Disrespect, harassment, and abuse
All in a day’s work for family physicians

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ABSTRACT

OBJECTIVE To examine harassment and abusive encounters between family physicians and their patients or colleagues in the workplace.

DESIGN Qualitative case study using semistructured interviews.

SETTING Province of New Brunswick.

PARTICIPANTS Forty-eight family physicians from across the province.

METHODS A collective case-study approach was developed, with 24 cases of 2 individuals per case. Cases were selected based on sex, location (urban or rural), language (French or English), and number of years since medical school graduation (< 10 years, 10 to 20 years, or > 20 years). Physicians were interviewed in either French or English. Participants were recruited using the College of Physicians and Surgeons of New Brunswick’s physician directory. Based on the rates of response and participation, some cases were overrepresented, while others were not completed. All interviews were audiotaped, transcribed verbatim, and analyzed thematically using a categorical aggregation approach. A coding scheme for the thematic analysis was developed by the research team before the interviews were transcribed.

MAIN FINDINGS Although the original intent of this study was to examine the work environment of family physicians in light of the increasing number of women entering the profession, harassment and abusive encounters in the workplace emerged as a main theme. These encounters ranged from minor to severe. Minor abusive encounters included disrespectful behaviour and verbal threats by patients, their families, and occasionally colleagues. More severe forms of harassment involved physical threats, physical encounters, and stalking. Demanding patients, such as heavy drug users, were often seen as threatening. Location of practice, years in practice, and sex of the physician seemed to affect abusive encounters—young, female, rural physicians appeared to experience such encounters most often.

CONCLUSION Abusive encounters in the workplace are concerning. It is essential to address these issues of workplace harassment and abuse in order to protect physician safety and avoid workplace dissatisfaction. Abusive encounters might push family physicians to leave clinical practice prematurely or refuse to work in higher-risk environments, such as emergency departments or rural areas.
Manque de respect, harcèlement et grossièreté

Le menu quotidien du médecin de famille

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RÉSUMÉ

OBJECTIF  Examiner les cas de harcèlement et d’impolitesse envers les médecins de famille de la part des patients ou des collègues en milieu de travail.

TYPE D’ÉTUEDE  Étude de cas qualitative à l’aide d’entrevues semi-structurées.

CONTEXTE  Province du Nouveau-Brunswick.

PARTICIPANTS  Quarante-huit médecins de famille d’un peu partout dans la province.


PRINCIPALES OBSERVATIONS  Même si cette étude avait pour but initial d’examiner l’environnement de travail des médecins de famille à la lumière du nombre croissant des femmes qui choisissent cette profession, le harcèlement et les comportements inacceptables sont vite apparus comme des thèmes importants. Les affrontements variaient de mineurs à graves. Les mineurs incluaient des comportements irrespectueux et des menaces verbales des patients, de leur famille et parfois des collègues. Les formes plus graves comprenaient des menaces et des confrontations physiques, et du harcèlement. Les patients exigeants, tels que les toxicomanes sévères, étaient souvent considérés comme des menaces. Le lieu de pratique, l’expérience de pratique et le sexe semblait influencer ces affrontements – les femmes médecins, les jeunes et les médecins ruraux subissaient apparemment plus d’affrontements.

CONCLUSION  Les cas d’affrontements en milieu de travail sont préoccupants. Il est essentiel de s’occuper de ces problèmes afin d’assurer la sécurité des médecins et d’éviter l’insatisfaction au travail. De tels comportements risquent d’amener les médecins de famille à quitter la pratique prématurément ou à refuser de travailler dans des milieux à risque élevé, tels que les salles d’urgence et les régions rurales.

POINTS DE REPÈRE DU RÉDACTEUR

• Le harcèlement et grossièreté envers le médecin de famille par des patients et des collègues sont de plus en plus fréquents en milieu de travail; les affrontements vont des comportements irrespectueux et trop exigeants aux menaces verbales et à la violence. Il y a eu peu de recherche sur ce sujet au Canada, bien qu’on croit que beaucoup de ces cas ne sont pas rapportés par les médecins.

