

Workplace Violence Against Junior Doctors in Iraq: Implications for Job Satisfaction and Retention

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Abstract

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Introduction: Previous quantitative research has suggested the majority of physicians report being exposed to workplace violence. A 2013 study of 567 Iraqi-trained physicians found nearly 2/3 had emigrated to mostly English-speaking countries; further, half of those remaining wished to leave Iraq. Prior studies on violence against Iraqi health care workers have been conducted, but none have used qualitative methods to describe motivations and implications to understand this phenomenon.

Methods: We consented and interviewed 73 junior physicians at six teaching hospitals across Central Iraq between December 2021, and January 2022. After selecting the transcripts with the most vivid narrations, we analyzed 22 interviews in depth.

Results: The physicians we interviewed had been practicing an average 3 years since graduating from medical school (ranging from 6 months to 7 years). Interviewees represented

eight hospital departments, with most coming from internal medicine and surgery. Half the group had never worked in a facility different from their current one.

We found the structure of the medical care system creates a sense of scarcity, which generates high emotions as patients compete for attention, supplies and space. Further, the public doesn't fully understand the concept of triage, explaining anger at delays in receiving health care services. The structure of the medical education pipeline generates doctors who are quite young, may not be fully prepared for these challenging roles, and lack skills and authority to respond in the moment to attacks. Doctors believed family attacks persist because patient families are not facing legal consequences. Doctors who are targets of violence reported experiencing mental health problems, including depression and loss of self-esteem, and contemplated leaving their positions. Doctors also experienced regret for choosing a career in medicine, as well as a need to leave the country.

Conclusion: Young, inexperienced junior doctors in Iraq are bearing the brunt of patient frustrations with the scarcity of resources in the health system. Hospitals would likely improve the job satisfaction of junior physicians, and their longevity in the health system, by attending to this problem. A long legacy of armed conflict in Iraq has planted seeds of violence in everyday human interactions.

Background

Decades of brutal violence caused by civil wars (1) and international invasions (2), have caused Iraq's health care systems to be in disarray. The country faces severe shortages of critical medical supplies, including oxygen tanks, medications, and vital medical equipment. (8, 9) Doctors remain underpaid, and Iraq's extensive history of suicide bombings has caused building infrastructures to remain disheveled and damaged. (5) The Iraqi government's under-spending¹ in the health sector continues to pose significant barriers to rebuilding Iraq's health care systems, and infrastructural damage obstructs adequate medical care delivery (6); these problems undermine trust in the medical system. (3) Doctors and human rights activists have pleaded to the government to intervene to repair the fragmented health care system, but local and state governments lack even the power to protect doctors from being assaulted by patients or patient family members. (4) One of the casualties of this stress on the health system is public civility and deference to the authority of physicians, especially the junior physicians who interface regularly with patients and the families who bring them to health centers and hospitals.

Iraq had prioritized health care at least since the 1920s when it established the Royal College of Medicine to train doctors locally. (7) Omar Al-Dewachi, a physician who worked in Iraq during the 1990s before emigrating to the United States, characterized Iraq's health care system as among "the most advanced in the region" by the 1970s. (7) In the 1970s and 1980s, Iraq's health indicators improved significantly, only to decline again after the 1991 Gulf War. (7) Government spending on health was drastically reduced during a decade of sanctions, leading to an Iraqi medical brain drain. (8) Since 2001, Iraqi doctors have increasingly reported violent assaults, threats, and aggression from patients and patients' family members in the hospital setting. (9)

Previous research indicates assaults against doctors stems from the grief of patient relatives, a lack of security and guard protection in hospitals, severe supply shortages, internal political corruption, and an inadequate distribution of physicians across the country. (10–12)

