Prevalence of abusive encounters in the workplace of family physicians

A minor, major, or severe problem?

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ABSTRACT

OBJECTIVE To examine the career prevalence of abusive encounters for family physicians in Canada.

DESIGN A 7-page cross-sectional mailed survey in English and French.

SETTING Canada.

PARTICIPANTS A total of 3802 randomly selected practising family physicians who were members of the College of Family Physicians of Canada.

MAIN OUTCOME MEASURES Demographic characteristics of survey participants, career prevalence of abusive encounters, and perpetrators of abuse.

MAIN FINDINGS Twenty percent (20.4%) of the surveys (n=774) were returned. Of the respondents, 44% were men and 56% were women. Most were in private practice in urban settings. The average number of years in practice was 15. The career prevalence of abusive encounters was divided into "minor," "major," and "severe" incidents. Of all the respondents, 98% had experienced at least 1 incident of minor abuse, 75% had experienced at least 1 incident of major abuse, and 39% had experienced at least 1 incident of severe abuse. Using χ^2 analysis, a number of demographic variables were found to be significantly associated with abuse including the physician's race and sex. Patients were the most common perpetrators of abuse. Ninety percent of family physicians surveyed reported that they had been abused by patients, while 70% reported that they had been abused by family members of patients.

CONCLUSION Approximately 2 in 5 family physicians surveyed were subjected to a considerable amount of severe abuse during practice. Abuse in the office setting might have grave consequences for the health and well-being of the victimized physicians and might hinder service retention where the risk of abuse is greatest.

EDITOR'S KEY POINTS

- There are no recent Canadian data on the prevalence of abuse encountered by physicians, but studies conducted in other countries suggest that abusive encounters are common in general practice. This study aimed to understand the career prevalence and severity of abusive encounters in family medicine in Canada.
- Very nearly all respondents (98%) had experienced some form of abuse in their careers. Troublingly, almost 40% had experienced at least 1 incident of severe abuse, such as physical or sexual assault or stalking, at some point in their careers.
- Despite a low response rate, and although physicians who had experienced abuse might have been more likely to complete the lengthy survey used in this study, the authors point out that, even under the assumption that none of the nonrespondents had experienced abuse, at least 1 in 5 family physicians in Canada had been subjected to abuse at work, 1 in 7 to major abuse, and 1 in 12 to severe abuse.

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Prévalence des incidents violents que doivent affronter les médecins de famille au bureau

Un problème mineur, majeur ou grave?

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RÉSUMÉ

OBJECTIF Déterminer la prévalence des incidents violents que doivent affronter les médecins de famille canadiens durant leur carrière.

TYPE D'ÉTUDE Enquête postale transversale de 7 pages, en versions anglaise et française.

CONTEXTE Canada.

PARTICIPANTS Un échantillon aléatoire de 802 médecins de famille actifs, membres du Collège des médecins de famille du Canada.

PRINCIPAUX PARAMÈTRES ÉTUDIÉS Caractéristiques démographiques des participants, prévalence des incidents violents durant la carrière, et auteurs de ces violences.

PRINCIPALES OBSERVATIONS Le taux de réponse était de 20,4% (n=774). Parmi les répondants, 44% étaient des hommes et 56% des femmes. La plupart pratiquaient en solo en milieu urbain et avaient en moyenne 15 années de pratique. Pour calculer la prévalence des incidents violents, on a distingué les incidents «mineurs», «majeurs» et «graves». Sur l'ensemble des répondants, 98% avaient vécu au moins un incident de violence mineur, 75% au moins un incident majeur et 39% au moins 1 incident grave. L'analyse de χ^2 a révélé que certaines caractéristiques démographiques sont associées de façon significative à la violence, y compris la race et le sexe du médecin. Les patients étaient le plus souvent les auteurs de la violence. Parmi les médecins de famille, 90% déclaraient avoir été victimes de violence de la part de patients tandis que 70% disaient avoir été menacés par des proches des patients.