• Les femmes médecins, les jeunes et les médecins ruraux sont davantage susceptibles de faire l’objet de formes légères ou graves d’irrespect en milieu de travail.

• S’ils ne sont pas résolus, les problèmes de cette nature peuvent amener le médecin de famille à abandonner prématurément la pratique ou à refuser de travailler dans des contextes à haut risque, tels que les urgences, les régions rurales ou le domicile des patients, qui exigent aussi beaucoup des médecins.

• Il n’existe actuellement aucune directive nationale pour aider le médecin de famille à prévenir ou à faire face à la violence en milieu de travail. Il faudra donc élaborer des politiques pour protéger les médecins de famille, mieux connaître les situations à risque et émettre une consigne de tolérance zéro.
Health care workers in general are at greater risk of workplace abuse than most other workers, with nurses and family physicians rated as most at risk of abusive encounters with patients and sometimes co-workers. Types of abusive encounters range in severity, from verbal threats to more extreme encounters, such as stalking and physical assault. Because family physicians provide a wide range of care, practise in a variety of settings, are frequently the sole physicians in small or remote communities, and function as the “fall-back” doctor when other specialist medical services are not available, they are more vulnerable to abuse than other medical specialists are.

The Canadian Centre for Occupational Health and Safety defines abuse as threatening behaviour, harassment, verbal abuse, physical attacks and grave physical or psychological harm. There are no recent Canadian data on prevalence and incidence rates of harassment and violent encounters in the family physician’s workplace, but some research in this area has been completed in other countries. An Australian study reported that 64% of family physicians indicated that they had been abused in the previous year—the most common type of abuse was verbal. More than 10% of respondents, however, reported more serious abuse, such as sexual harassment and physical abuse. According to the literature, physicians at increased risk of being abused or mistreated on the job are those who work in emergency departments (EDs) or walk-in clinics; do house calls; have large patient loads; have patients with histories of mental illness; or have patients with addictions. An American study that looked at workplace violence in the ED reported that 1 in 3 ED physicians had been physically assaulted and 1 in 10 had been confronted by patients outside the ED.

The most frequently cited perpetrators of disrespectful, harassing, or abusive behaviour are patients and their relatives. However, physicians have also reported instances of victimization by other physicians and co-workers. Physicians-in-training are particularly vulnerable and are sometimes harassed, humiliated, or abused by supervising physicians, senior co-workers, or nurses. A decade-old Canadian study reported that one-third of medical students and residents had experienced abusive encounters, mostly verbal, and the most common perpetrators were other staff members. A recent New Zealand study concluded that two-thirds of medical students experienced at least 1 negative encounter, such as humiliation, with their superiors. An American study noted that harassing and belittling medical students increased the likelihood of the students’ eventually becoming depressed, using drugs, or developing suicidal thoughts. Further, abusive encounters in the workplace might lead to posttraumatic stress disorder, might contribute to attrition, and could make physicians refuse to work in high-risk areas, such as EDs, walk-in clinics, or patients’ homes.

In addition to the number of abusive encounters reported in these studies, it is believed that a large number of abusive encounters experienced by physicians in the workplace remain unreported. The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada have therefore drafted a set of guidelines for accreditation surveyors to examine actions or policies to protect medical students and residents. These guidelines are based on the assumption that “there is an on-going and substantial problem across a variety of Canadian training programs regarding intimidation and harassment.”

Initially, the overall focus of this qualitative study was to examine how the increasing number of female physicians affects the day-to-day work environment of family physicians in New Brunswick. Upon analyzing the data, however, issues surrounding disrespect, harassment, and abuse emerged as an important theme.