Patient-induced violence against Iraqi doctors was first characterized in 2001, when Muhammad Lafta queried 80 physicians in two Baghdad hospitals, finding 87% reported violence from patients. (9) Nearly 20 years later, Riyadh Lafta led another study of 700 health care workers in six hospitals and twenty primary health care centers in Baghdad, finding the majority of respondents (85%) reported exposure to one or more types of violence, noting the stresses of hospital supply-shortages. (1) Verbal violence was especially aimed at younger doctors, male doctors, and those reporting fewer years of practice as a doctor. The most frequent attackers were patients' relatives. (1)

A 2017 study found 65% of 323 responding physicians reported being exposed to violent behavior, while 77% had witnessed at least one or more of their colleagues being abused. (13) One in five reported a history of being arrested, kidnapped, or injured by patients or patient relatives, while two in five doctors reported having had one of their family members killed,

¹

kidnapped, or injured. (13) About 90% reported it would be safer to leave Iraq, and three out of four doctors (77%) already intended to leave. (13)(19)

According to the World Health Organization (WHO), the country has a mere 7.8 doctors per 10,000 people--a ratio that is 2-4 times lower than its Levantine counterparts. (8) Since an emigration peak in 2006, doctors have continued to leave the country at a high rate in search of safer, more dignified working conditions. (8,13)

We investigated how Iraqi junior doctors' exposure to violence from patients in Central Iraq hospitals influenced their views of medicinal practice, job satisfaction, mental health, and job retention. While prior studies have examined the phenomenon of violence against health care workers in Iraq, no study has employed qualitative methods to understand this phenomenon more deeply in Iraq. Our study was also conducted in part to inform new conflict-mitigation training in Iraqi medical school curriculums.

Methods

With the permission of administrators at six teaching hospitals in Baghdad and Karbala, first author FA spent 2-3 days at each site during December 2021- January 2022, conducting 73 in-person, semi-structured interviews with junior doctors (Table 2).

Hospitals were sampled from Baghdad and Karbala, two Central Iraq cities. Baghdad is the country's capitol, as well as Iraq's largest, most populous city. (14) Researcher RL was appointed in Baghdad's largest and oldest teaching hospital, Al-Yarmouk Hospital, which presented great potential for study recruitment and data collection. Karbala was selected because of its abundance in hospitals and its proximity to Baghdad. Researcher RL had connections at Imam Hussain Teaching Hospital that helped gain administrator approval for data collection. All other hospitals were selected through snowball sampling.

We developed English and Arabic interview guides, (Appendix XX), which were piloted at Baghdad's Al-Yarmouk Hospital with three junior doctors; minor revisions were then made to the Arabic version for clarity. Both guides were available to interviewees during the conversations.

To recruit subjects, the interviewer visited break rooms and explained our study purpose. Some physicians introduced the interviewer to others after their own interviews (snowball sampling). After obtaining verbal consent, the interviewer conducted conversations in English or Arabic (depending on physicians' preferences), in hospital conference rooms. The average length of each interview was 42 minutes.

Interviews were transcribed in real-time using MacBook Dictation software, with transcripts promptly sent to study team members via email. Co-investigators queried the interviewer upon reading transcripts, shaping future interviews with additional prompts as themes emerged.

The study design and reporting of data were based on the consolidated criteria for reporting qualitative research (COREQ) guidelines (15). After conducting 73 interviews across six hospitals, 32 transcripts were excluded for being incomplete, or not reporting violent experiences. Overall, the sample contained 41 records (23 from Baghdad, 18 from Karbala). Inclusion criteria for the episodes in this analysis were records describing cases of violence perpetrated by patients, relatives, or visitors. Following further review, 22 interviews were chosen for vivid narrations; since saturation was reached, additional interviews were not needed. Two researchers (FA, KB) worked together to read transcripts, develop, and compare codes, to

ensure rigor. Codes were developed using ATLAS.ti Version 9 software to derive meaning. After independently coded interviews were merged, (AH) addressed discrepancies.

We initially applied an inductive approach to analyze data. (16) We then considered Chappell and Di Martino's workplace violence model distinguishing risk factors at various levels (individual, contextual, workplace and societal) (17), and organized our themes by level.

