent exposure. The least endorsed item was “How often are you unfairly humiliated in front of others at work?,” with 17% experiencing this infrequently and 4% frequently.

We then counted experiences of unfair treatment at work that each participant reported (Figure 1B). When we used ever exposed (a few times a year or more) as our metric, nearly half (46%) reported none of the three types of unfair treatment, about one-quarter (24%) reported one type of unfair treatment, 16% reported two types of unfair treatment, and 13% reported experiencing all three types of unfair treatment. When assessing high-frequency unfair treatment (a few times a month or more), 77% reported no high-frequency exposure, 16% reported high-frequency exposure to one type of unfair treatment, 4% to two types of unfair treatment, and 3% to all three types.

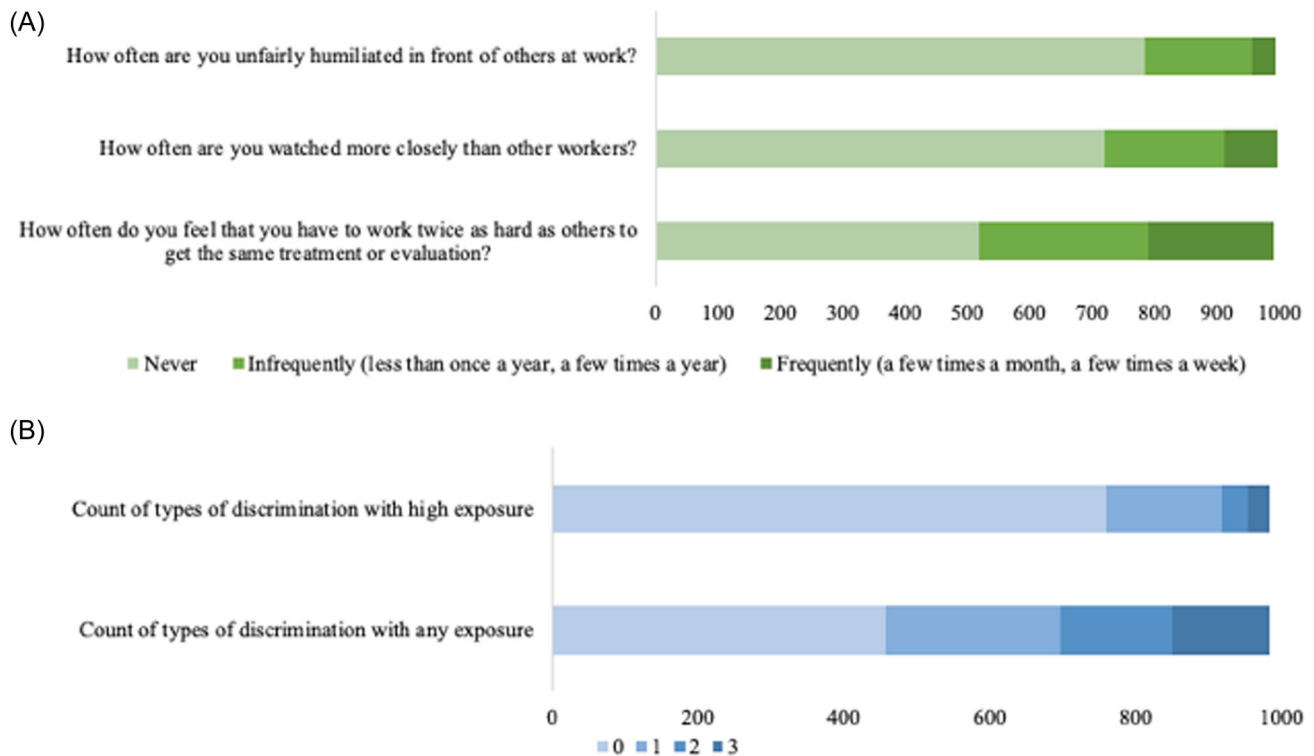


FIGURE 1 Distribution of experiences of work-related unfair treatment in the Boston Hospital Workers Health Study (BHWHS) cohort. (A) Frequency of exposure to each type of work-related unfair treatment. (B) Count of work-related unfair treatment experienced. Any exposure was defined as occurring less than once a year, a few times a year, a few times a month, or a few times a week (vs. never). High-frequency exposure was defined as occurring a few times a month or a few times a week (vs. never, less than once a year, or a few times a year).