METHODS

New Brunswick has a population of approximately 760,000 people, half of whom live in rural areas and one-third of whom are French-speaking. According to the College of Physicians and Surgeons of New Brunswick’s website, there were 866 licensed family physicians practising in New Brunswick in 2007. We created a New Brunswick family physician profile based on the 2007 National Physician Survey results, which stated that the average age of New Brunswick physicians was 47 years, with male physicians being older than female physicians (mean age 50 years versus 43 years). Sixty-three percent of New Brunswick family physicians were male and 50% practised in rural areas or small towns. Forty-four percent of physicians spoke French with their patients (although many of these physicians also spoke English with other patients), 42% worked in solo practices, 34% worked in group practices, and 22% worked in interprofessional practices. On average, family physicians reported working 50 hours per week, but when on-call hours were added the average work week total was 86 hours.

A qualitative case study methodology was used to explore the “bounded system” through in-depth interviews. Time and place are the prevailing characteristics of a bounded system; in this case, the work environment of family physicians was the parameter studied. We used collective cases to examine the system by creating several distinct groups of family physicians based on demographic characteristics that shape workplace experiences. The characteristics we selected were as follows: primary language (French or English), sex, location of practice (urban or rural), and years since graduation from medical school (< 10 years, 10 to 20 years, or > 20 years). For example, one case would be “female/young/urban/French,” while another would...
be “male/older/rural/English.” Based on these characteristics, 24 distinct cases were created with 2 participants per case for a total of 48 participants required. No social demographic information was asked of the participants to protect their identities as much as possible. Ethics approval was granted by review committees of Dalhousie University and the Université de Moncton.

The College of Physicians and Surgeons of New Brunswick’s physician directory provided basic potential participant information, such as year of graduation, location of practice, and contact information. We used a purposive sampling strategy, sending letters of invitation explaining the study to potential participants in 8 separate mailings to ensure that we would target physicians who fit the case-study criteria. A reply card was included with the invitation letter, as was a self-addressed, stamped envelope and a fax number. The information was sent in both French and English, and potential participants were given the option to select their preferred language for the interview. Potential participants were offered honorariums of $120 to cover their overhead costs during the study.

Research team
The multidisciplinary research team consisted of 3 coinvestigators (a sociologist, a family physician, and a professor of philosophy and ethics) and 3 research assistants trained in qualitative methods. Interviews were conducted by 4 members of the research team, including 1 bilingual coinvestigator who conducted all of the French interviews. On the consent form, before the interview, participants were given the option to be audiotaped. Only 2 refused. For these cases the research assistants took detailed notes and did audiotaped recaps after the interviews were completed. Most of the interviews took place in the participants’ homes or offices.

Analysis
All audiotaped interviews were transcribed verbatim and analyzed thematically using a categorical aggregation approach. In this type of analysis “the researcher seeks a collection of instances from the data, hoping that issue-relevant meanings will emerge.” Each member of the team read and analyzed 2 transcripts, making notes to help generate initial codes. At a preliminary team meeting, comparisons were made both within and among transcripts, further contributing to the development of thematic categories. Related themes were then compared and collapsed into major categories. Most codes were easily agreed upon; however, in cases where there was disagreement, team discussion led to consensus about the importance of the codes. After development of the initial coding scheme, some minor revisions and additional codes were discussed by the research team through telephone and e-mail correspondence. A second team meeting took place in order to finalize the coding scheme. A bilingual research assistant used the English coding scheme to analyze the French transcripts. Dependability and confirmability of the data were assessed by sending a summary of the analysis back to the interviewees for review. None of the participants sent back any comments.

FINDINGS
The response rate to the mailing was 35%, achieving the target of 48 participants required. Of the 24 cases, 15 were complete (2 participants per case); 6 cases had only 1 participant, 5 of whom were male; and 3 cases had more than 2 participants, all of whom were female. One case—“female/older/rural/French”—had no participants. We opted to interview 48 participants instead of reducing the number of interviews, even if that meant overrepresentation in some cases. Of the 48 participants, 29 were female and 19 were male. The distribution of characteristics among the study participants is presented in Table 1.