CONCLUSION Environ 2 médecins de famille sur 5 ont dû subir une quantité importante de violence grave durant leur pratique. La violence au bureau pourrait avoir de graves conséquences pour la santé et le bien-être des médecins qui en sont victimes, et pourrait entraver le recrutement d'effectifs là où le risque est trop élevé.

POINTS DE REPÈRE DU RÉDACTEUR

- Il n'existe pas au Canada de données récentes sur la prévalence des incidents violents que doivent affronter les médecins, mais les études provenant d'autres pays donnent à penser que ces incidents sont fréquents en médecine générale. Cette étude voulait connaître la prévalence et la gravité de ces incidents chez les médecins de famille canadiens durant leur carrière.
- Presque tous les répondants (98%) avaient été victimes d'un type quelconque de violence dans leur carrière. Ce qui est inquiétant, c'est que près de 40% avaient été victimes d'au moins un incident de violence sévère, comme une agression physique ou sexuelle ou du harcèlement sexuel à un moment ou l'autre de leur carrière.
- Malgré un faible taux de réponse et le fait que les médecins qui avaient subi de la violence pourraient avoir été plus susceptibles de répondre à cette longue enquête, les auteurs font remarquer que même en supposant qu'aucun des non-répondants n'avait subi de violence, au moins 1 médecin de famille sur 5 au Canada avait été victime de violence au bureau, 1 sur 7 de violence majeure et 1 sur 12 de violence grave.

Cet article a fait l'objet d'une révision par des pairs.
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Among health care workers, physicians and nurses are most at risk of violent encounters in the workplace.[1,2] Long wait times for appointments, physician shortages, limited resources, and general stress can all lead to patient frustration and violence.[3] We do not have recent Canadian data on the degree to which workplace abuse is encountered by family physicians; however, studies have been conducted in other countries.[4-11] A small New Zealand study reported that in the previous year, 15.4% of general practitioners were verbally abused, 3.5% were assaulted, and 1.9% were stalked.[11] An Australian study reported that 63.7% of general practitioners experienced violence on the job in the previous year. Most study participants had experienced "low level" violence such as intimidation, while 9.3% reported having been sexually harassed, and 2.7% reported being physically abused. Younger physicians and those working in after-hours settings experienced the highest levels of workplace abuse.[10] A Japanese study revealed that verbal violence was reported by 31.8% of physician respondents in the 6 months before the survey was conducted.[12] In 2005, Kowalenko et al reported that in the previous 12 months, 75% of all US emergency department (ED) physicians experienced at least 1 verbal threat.[13] Half of the ED workers who had experienced violence while working reported that their job performance was impaired during the remainder of the shift or for the entire week.[14] In a Polish study, 91% of doctors working in an outpatient setting had experienced disrespectful behaviour, such as yelling, and 1% were subjected to more severe abuse, including assault and hitting.[15]

Few studies have examined the issue of physician workplace violence in Canada. A 1993 study into the sexual harassment of female physicians in Ontario revealed that 77% of the respondents indicated that they had been sexually harassed at least once in their careers.[16,17] There are reports of physical abuse toward physicians in training,[18] and a family physician from Alberta went public with her experiences of being stalked by a patient.[19] Many countries are developing policies to protect physicians from violent patients,[1] but Canada does not, as yet, have such a policy. In fact, before this study, the extent of the problem in Canada had not yet been clearly delineated. In this study we have documented the career prevalence of abusive encounters in the workplace of family physicians across Canada.

METHODS

The overall study employed mixed methods, using a cross-sectional survey to collect quantitative data and telephone interviews with physicians who had indicated that they had experienced abusive encounters in the past year. The survey was a modification of a survey developed by a New Zealand research team.[11] Part 1 of the survey included demographic questions (eg, pertaining to sex, practice location, and type of practice). Part 2 included questions about the career prevalence and frequency of 14 different types of abusive encounters ranging from minor to severe. A 5-point Likert scale, ranging from "never" to "very often," was used to collect information about the frequency of abuse. Part 3 asked about the monthly incidence of abusive encounters by perpetrators, ranging from minor to severe. Finally, Part 4 asked questions regarding policy and actions. The survey was 7 pages in length, and face validity was tested by expert review by several Fredericton, NB, family physicians.