Results

We analyzed interview transcripts from 22 junior doctors, ages 24 - 32 (average 27 years), including 14 females and 8 males (Table 1). The subjects had practiced an average 3 years since graduating from medical school (ranging from 6 months to 7 years). Interviewees represented eight hospital departments, with most coming from internal medicine and surgery, respectively (Table 2).

Of the 22 doctors, 20 experienced physical violence, and all 22 experienced verbal violence or threats. All doctors acknowledged verbal violence is "very common," "part of the job," and "happens everyday." But there was no consensus on what constitutes physical violence. Some doctors were reluctant to share their physical violence experiences because they believed instances like having something thrown at them were not real forms of physical violence; 16 doctors defined physical violence as being struck by a perpetrator. All doctors were encouraged to share their story if any actual or attempted harm from perpetrators was experienced.

Six themes emerged from our thematic analysis, with three at the societal/structural level, two at the hospital level, and one at the individual physician level.

Theme 1 (structural level): The structure of the medical care system creates a sense of scarcity, which generates high emotions as people compete for attention, supplies or space—which are often difficult to afford or find.

This theme acknowledges the health system often undermines doctors' abilities to give adequate care to patients. Because the country faces a shortage of doctors and lacks sufficient funding to equip hospitals with the necessary medical supplies and hospital beds, patients and their families will project their aggravation in forms of violence against the doctors. In Interview 9, one doctor reflected on the challenges of referring patients to have lab tests done and referenced high costs that create burdens for families. Instances like these would aggravate negative feelings like mistrust toward the doctor, and lead to abuse.

"For example, we could tell a patient to go to a lab and the family cannot pay for it, they will fight with us and say, 'just do the surgery, we don't want to do that lab, it is too expensive.'"

In Interview 2, another doctor described how doctors were blamed for patients' frustrations—even when the challenges in getting treatment were beyond the doctors' control.

"It is not fair. They think the doctor controls everything: the laws, the medicines, the symptoms the patient is feeling. We can only diagnose and treat them. If the pharmacy does not carry the medicine, it is not our doing. But they come back to the ward and blame us."

Due to the medical system's lack of capacity, patients and patient relatives may often find themselves competing for medical attention or supplies. In Interview 18, one doctor recalled her experience with a patient's daughter, who accused the doctor of withholding critical treatment from the patient. After the doctor communicated to the patient and patient's family that there was a shortage of blood that matched the patient's blood type, the doctor was met with verbal and physical violence (see Table 3, Quote 1.3.). In addition to a scarcity of resources and rooms, the country also faces a shortage of doctors. In Interview 2, one doctor noted that there simply weren't enough doctors working in the hospital to meet the high patient volumes (see Table 3, Quote 1.4.). The doctor in Interview 9 agreed, stating that he and his colleagues experienced verbal abuse from a patient's relative, when there were not enough hospital beds to accommodate the volume of patients.

“Verbal violence occurs on a daily basis, especially when it's really busy here. Recently one patient's relative was yelling, ‘you stupid doctors!’ because there was no bed for the patient. It was busy. He was yelling and very frustrated, and we were frustrated also.”

The doctor in Interview 13 summarized the gap between the hospital's low capacity to treat patients, and the high demand for treatment.

“We don't always have enough rooms, equipment, or doctors. It's not our fault if we are not functioning [to meet] society's needs.”

Theme 2 (structural level): The public doesn't understand the concept of triage well, explaining anger at delays in receiving health care services.

This theme illustrates how patients' and patient relatives' perceptions of the health care system creates frustrations. This is particularly true when p with expectations for care are inconsistent with the concept of triaging patients with the highest needs—before those who may have arrived earlier. For instance, one doctor in Interview 2 recalls that most patients are coming from rural areas and are unfamiliar with how hospitals operate.

“Here, the patients mostly are coming from small areas, they are not very educated, they don't know a lot about health systems.”