For the purposes of this paper, all French quotations were translated into English. In addition, in order to protect the identities of the research participants as much as possible, we restricted the identification to sex only, unless the context of the quote required further demographic information.

Levels of abuse
Application of the term abusive ranges from “minor” events, such as disrespectful behaviour, to more serious occurrences, such as threats and physical violence. Many of the abusive encounters reported involved disrespectful behaviour; however, a few participants reported serious abusive encounters, such as being threatened or stalked.

Treatment with disrespect. Many physicians expressed their displeasure with the lack of respect they received from patients and sometimes colleagues. More female physicians described being treated disrespectfully than male physicians. One female participant said the following:

I think it is disrespectful to come in here and just kind of look at this like the McDonald’s drive-thru, “I’m
Some disrespectful behaviour is completely a result of
gender bias. A few female physicians reported receiv-
ing derogatory comments from both patients and col-
leagues when taking maternity leave. One female
physician said: “I was forced to continue treating the
man who had insulted me head to toe each time I took
maternity leave.” (Interview 9) In a few cases, the disre-
spectful work environment caused the physician to leave
the community. As one female physician described,

[T]he nurses would talk behind your back … ques-
tioning your judgment, and wondering what you were
doing, and why the heck would you admit a patient
with chest pain … [It was] totally uncalled for, and
that’s one of the reasons why I left. (Interview 22)

Demanding patients. Demanding patients were also
discussed as a potential source of abuse, making the
physicians feel very uncomfortable or even personally
threatened. Patient demands included pressure to fill
out insurance and disability claim forms in ways that
contradicted physicians’ assessments and insistence on
unwarranted prescriptions for narcotics. The severity of
these threats and demands was highlighted by the expe-
rience of one male physician:

I had a patient throw her medical file in my face
because she was really unhappy that I wouldn’t claim
her as disabled …. She didn’t meet the criteria. She
started to threaten me, saying that she knew where I
lived and that she was going to hit my children with
her car. I called the police. (Interview 43)

Many participants discussed how drug-seeking
patients applied a great deal of pressure to get what they
wanted. One rural physician explained her predicament
dealing with patients who had addictions and patients
who were upset because of long ED wait times. She said,

[I]f there is any narcotic abuse, those patients are
often more demanding …. Here [in a rural area], you
do get a fair amount of abuse because when you are
on call you are responsible for delivering the babies,
dealing with the [intensive care unit], dealing with the
floor, plus the [ED], so sometimes you are 3 or 4 hours
[behind and ED patients have to wait], and you get a
lot of abuse from patients with that. (Interview 7)

Severe abusive encounters. Severe abusive encoun-
ters did not often occur, but when they did they were
described as frightening, particularly if they involved
a physician's family. In some cases, it was colleagues
who were abusive. In one instance, a female physician
described an exchange with a male colleague:

The area of contention that day was that he came in
and he was screaming, because he always screams
when he gets mad. He had been away for a month, as
usual, and was screaming that I had stolen some of
his patients, and it was “bitch” and “witch” and I was
slapped and thrown into my chair during this conver-
sation. (Interview 6)

Abusive encounters with patients were more com-
mon. One female physician was threatened with vio-
lence in a rural ED: “We had to call the RCMP to come
because the patients were threatening the personnel,
stuff like that. A patient came in with a piece of wood,
two-by-four, to threaten us.” (Interview 9)

Two female physicians described very unpleasant
encounters. One physician, who had moved her practice
location to the other side of Canada, encountered one
of her former patients who had also moved to her new city.
Subsequently, when she decided to move to another new
practice, the patient started to stalk her: “When I left that
practice, that’s when he started sending me letters and mak-
ing contact that wasn’t wanted. He also involved my family
... it was horrible actually.” (Interview 21) The other female
physician reported that a patient became very displeased
when she declined his romantic advances. She said,