The College of Family Physicians of Canada's National Research System (NaReS) distributed the survey for this study using a modified Dillman approach. This survey was pilot-tested by NaReS by 4 English and 4 French family physicians across the country. Some slight changes were made to the English survey; for the French survey several terms were altered to mirror the language used in the National Physician Survey (NPS). The pilot surveys were not included in the final sample. No additional inclusion or exclusion criteria were used. In total, 3802 survey packages were mailed to a random sample of active or practising family physicians who were members of the College of Family Physicians of Canada, between November 2008 and April 2009. The data were entered into SPSS 15.5 software for analysis. Ethical approval for the study was granted in 2008 by the research ethics boards of Dalhousie University in Halifax, NS, the University of Alberta in Edmonton, and the University of Saskatchewan in Saskatoon.

RESULTS

This paper focuses only on the career prevalence of abusive encounters in the workplace in which patients and family members of patients were the perpetrators. A total of 774 surveys were returned (20.4%) out of the 3802 mailed. Four surveys were returned blank and were excluded from the analysis, leaving 770 surveys for analysis. We have limited data on the nonrespondents (**Table 1**). For a more detailed understanding of our sample, we compared the demographic information from our study with data from the 2007 NPS.[20] There was a greater percentage of women in our sample than among respondents to the NPS (57% vs 42%). Our respondents had been in practice for 14.5 years on average compared with 20.5 years for respondents to the NPS. The participating physicians in this study worked 46.3 hours per week (excluding on-call coverage). The largest group of practitioners were in "private practice" working in a "group setting" (**Table 2**). Thus, compared with the NPS respondents, our sample contained a higher proportion of women and, based on years in practice, was perhaps younger on average. Many of the

Table 1. Demographic characteristics of nonrespondents compared with those of respondents

CHARACTERISTICS	NONRESPONDENTS	RESPONDENTS
French-speaking, % (n)	78.2 (353)	22.9 (105)
• Mean age, y	40.6	38.7
• Proportion of men	60.0	38.3
• Proportion of women	40.0	61.7
English-speaking, % (n)	80.4 (2675)	19.6 (665)
• Mean age, y	43.7	44.4
• Proportion of men	54.4	44.0
• Proportion of women	45.6	56.0

respondents in our study, in addition to their main practice settings, were involved in additional clinical care, including housecalls (42%), nursing home care (30%), and care in walk-in clinics (24%).

In total, 98% of the study sample reported having experienced at least 1 abusive encounter in their careers, with the type of abuse ranging from disrespectful behaviour to stalking. For analytical purposes we have grouped the following abusive encounters into *minor incidents* of abuse: disrespectful behaviours, bullying, verbal anger, verbal threats, and humiliation. Physical aggression, destructive behaviour, and sexual harassment were categorized as *major incidents* of abuse. Attempted assault, assault, assault causing injury, sexual assault, and stalking were categorized as *severe incidents* of abuse (**Table 3**). Almost all respondents (97.9%) reported at least 1 minor abusive incident, 75.1% reported at least 1 major abusive incident, and 39.2% reported at least 1 severe abusive incident in their careers in family medicine to date.

In **Table 4** the various abusive incidents are reported individually. It is clear that almost all participants had experienced disrespectful behaviour. The more worrying data in this table are those pertaining to severe abuse, such as sexual harassment, attempted assault, and stalking, which was experienced by a large number of physicians. One in 4 of the respondents reported having been a victim of attempted assault, almost half had been sexually harassed, and 1 in 7 indicated that they had been stalked.