When patients and their relatives do not understand the concept of triage, they will feel that the doctor is neglecting their patient. Perceived feelings of neglect, combined with the protective instinct of patient relatives, are met with violent retribution against doctors. In Interview 7, one doctor described how a patient's brother became verbally abusive when doctors used their best judgment to allocate time and (human) resources toward a more urgent case (see Table 3, Quote 2.3.).

Another doctor, from Interview 1, recalls how he was abused when a patient's mother disagreed with how the doctor triaged the case in the Emergency Room. The patient's condition was not as bad as the mother had perceived it to be, and her disagreement caused her to lash out against the doctor (see Table 3, Quote 2.4.).

Theme 3 (structural level): The structure of the medical education pipeline generates doctors who are quite young, may not be fully prepared for these challenging roles, and lack skills and authority to respond in the moment to family attacks.

In several interviews, junior doctors shared experiences that demonstrated their lack of confidence in their work. When doctors are not confident, patients and patient relatives may doubt the doctors' capability to diagnose and treat. This sense of doubt, coupled with relatives' protective instincts, targets doctors for abuse. In Interview 15, one doctor acknowledged his error that could have led to adverse outcomes for the patient (i.e., malpractice)—while sympathizing with his abuser (see Table 3, Quote 4.1.). Another doctor, in Interview 6, attributed doubt in doctors' competencies, to abuse from patients and patient relatives who consider doctors from public hospitals to be less competent than private hospital doctors (see Table 3, Quote 3.4.). Finally, in Interview 15, acknowledged that junior doctors make mistakes, which he attributed that to the high volume of patients and severe shortage of doctors and hospital rooms.

“I think many things can cause the violence. One example is the whole structure of the hospital. We need more hospital rooms, more doctors. One doctor cannot be responsible for the whole floor, because we might make mistakes if there is too much work for us.”

Theme 4 (hospital level): Patient families perform violent or hostile acts towards physicians who may not meet their expectations to exercise instinctive protection or devotion to the patient.

This theme articulates the lack of trust in the medical system, which fosters hostility on the part of patients and patient relatives toward their doctors. When patients enter with the pre-conceived notion that doctors do not put the best interest of patients forward, patient relatives will often feel threatened and feel protective of their patient. This protective instinct can manifest in the form of anger or violence towards doctors—especially when doctors do not give relatives the impression that resources and time are being prioritized to the patient. In interview 2, one doctor described how patient relatives will feel offended when doctors do not share the sense of urgency that the relatives have. This offense is expressed through violence and abuse toward the doctor (see Table 3, Quote 4.2.).

In that same interview, the doctor shared an anecdote about one of his colleagues, mentioning how the protective instincts of a patient's father, combined with feelings of devastation after an unsuccessful medical procedure, turned the patient's father violent. The patient's father even displayed a weapon and threatened to kill the doctor if his son was not revived.

“It was a small boy [being treated] and the boy died. My cousin was the doctor. The father held a gun to my cousin's head and he said, ‘if you don't bring my son back, I will kill you.’”

Another doctor, in Interview 1, described the public's fear and mistrust of the health system, and how it can manifest as violence. When a patient or patient relative has already formed thoughts around how neglectful the health care system is, it will take more than efficient communication skills to calm a perpetrator before a tense situation escalates to a violent one (see Table 3, Quote 4.3.).

Theme 5 (hospital level): Doctors reported they believed family attacks persist because patient families are not facing legal consequences.

Many of the doctors we interviewed attributed the high rates of attacks to the lack of legal consequences for perpetrators. In Interview 13, one explained how violence could be reduced if perpetrators faced harsher punishment.

“The system [welcomes] this behavior. If the law was stricter...patients wouldn't dare to hit any doctor. Doctors aren't always the victims because sometimes they do make mistakes, but it shouldn't be resolved by hitting. There should be a strong law and a strong court to deal with it.”