For the experience of having to work twice as hard as others to get the same treatment or evaluation, we did not observe a statistically significant increased odds of self-reported injury for infrequent exposure (OR 1.47; 95% CI 0.85, 2.55) or frequent exposure (OR 1.45; 95% CI 0.78, 2.70) (Table 2). While the odds of self-reported injury with infrequent exposure were not significantly associated with reports of being watched more closely at work (OR 0.89; 95% CI 0.46, 1.74), frequent exposure to this experience was associated with increased odds of self-reported injury (OR 2.26; 95% CI 1.13, 4.51). Infrequent exposure to the experience of being unfairly humiliated in front of others at work was associated with elevated odds of self-reported injury, although the CI included the null (OR 1.46; 95% CI 0.81, 2.63); frequent exposure to this experience was associated with increased odds of self-reported injury (OR 2.73; 95% CI 1.05, 7.08). Thus, for both of the latter types of work-related unfair treatment, we observed a dose-response pattern, wherein frequent exposure (a few times a month, a few times a week) was associated with significantly greater odds of self-reported injury compared with no exposure.

When evaluating the impact of total load (i.e., number of different types of work-related unfair treatment ever experienced) on self-reported injury, we observed monotonic associations (Table 3). Compared with no experience of unfair treatment, experiencing one (OR 1.07; 95% CI 0.58, 1.99) or two types (OR

1.20; 95% CI 0.60, 2.41) were somewhat associated with self-reported injury, while experiencing all three types was associated with increased odds of injury (OR 1.99; 95% CI 1.03, 3.87).

We observed a similar pattern with high-frequency exposure to unfair treatment; an increase in the number of experiences was progressively associated with greater odds of self-reported injury (Table 3). Experiencing one type of high-frequency unfair treatment, compared to zero high-frequency experiences, was not significantly associated with self-reported injury (OR 1.48; 95% CI 0.80, 2.75). However, experiencing two or three types of unfair treatment at high-frequency was associated with a 159% increase in the odds of self-reported injury (OR 2.59; 95% CI 1.20, 5.57).

In sensitivity analyses, we repeated analyses replacing self-reported injury with administratively-reported injury in the year before the survey (Supporting Information: Tables 1 and 2). Administratively-reported injury was less common overall, with a prevalence of 5% across the sample compared to 9% for self-reported injury. Associations using administratively-reported injury were similar in direction, magnitude, and significance to the models using self-reported injury as the outcome, though in some cases less precise. Additionally, all dose-response patterns that we observed between experiences of unfair treatment (either total load or high-frequency exposure) and self-reported injury were mirrored in models using administratively-reported injury.

TABLE 2 Association between frequency of *specific types of work-related unfair treatment* and self-reported injury.

	Crude OR (95% CI)	Adjusted ^a OR (95% CI)
<i>Having to work twice as hard as others to get same the treatment or evaluation</i>		
Never	(Ref)	(Ref)
Infrequently (less than once a year, a few times a year)	1.45 (0.85, 2.50)	1.47 (0.85, 2.55)
Frequently (a few times a month, a few times a week)	1.39 (0.77, 2.52)	1.45 (0.78, 2.70)
<i>Watched more closely than other workers</i>		
Never	(Ref)	(Ref)
Infrequently (less than once a year, a few times a year)	0.87 (0.46, 1.67)	0.89 (0.46, 1.74)
Frequently (a few times a month, a few times a week)	2.13 (1.09, 4.16)	2.26 (1.13, 4.51)
<i>Unfairly humiliated in front of others at work</i>		
Never	(Ref)	(Ref)
Infrequently (less than once a year, a few times a year)	1.28 (0.71, 2.30)	1.46 (0.81, 2.63)
Frequently (a few times a month, a few times a week)	2.34 (0.94, 5.80)	2.73 (1.05, 7.08)

^aAdjusted for age, gender, race and ethnicity, job title, and hospital unit. Units were specified as random effects to account for clustering.

TABLE 3 Association between count of types of work-related unfair treatment and self-reported injury.

