



Physicians and violent patients

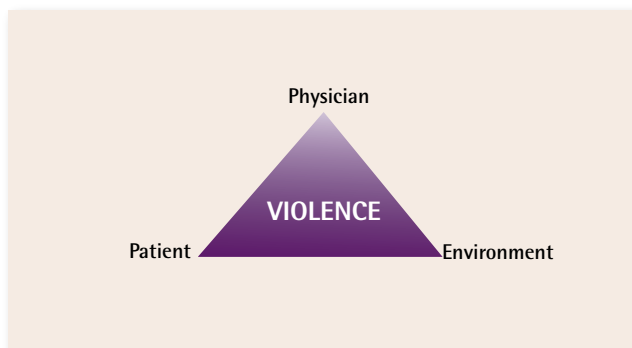
Where does this violence come from?

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According to Magin and colleagues (page 1279), physicians are often victims of violence. In a survey of 172 Australian general practitioners, these authors found that the annual incidence of violence against physicians was as high as 64% in some regions. In other words, 2 out of 3 physicians were assaulted each year. That's hardly reassuring! Using qualitative methods, these authors attempted to understand the phenomenon of violence against physicians by exploring physicians' opinions on the matter. They were able to identify 3 broad categories of violence: violence attributable to patients, violence that arises from the context of care, and violence attributable to physicians themselves.

Among the causes of violence attributable to patients, the Australian physicians mentioned problems of individuals, such as psychiatric illnesses, use of alcohol and drugs, sexual misconduct, physical diseases, personality problems, and problems of society, such as poverty, unemployment, dislocation of families, lack of respect for authority, the "Bowling for Columbine" effect, and crowded living conditions. Causes attributable to the context of care included some directly linked to the provision of care (waiting times and lack of access to care) and others to the inability to control violence (immature behaviour and inadequate interpersonal skills). As to causes attributable to physicians, the authors emphasized physicians' vulnerability as the main factor contributing to violence.

This categorization of the causes of violence is very interesting (patients ↔ environments ↔ physicians). In my opinion, it's true that all violent incidents occur within this framework: they all involve patients (or their families), physicians (or their teams), and some environment or other.



Is it true that we have nothing to do with it?

What surprises me the most in this study is how little attention is paid to the causes of violence attributable to physicians themselves. Two small paragraphs, hardly 200 words among the 2000 in this article, deal with this aspect. We might have the impression that, for the physicians questioned and for the researchers coding their responses, outside of their vulnerability or the fact that they were in the wrong place at the wrong time, these physicians were victims of violence that was completely exterior to them and had nothing to do with them. Now, as we all know, "It takes two to tango."

I am not suggesting, however, that physicians are responsible for the violence they experience. Doctors can certainly be victims of aggression without cause and without warning. For example, patients who are delirious, intoxicated, restrained, or driven by desperation constitute a menace to anyone they meet, even the doctors who are going to examine them. And borderline patients, schizophrenics, or those having hallucinations explode sometimes for no reason. But the opposite is also true: some physicians put a match to the gunpowder with their unempathetic, disrespectful, or even belligerent attitudes, while others "blow a fuse" for no reason. Finally, very poor conditions of care can, in themselves, engender violence. But generally, violence erupts within the confines of the 3 poles.

It's important to remember that, in difficult relationships prone to violence, we need to take time to analyze the situation and understand the emotions generated and felt by patients and by doctors. Does the violence originate from the patient, the context, the physician, or from a combination of all 3? We need to define the origin of the difficulty. Do we need to redefine the problem? Do we need to have a mutual understanding of the changes proposed? Do we need to agree on the plan for investigation and treatment?

Finally, we need to know whether the problem of violence is as serious in Canada as it is in Australia. 🍁