When we examined the relationships between the individual types of abuse and sex or race, some patterns emerged: women were more frequently bullied ($P=.026$) and sexually harassed ($P<.001$), while male physicians were more often verbally threatened ($P=.011$), humiliated ($P=.007$), and assaulted ($P=.002$), and were more likely to experience destructive behaviour ($P=.005$). White physicians experienced significantly higher levels of disrespectful behaviour ($P=.001$), bullying ($P<.001$), verbal anger ($P=.001$), humiliation ($P=.047$), destructive behaviour ($P<.001$), attempted assault ($P=.004$), assault ($P=.007$), sexual harassment ($P<.001$), and stalking ($P=.008$) than non-white physicians, and they reported significantly more assaults causing injury ($P=.001$).

When we examined the relationships between demographic variables and prevalence of abusive incidents (**Table 5**), being white ($P<.001$) and working in urban or suburban areas and small towns ($P=.039$) were

Table 2. Description of study sample: *N = 770.*

DEMOGRAPHIC CHARACTERISTIC	N (%)
Sex	
• Female	435 (56.5)
• Male	335 (43.5)
Language	
• English	669 (86.9)
• French	101 (13.1)
Race	
• White	599 (77.8)
• Non-white	171 (22.2)
Practice location	
• Urban	441 (57.3)
• Small town	125 (16.2)
• Inner city	92 (11.9)
• Rural and remote	86 (11.2)
• Other	26 (3.4)
Main practice setting*	
• Private office	478 (62.7)
• Emergency department	87 (11.4)
• Community clinic	79 (10.4)
• Academic practice	52 (6.8)
• Hospital inpatient	27 (3.5)
• Freestanding walk-in clinic	21 (2.8)
• Nursing home	8 (1.0)
• Other	10 (1.3)
Organization of practice*	
• Group	429 (56.2)
• Interprofessional	174 (22.8)
• Solo	131 (17.2)
• Other	29 (3.8)
Additional clinical care settings*†	
• Walk-in clinic	187 (24.4)
• Housecalls	322 (42.0)
• Nighttime housecalls	121 (15.9)
• Nursing home care	228 (29.9)
• Emergency department shifts	140 (18.3)
• Obstetric calls	127 (16.7)
• Community health centre	82 (10.7)
• Hospital inpatient care	321 (42.0)

*Not all respondents answered all questions.
†Not mutually exclusive.

significantly associated with minor abusive incidents. Physicians who were white ($P<.001$), who worked in EDs either full-time ($P<.001$) or on occasion ($P<.020$), or who worked in nursing homes ($P=.001$) were significantly more likely to experience major abusive incidents. For severe abusive incidents, being white ($P<.001$), working in an ED as a main practice setting ($P<.001$), doing housecalls ($P=.029$), and working in the hospital as a main practice setting ($P=.032$), elevated our respondents' risk significantly.

When asked about the perpetrators of abusive incidents, more than 9 out of 10 family physicians reported that they had been victimized by patients, while 7 out of 10 respondents identified family members of patients as those responsible for the abusive incidents (**Table 6**).

Table 3. Categories of seriousness of levels of abuse

SEVERITY OF INCIDENT	TYPE OF ABUSIVE ENCOUNTER
Minor incidents	
	Disrespectful behaviour • Abuser was rude or disrespectful
	Bullying • Abuser was belittling or professionally humiliating
	Verbal anger • Abuser was loud, angry, insulting, but *not* threatening
	Verbal threats • Abuser was loud, angry, insulting, and threatening
	Humiliation • Personal insults, name calling, or gestures perceived as decreasing your self-esteem or as humiliating
Major incidents	
	Physical aggression • Abuser was throwing objects, slamming doors, kicking, or gesturing but *did not* damage persons or property
	Destructive behaviour • Abuser broke or smashed objects and was kicking or striking out toward and causing damage to possessions and property but *not* to any persons
	Sexual harassment • Abuser spoke, looked, or gestured in a manner that you perceived as an unwanted sexual advance
Severe incidents	
	Assault • Abuser was hitting, punching, kicking, pulling, or pinching you *without* causing injury
	Assault causing injury • Abuser was hitting, punching, kicking, pulling, or pinching you causing injury
	Attempted assault • Abuser broke, smashed, kicked, or was striking out toward you but *not* physically hitting or harming you
	Sexual assault • Abuser physically touched or assaulted you in a manner you perceived as unwanted and of a sexual nature
	Stalking • Abuser monitored, followed, or stalked you