	Crude OR (95% CI)	Adjusted ^a OR (95% CI)
Number of different types ever experienced		
0 types (ref)	(Ref)	(Ref)
1 type	1.07 (0.58, 1.95)	1.07 (0.58, 1.99)
2 types	1.26 (0.64, 2.47)	1.20 (0.60, 2.41)
3 types	1.72 (0.90, 3.28)	1.99 (1.03, 3.87)
Number of types experienced at high-frequency ^b		
0 types (ref)	(Ref)	(Ref)
1 type	1.47 (0.82, 2.66)	1.48 (0.80, 2.75)
2 or 3 types	2.34 (1.16, 4.90)	2.59 (1.20, 5.57)

^aAdjusted for age, gender, race and ethnicity, job title, and unit type. Unit IDs specified as random effects to account for clustering;

^bHigh-frequency was defined as occurring a few times a month or a few times a week (vs. never, less than once a year, or a few times a year).

4 | DISCUSSION

In this study, we evaluated the extent to which three types of work-related unfair treatment were associated with self-reported injuries among nurses and nursing assistants at two large hospitals. We observed increased frequency of specific types of experiences (particularly being unfairly humiliated in front of others and being watched more closely than other workers) was associated with progressively greater odds of injury at work. We also found that odds of injury increased monotonically with increasing burden of experiences of unfair treatment at work.

4.1 | Potential explanations for observed associations

Several theoretical models have proposed biological mechanisms that could explain associations between unfair treatment at work—particularly unfair treatment that the individual experiences to be rooted in an aspect of their identity—and occupational injury. First, stereotype threat occurs when an individual from a marginalized group fears being judged according to a stereotype; that fear can elicit reactive behaviors that undermine the individual's performance and inadvertently lead the individual to conform to the stereotype.⁴⁵ In the present study, a worker who feels that they are being “watched more closely than other workers” (reported by 28% of the sample) might sense that the person watching them (e.g., supervisor, coworker) is expecting them to make a mistake because they perceive the worker to be unskilled or incapable of the task at hand. Additional performance pressure exerted by this scrutiny could lead the worker to cognitive distraction that could, for example, result in a sharp injury to the worker.²⁴

Physiological and psychological responses to acute stressors may also help explain observed associations with injuries, especially in a physically demanding work environment such as a hospital. Experiences of acute stress—for example, being unfairly humiliated in front of others at work—can lead to muscular tension and tightening.²¹ Tense muscles are more susceptible to injury when performing physical tasks common in healthcare settings, such as lifting or moving a patient.^{6,46} Another explanation is that adrenaline released during episodes of acute stress can dull pain perception, leading individuals to inadvertently exert themselves beyond their pain threshold and develop a musculoskeletal injury as a result.^{22,23,47} Finally, high emotional loads and emotional dissonance created by

experiences of unfair treatment can result in distress, distraction, and emotional exhaustion, all of which may be risk factors for injury.⁴⁸

We observed that for the other two types of unfair treatment—“being unfairly humiliated in front of colleagues” and “being watched more closely than others”—frequent exposure was associated with greater risk of injury. As noted above, having to work twice as hard as others did not have a similar association with injury as the other two types of unfair treatment at work we measured. Having to work twice as hard is characterized by the worker's *response* to experiences of unfair treatment, while the first two experiences are characterized by others' *direct behavior* toward the worker.¹⁶ Given the physiological pathways that we hypothesized (e.g., muscular tension and cortisol release), it is perhaps not surprising that direct and overt experiences of unfair treatment at work are more strongly associated with injury.

4.2 | Contribution to the evidence base

These findings contribute to the occupational health literature in several ways. First, the questions about unfair treatment at work are a subscale of a measure of job discrimination.⁴¹ Discrimination is a unique exposure in that perpetrators frequently draw upon negative stereotypes of the marginalized group of which the victim is a member. While we did not analyze individuals' perceived reason for mistreatment, the questions we asked included having to work twice as hard as others for the same reward; being watched more closely than other workers; and being unfairly humiliated in front of others. These particular questions reflect negative stereotypes of laziness, untrustworthiness, and incompetence that workers may have experienced both on and off the job based on factors such as their age, gender, or race and ethnicity. Chronic exposure to mistreatment, stemming from these stereotypes, may carry acute and chronic physical, physiological, and psychological consequences for victims.^{49–51}