I had a patient who straightforwardly said that he was
in love with me and that he was certain that I had
feelings for him, because I had listened to his prob-
lems a little, and I had been a little bit empathic with
his relationship problems …. I was obliged to meet
with him and to find him another family physician
because it was the regulations. (Interview 34)

Another female physician who had been practising
family medicine for more than 20 years described her
strategy to prevent abusive encounters:

[I]n 20 years of working, you’re continually watching for
body language signs, movement. You learn that you never
let a patient get between you and the door; you always
position yourself. “Would you like to sit over there?” Not
because it’s the most comfortable seat, it’s because it’s in
the corner and the door is over here. (Interview 28)

DISCUSSION

Based on the interview data and evidence from the lit-
erature, disrespectful, harassing, and abusive encoun-
ters are not uncommon in the workplace of the family
experienced physicians. Although the majority of
physicians reported being able to handle most patient
behaviours, some did describe challenging situations
that required additional support or assistance. This
suggests that resources and strategies need to be in
place to support physicians when dealing with abusive
encounters. Further research is needed to better un-
derstand the prevalence, impact, and potential solutions
for abusive interactions in family medicine.
physician. According to our findings, younger, female, and rural family physicians seemed to be most at risk. Although some abusive encounters occurred with colleagues, most conflicts were related to patients. Regardless of the nature of the abusive encounter—from disrespectful behaviour to acts of violence—these encounters make the workplace unpleasant, even dangerous, for practitioners.

That female physicians feel harassed or abused more than male physicians is a worrisome trend in light of the fact that more than 59% of medical students who registered for the 2007 Canadian Resident Matching Service were women. This trend is consistent with other studies that found women to be at higher risk than their male counterparts for abuse and harassment. Hence, examining, addressing, and providing training to deal with these issues are essential steps.

Little focused research examines the existence of workplace violence for family physicians in Canada. We do not have a good understanding of the extent of this problem, and few guidelines exist for family physicians on how to deal with abusive and violent encounters. In Canada, there are currently no national policies or guidelines in place to help family physicians prevent or deal with workplace violence. Some individual health institutions and professional organizations have policies or guidelines available; however, these guidelines are not easily accessible and do not focus on violence prevention. In the United States, the Occupational Safety and Health Administration (US Department of Labor) developed recommendations for a “clear policy of zero-tolerance for workplace violence, verbal and non-verbal threats and related actions.” This “zero-tolerance” approach is 2-fold with respect to health care workers: 1) in cases of abuse, a physician can terminate care without jeopardizing the health care of that individual, and 2) patients are made aware that abusive language and actions toward their physicians are not tolerated. Although the kinds of violence-prevention policies vary greatly among studies and few focus specifically on health care workers, researchers have reported primarily positive effects after policy implementation. These effects include an increased awareness of risk situations and avoidance of dangerous situations, an improvement in dealing with violent and abusive encounters, and a decreased number of abusive encounters after policy implementation.

Given the reality of primary care as the cornerstone of the Canadian health care system and the fact that most Canadians (80%) prefer to receive health care from their family physicians, it is essential to address these workplace issues. Support for physicians working in high-risk work environments, such as EDs or rural practice locations, needs to be a priority in order to improve workplace satisfaction and recruit and retain family physicians in these high-need areas.

### Conclusion

Many family physicians, particularly rural, young, and female family physicians experience worrisome levels of harassment and abuse on the job. The perpetrators are mostly patients; however, occasional abusive encounters with colleagues do occur. It is important that policies to protect family physicians in their workplaces are developed to make a clear statement to patients that such behaviour is unacceptable. If this issue is not addressed satisfactorily, the risk of family physicians leaving their clinical practices prematurely or refusing to work in certain settings, such as EDs or walk-in clinics, will only increase.

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### Competing interests

None declared.

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