DISCUSSION

The response rate to the survey was low (20.4%). Although not dissimilar to the response rates of some studies examining family physicians abuse issues,[21,22] it was markedly lower than others that reported response rates up to 63%.[4,23] We speculate that the length of our survey was a considerable deterrent to its completion by busy family physicians. Furthermore, those study surveys that generated higher response rates were often conducted in small settings. It could be argued that social pressures in smaller settings contribute to higher participation rates in those studies. Our survey was a national mailed survey and, unlike the NPS, there was no advanced advertising that it was going to take place. Nevertheless, this survey is the largest and most comprehensive examination of abusive encounters in the workplaces of family physicians in Canada, with almost 800 participants.

Minor abusive encounters are experienced in the workplace by almost all family physicians. This is not surprising for a number of reasons, starting with the fact that family medicine is a profession that provides first-line health care to the general public in a universal health care system that is forever challenged to provide timely care for all Canadians. The national physician shortage and long wait times for some treatments can tax patients' abilities to interact appropriately with health care providers. Similarly, it is not surprising that a large Canadian survey among nurses reported that 47% believed that they had been subjected to emotional abuse and 34% had been victims of physical assault in the previous year.[24]

What is worrisome is the high prevalence of major and severe abusive encounters experienced by family physicians in practice. Our finding that 13.6% of respondents had been stalked at some point in their careers is striking, but not entirely surprising given the data from a New Zealand study that reported close to 2% of general practitioners being stalked in the previous year.[11] Our career prevalence rate is in keeping with an Italian study of the prevalence of stalking among a group of Italian

Table 4. Prevalence and intensity of each abusive encounter

TYPE OF ABUSIVE ENCOUNTER	N	AT LEAST 1 OCCURRENCE, N (%)	SEX		HERITAGE IDENTIFICATION	
			PROPORTION EXPERIENCING AT LEAST 1 OCCURRENCE	*P* VALUE	PROPORTION EXPERIENCING AT LEAST 1 OCCURRENCE	*P* VALUE
Minor incidents						
• Disrespectful behaviour	768	750 (97.7)	Male 96.4 Female 98.2	NS	White 98.3 Minority 93.7	.001
• Bullying	762	598 (78.5)	Male 74.7 Female 81.4	.026	White 81.2 Minority 67.1	<.001
• Verbal anger	765	706 (92.3)	Male 92.2 Female 92.4	NS	White 92.9 Minority 89.3	.001
• Verbal threats	758	543 (71.6)	Male 76.4 Female 68.0	.011	White 73.2 Minority 66.2	NS
• Humiliation	759	449 (59.2)	Male 64.6 Female 54.9	.007	White 61.0 Minority 52.3	.047
Major incidents						
• Physical aggression	766	443 (57.8)	Male 61.3 Female 55.2	NS	White 59.1 Minority 53.8	NS
• Destructive behaviour	763	271 (35.5)	Male 41.1 Female 31.3	.005	White 38.9 Minority 23.7	<.001
• Sexual harassment	764	363 (47.5)	Male 30.5 Female 60.7	<.001	White 52.1 Minority 31.6	<.001
Severe incidents						
• Assault	765	136 (17.8)	Male 22.6 Female 14.1	.002	White 20.0 Minority 10.8	.007
• Assault causing injury	759	37 (4.9)	Male 6.6 Female 3.5	NS	White 4.9 Minority 5.2	.001
• Attempted assault	764	202 (26.4)	Male 29.0 Female 24.4	NS	White 29.1 Minority 17.7	.004
• Sexual assault	767	59 (7.7)	Male 5.7 Female 9.2	NS	White 8.5 Minority 5.1	NS
• Stalking	766	104 (13.6)	Male 11.1 Female 15.5	NS	White 15.1 Minority 7.0	.008