Findings also add to epidemiologic evidence on the range of health effects associated with experiences of unfair treatment at work. Experiences of unfair treatment, particularly when such mistreatment is perceived to be rooted in discrimination, is associated with adverse physical and psychosocial health outcomes for workers in both occupational cohorts and population-based studies; these outcomes include substance misuse, self-rated health, and depression.^{12,38,52,53} Each of the latter conditions have complex etiology and may develop over a long time period, with multiple risk factors in both occupational and nonoccupational settings. Thus, establishing a direct link between discrimination on the job and these outcomes can be challenging. In contrast, occupational injury is usually an acute event, with an identifiable proximal cause. As a result, occupational injuries are spatially and temporally tied to workplace experiences and exposures, making potential pathways between work experiences (e.g., discrimination) and injury clearer. Although factors such as family-to-work spillover or working multiple jobs can predispose some worker groups to occupational injury,^{54,55} the proximal cause of a given occupational injury still lies within the workplace.

4.3 | Limitations and strengths

Our study has several limitations, mainly related to our measurement of unfair treatment at work. The measure contained only three items. It is possible that with a more nuanced measure, we would be able to further understand mechanisms and pathways between workplace discrimination and injury. We were also not able to differentiate between health effects of unfair treatment based on the source of perpetrator (e.g., colleague and patient) or the participant's perceived reason for this treatment (e.g., race, gender, age, job type, sexual orientation or gender identity, and weight). Although we asked individuals to name their primary perceived reason for experiences of unfair treatment, the number of responses to each category was small. The questions themselves also have limitations. In a workplace context, it is possible that a worker could be watched more closely than other workers for nondiscriminatory reasons, for example because they are new. As in other measures of psychosocial workplace exposures, the questions ask about subjective perceptions of experiences such as humiliation, versus the presence or absence of a given exposure.

Our study uses a self-reported measure of work-related injury, in keeping with prior findings that self-reported injuries may be a more accurate way to assess injury history in minoritized populations, compared with administratively-reported injuries.⁴⁴ Given limitations of self-reported data, a strength of our study is our sensitivity analysis in which we repeated the analyses with administratively-reported injury over the same time period as our outcome. The similarity of unfair treatment-injury associations in both sets of analyses reduce suspicion that findings are attributable to common-method bias. However, the study carries limitations common to all cross-sectional studies, namely reverse causation and confounding (i.e., that poorly managed workplaces result in higher levels of unfair treatment *and* higher injury rates).

4.4 | Next steps in research and practice

In helping and service professions, unfair treatment at work (including discrimination) can result from both within the organization (e.g., managers and coworkers) or from those who receive care or services from these workers (e.g., clients, patients, and customers). Discrimination and other forms of mistreatment of workers by coworkers can be addressed through human resources actions or by addressing organizational dynamics that allow mistreatment to occur, although there are many barriers to such actions.

A perceived challenge to intervention on discrimination and mistreatment in healthcare settings is that many instances of worker mistreatment originate from patients or patients' visitors.⁵⁶ These instances of mistreatment have escalated in the wake of the COVID-19 pandemic.^{3,57,58} Direct sanctions are often not possible when patients are perpetrators, especially if patients are dysregulated or not fully in control of their faculties. Healthcare workers are less willing to report negative acts perpetrated against them by patients

when they feel that nothing will change as a result of the reporting, when reporting systems are too complex, or when workplace aggression by patients is normalized as being part of the job.^{59,60} Nonreporting, or reporting that remains within clinical channels (e.g., documentation in the medical record) may render a problem invisible. High-profile incidents of worker mistreatment and physical harm by patients during the COVID-19 pandemic have countered that invisibility, and in some cases has led to institution-level policy responses, such as empowering workers to walk away from abusive patients or visitors and ask a colleague to step in instead.⁶¹

5 | CONCLUSIONS

Our findings suggest that unfair treatment at work, a component of job discrimination, is associated with injury among hospital patient-care workers. However, acts of unfair treatment and their downstream effects on worker health and well-being, are not inevitable. It is possible to create and implement organizational policies supporting the reporting of patient violence and aggression and acting on those reports. Ideally, these policies and practices could help mitigate the negative health impacts of such episodes, including occupational injury.

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Data contain confidential employee records and cannot be made public.

ETHICS APPROVAL AND INFORMED CONSENT

The study was approved by Mass General Brigham Institutional Review Board. Survey respondents indicated informed consent electronically before beginning the survey.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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