Another doctor, in Interview 2, noted that while there were consequences for violence, perpetrators did not take them seriously, and recommended that measures be taken to enforce the law (see Table 3, Quote 5.2.). The doctor in Interview 12 agreed, stating that patients and patient relatives need to be reminded of the consequences of their actions, before violence takes place; only then, could the rates of violence be reduced in public hospitals.

“The problem is that hospitals never tell patients the consequences of violence until the violence happens and the [perpetrators] start to beg us to not complain to police or the FPS.”

Theme 6 (individual level): Doctors who are the targets of verbal and physical violence experience mental health problems, including depression and loss of self-esteem, and contemplate leaving their positions.

One of the consequences of violence is that doctors will often face mental health problems, from living in fear that they may be subjected to abuse again, or from the trauma of repeated encounters with violence from patients. One doctor, in Interview 22, stated that while she loves her job, she is fearful of having to deal with relatives—especially under circumstances where she must convey bad news. This fear stems from her previous experience of being choked by a patient's relative when a patient's baby was not breathing after it was delivered.

“It makes me very scared. I really don't like dealing with relatives. I love my job as a doctor in the delivery room...I check if the baby is breathing. But once I have to answer to the family, I get really scared. Especially because I get [flashbacks] from when I was choked.”

Another doctor, in Interview 10, who was badly beaten by a patient, recalled how the bruises served as a constant reminder of the abuse. After the doctor filed a complaint with police, the perpetrator began threatening him. The victim was also fearful that he would be abused physically again, and even took extra measures to ensure his safety by arranging a ride home every day since the attack. He recalls how traumatic his experience was (see Table 3, Quote 6.1.).

In addition to fear, some doctors reported a sense of regret for choosing a medical career, as their profession has placed them in positions that expose them to violence. In Interview 5, one doctor was exasperated by how much effort she put into becoming a doctor, noting the difficulty and time it took for her to graduate, only to be abused and insulted in her profession (see Table 3, Quote 5.4.). A consequence of violence is that doctors may fear going to work. In Interview 8, one doctor stated he would avoid going to work to avoid experiencing violence, by pretending to be sick (see Table 3, Quote 6.2.). One doctor, who had been practicing for more than five years, stated in interview 19 he attempted to leave the country multiple times but was unsuccessful in doing so. He noted there may be corruption in the paperwork process (see Table 3, Quote 6.3.).

Discussion

Decades of violent conflict have undermined Iraq's education, social service, and health sector infrastructures. Societies that endure war and violence find this history breeds further violence (18); violence can manifest itself in essential components of society, including hospitals, clinics, and pharmacies. (18) As a result, patient-induced violence against doctors becomes ingrained where it is perceived as an inherent component of the profession. (19)

Our qualitative approach produced nuanced information about how situations between patients and their doctors in Iraq can trigger or escalate to violence. We analyzed interview responses at structural, hospital, and individual levels. We found that the complexity of health systems, combined with socioeconomic inequities, creates a confluence of stressors and negative feelings for all stakeholders of the Iraqi health care system—which ultimately leads to violence. Patients and their relatives experience frustration, anger, and dissatisfaction from their interactions with junior doctors. Junior doctors are also suffering under various organizational and systemic constraints. These include infrastructure (e.g., inadequate staffing and security, shortages in medical equipment and supplies, other environmental issues), care delivery problems (e.g., long wait times, crowding, lack of privacy), and the larger social context. Verbal violence from patients and patient relatives was experienced by 100% of junior doctors in our study, while 91% experienced physical violence. Previous research suggests that between 8 – 38% of health care workers globally have experienced patient-induced physical violence. (20) The violence, coupled with doctors' inability to mitigate the structural and financial gaps of hospitals, undermine junior doctors' mental health—causing symptoms of post-traumatic stress disorder and the intention to leave the organization or profession. These findings are consistent with prior studies in other countries, which linked violence to mental health consequences among physicians, having regrets about practicing medicine, and wanting or attempting to leave the country.