NS—not significant.

mental health professionals, which was determined to be 11%. The same study also found that male mental health care professionals were more often stalked than female workers.[25] Although our results differ slightly, comparison with other studies is compromised owing to dissimilar working conditions and patient populations. Nonetheless, being stalked by patients seems to be relatively common for workers in the medical profession. The sexual harassment prevalence rates of 31% for male respondents and 61% for female respondents are high, but the rate among female physicians is in accordance with similar findings from a previously conducted Canadian study.[17]

Violence in the health care workplace can have a negative effect on victims and their families and can reduce quality of life.[26] Some studies have indicated that victims of abuse might develop stress disorders or experience somatic complaints that can affect job performance.[27-29] Other physicians might withdraw their services from particular environments (eg, EDs or housecalls) where they deem themselves to be at high risk of abuse.[10] Although male and female physicians experience different types of abusive encounters, neither sex is more at risk for minor, major, or severe abuse. White physicians were more likely to encounter minor as well as severe abuse than their non-white counterparts. We do not have a clear explanation for this finding. In fact, we had expected that physicians who belonged to minority groups would have experienced higher levels of abuse.

Physicians practising in small towns and urban or suburban settings reported higher minor and severe abusive encounters than physicians in other geographic locations. Working in an ED as the main practice setting, or as an additional practice setting, increases exposure to major and severe abusive encounters. This phenomenon has been well documented.[13,30] Also, physicians

Table 5. Prevalence of minor, major, and severe incidents and correlation with participant characteristics including levels of statistical significance

DEMOGRAPHIC VARIABLE	INCIDENCE, N (%) YES	NO	*P* VALUE
Minor abusive incidents			
Race			<.001
• White	579 (98.8)*	7 (1.2)	
• Minority	139 (93.9)	9 (6.1)	
Geographic location			.039
• Inner city	81 (95.3)	4 (4.7)	
• Urban or suburban	425 (98.6)*	6 (1.4)	
• Small town	118 (99.2)*	1 (0.8)	
• Rural or remote	97 (95.1)	5 (4.9)	
Major abusive incidents			
Heritage identification			<.001
• White	467 (78.8)*	126 (21.2)	
• Minority	98 (63.2)	57 (36.8)	
Main practice setting			.001
• Private office	339 (71.8)	133 (28.2)	
• Community clinic	56 (70.9)	23 (29.1)	
• Academic setting	42 (82.4)	9 (17.6)	
• Emergency department	81 (94.2)*	5 (5.8)	
• Nursing home	7 (87.5)*	1 (12.5)	
• Walk-in clinic	15 (75.0)	5 (25.0)	
• Hospital or inpatient	18 (69.2)	8 (30.8)	
Any emergency department work			<.001
• Yes	196 (87.1)*	29 (12.9)	
• No	363 (69.7)	158 (30.3)	
Emergency department as main work setting			<.001
• Yes	81 (94.2)*	5 (5.8)	
• No	483 (72.5)	183 (27.5)	
Emergency department (additional only)			.020
• Yes	115 (82.7)*	24 (17.3)	
• No	450 (73.3)	164 (26.7)	
Severe abusive incidents			
Heritage identification			<.001
• White	250 (42.6)*	337 (57.4)	
• Minority	41 (26.5)	114 (73.5)	
Main practice setting			<.001
• Private office	167 (35.8)	299 (64.2)	
• Community clinic	25 (32.1)	53 (67.9)	
• Academic setting	21 (41.2)	30 (58.8)	
• Emergency department	56 (64.4)*	31 (35.6)	
• Nursing home	3 (37.5)	5 (62.5)	
• Walk-in clinic	5 (23.8)	16 (76.2)	
• Hospital or inpatient	15 (60.0)*	10 (40.0)	
Geographic location			.009
• Inner city	40 (44.4)	50 (55.6)	
• Urban or suburban	150 (35.0)	279 (65.0)	
• Small town	63 (51.2)*	60 (48.8)	
• Rural or remote	41 (39.8)	62 (60.2)	
Any emergency department work			<.001
• Yes	118 (52.0)*	109 (48.0)	
• No	174 (33.9)	339 (66.1)	
Emergency department as main setting			<.001
• Yes	56 (64.4)*	31 (35.6)	
• No	238 (36.1)	421 (63.9)	
Hospital inpatient as main setting			.032
• Yes	15 (60.0)*	10 (40.0)	
• No	279 (38.7)	442 (61.3)	
Housecalls			.029
• Yes	202 (62.7)*	129 (37.3)	
• No	240 (54.7)	198 (45.8)	