Iraq already suffers from a severe shortage of doctors, and the workplace violence that doctors continue to experience is driving more to want to leave the country. A study conducted with medical students in Iraq found that more than half (57% of the sample of 418) stated they were thinking frequently about leaving Iraq after graduation. (21) In our study of junior doctors, 59% of 22 doctors were actively trying to leave the country (e.g., submitting applications for work visas abroad, searching for work opportunities, contacting embassies). Reasons mentioned by the junior doctors in our study included fear of further retaliation from their perpetrators, a lack of real legal consequences (due to corruption), and potential ramifications from tribal connections. Many doctors viewed verbal and physical violence as “part of the job.”

The medical students surveyed in the Lafta et al. study (21) also cited their motivations for wanting to leave the country, including the desire for further education, a better lifestyle, and a safer country. Leading reasons for staying in Iraq included the pull of friends and family, familiarity with the health system, and a sense of responsibility toward the country. (21) In our study, 86% of doctors had researched the process for leaving the country—alluding to their desire to find safer and more dignified working conditions, greater respect and gratitude from patients, and better-funded hospitals with medical equipment, supplies, and resources. Among doctors who preferred to stay in Iraq, most stated they had to care for their elderly parents or support their families. In contrast, only two doctors stated it was because they felt a duty to serve the Iraqi people and remain close to home.

There are no simple solutions to ending workplace violence. However, concentrated efforts by the Iraqi Ministry of Health (MOH) could reduce workplace violence significantly. The MOH

has moved to train young doctors in recognizing situations that could escalate to violence and to employ conflict-mitigation communication to prevent escalated tension. Implementing interpersonal and communication skills training for physicians will not prevent violence, but it would significantly reduce violence that stems from high emotions. (36) Additionally, addressing organizational issues, including care quality and processes (e.g., long wait times, lack of patient privacy) through strengthening medical infrastructure and personnel is essential to addressing the public's medical needs. Additionally, it is necessary for the public to understand the concept of triage. The MOH could take steps to inform the public about triage through educational channels and media. Finally, the system will benefit from efforts to retain physicians familiar with the Iraqi systems and who have learned to navigate them.

Conclusion

Suffering is the source and result of violence. Decades of war have diminished infrastructure and undermined doctors' ability to provide adequate medical treatment to their patients. Significant societal issues that perpetuate workplace violence also affect population health (e.g., inequitable, and inadequate distribution of resources, staffing shortages, rising costs of care, etc.). Junior doctors in Iraq continue to experience high rates of physical and verbal violence daily and actively seek ways to leave the country. Identifying and addressing these complex problems requires the involvement and collaboration of multiple stakeholders and robust monitoring. Strengthening the country's health systems by addressing patient concerns and providing better-staffed hospitals can reduce violence in the hospital and greater Iraqi society.

Abbreviations

WPV: Workplace violence

MOH: Ministry of Health

FPS: Facilities Protection Services

HCW: Health care workers

Ethics Approval

The University of Washington's Institutional Review Board (IRB) granted approval for the study (STUDY00014536).

Consent to Participate

All junior doctors gave verbal consent to participate in the interviews.

Conflict of Interest

The authors declare that they have no conflict of interest.

Positionality

The study team included FA, a University of Washington graduate student (the daughter of Iraqi refugees to the U.S.); AH, a University of Washington (UW) professor with prior research experience in Iraq (22–27); and RL, a Mustansiriyah medical school professor with a UW faculty appointment and decades of research experience in Iraq. (7,10,15,18,22,26)

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Footnotes

In 2019, the government spent a mere 2.5% of the country's \$106.5 billion budget on health care. By contrast, security forces received 18% of that budget, while 13.5% was allocated to the oil sector (12). According to WHO, Iraq's central government has consistently spent significantly less on health care than its neighbors - averaging only \$161 per citizen annually (12). Its Levantine counterparts, Jordan and Lebanon, continue to average \$304 and \$649 per citizen (12).

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