*Highest levels.

who make housecalls are at increased risk of severe abusive encounters. What has not been previously well documented, however, is our finding that family physicians working as hospitalists are at higher risk of severe abusive encounters than family physicians in private practice.[24]

Limitations

As with all survey studies, this study was based on self-report, and abusive encounters were not corroborated with administrative data. We have no reason to doubt the responses of the family physicians who took the time to complete this lengthy survey and who provided additional responses to some of the questions.

Our study response rate was admittedly low, and it could well be argued that those who took the time to complete the survey were those physicians who had been abused and who were therefore motivated to "report" their experiences, thus skewing the results toward a positive finding. Even if we were to assume, however, that none of the nonrespondents had been abused, we would still be able to safely report that at least 1 in 5 family physicians is subjected to abuse at work, 1 in 7 to a major abusive encounter, and 1 in 12 a severe abusive encounter. In reality, the numbers are likely higher than these; but if the lengthiness of the survey was a deterrent to its completion, those respondents who completed the survey might have been motivated by the effect of the abusive encounters on their job satisfaction. Despite our early misgivings about the length of the survey, and the effect that it would have on our return rate, we believed that the value of a clear knowledge of the categories of abuse would better inform policy decisions that need to be implemented to rectify this aberrant behaviour.

Conclusion

The family physicians participating in this study were, on average, in the middle of their careers and had already experienced substantial rates of minor, major, and severe abusive encounters.

Table 6. Perpetrators of abusive incidents

PERPETRATOR*	ONCE OR MORE OFTEN, %	RARELY, N (%)	SOMETIMES, N (%)	OFTEN, N (%)	VERY OFTEN, N (%)
Patient	89.9	299 (39.6)	195 (25.8)	107 (14.2)	79 (10.4)
Family of patient	70.1	286 (37.9)	193 (25.6)	39 (5.2)	11 (1.5)

*Not mutually exclusive.

In this paper we have reported the career prevalence of abusive encounters experienced by family physicians. Future papers will address the effects that these encounters have on physicians and their families. Workplace violence for family physicians is a serious issue that needs to be addressed at local, provincial, and national levels. All service providers who deal with the public expect some level of disrespectful behaviour or humiliation. However, abusive incidents like stalking, assault, and sexual harassment should not be a regular aspect of family practice. Our study points to the fact that family physicians working in certain practice settings, such as the ED, are at increased risk of abuse, and physician sex and race influence the type of abuse. This study has highlighted some serious issues that family physicians in Canada must deal with daily, and we hope that this study will be a foundation for discussion to make practice settings in Canada safer for family physicians and more conducive to physician well-being and physician retention in practice.

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Contributors
Dr Miedema was involved in all aspects of the project from conception and grant writing to project design, data analysis, and writing of the manuscript. **Mr Hamilton** made a substantial contribution to the analysis of the data and the writing of the manuscript. **Dr Tatemichi** made a substantial contribution to the concept of the study and the writing of the manuscript. **Ms Lambert-Lanning** made a substantial contribution to coordinating the data collection, analyzing the data, and writing the manuscript. **Drs Lemire, Manca,** and **Ramsden** made substantial contributions to the concept of the study and review of the manuscript.

Competing interests
None declared

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