Physician, protect thyself

Barbara Sibbald

In brief

INCREASINGLY, HEALTH CARE WORKERS are being threatened and physically attacked by the people they are trying to help. What can physicians do to protect themselves and their coworkers?

En bref

LES TRAVAILLEURS DE LA SANTÉ sont de plus en plus souvent la cible de menaces et d'agressions de la part de la clientèle qu'ils cherchent à aider. Que peuvent faire les médecins pour se protéger et protéger leurs collègues de travail?

A Canadian female physician and her receptionists are bound, gagged and raped by a new patient. An internist from Kootenay, BC, is attacked from behind and hit on the head. Dr. Bill Campbell of Calgary is assaulted in his office by a patient (see sidebar). A retired Vancouver psychiatrist faced 6 months of terror, including fire bombings and slashed tires, before being stabbed and suffering a punctured lung. In 3 different cities, physicians are shot and seriously wounded in their homes in a series of attacks the police believe are linked. But there's worse. On Sept. 23, 1997, Toronto family physician Bernard Lau was murdered in his office by an angry patient.

These apparently isolated incidents are actually part of a growing trend toward violence in society at large. Statistics Canada data indicate that the number of violent crimes committed annually per 100 000 Canadians increased from 865 to 1037 between 1988 and 1994. There is also some evidence that violence is increasing in the health care sector. BC Workers' Compensation claims resulting from workplace violence more than doubled between 1982 and 1991, rising from 539 to 1158. The rate quadrupled for health care workers, who accounted for 55% of claims. BC nurses now face the same risk of workplace violence as police officers — nearly 4 times the incidence of any other profession. Between 1991 and 1995, disability claims related to violence were paid to about 2500 BC health care workers.

Other research points in the same direction. A survey of health care professionals in Ontario, Manitoba and Saskatchewan indicated that between 20% and 80% of respondents had been assaulted during their career. The incidence of assaults was higher in institutions than in the community, and higher in psychiatry and emergency medicine than in other hospital departments.

Why is this happening?

There are many theories about why this violence is occurring. One contributing factor may be downsizing in the health care system, which has made hospitals the entry point to the mental-health system. It also means that fewer staff members have to do more. Dr. Joe Noone, chair of the British Columbia Medical Association's (BCMA) Committee on Violence, says he has seen many professionals be dismissive with patients, even rude. "It goes on all the time and workers are completely unaware of it," he says.

Neil Boyd, a criminology professor at Simon Fraser University who is studying physical abuse in the health care sector, says the main reason for increasing vi-

Features

Chroniques

Barbara Sibbald is *CMAJ*'s Associate Editor, News and Features.

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olence is the aging population. Twenty years ago, 90% of long-term-care residents were largely self-sufficient. Today, 90% require varying degrees of care and 50% have psychogeriatric disturbances. He says abuse of workers occurs most frequently in long-term-care facilities, where residents have disabilities such as brain injuries, age-related dementia and chronic progressive diseases. "As the population ages, we're going to face more difficulties."

Noone, a forensic psychiatrist who has presented security workshops since 1990, says a 1996 risk-assessment study at the Vancouver General Hospital indicated that 90% of violent incidents — 994 in all — occurred in the emergency or psychiatry/emergency departments. Three-quarters of the incidents involved verbal assaults, one-quarter physical attacks. Police were called to deal with 13% of the latter incidents.

Violence against physicians, which even merited a feature story in September's *Chatelaine*, is now drawing the attention of medical associations in BC, Ontario and elsewhere. The BCMA formed the first and only physician-sponsored Committee on Violence in 1995, and even though this 7-member committee is concerned about violence in society — it lobbies on issues such as firearms legislation — it also promotes education programs to help doctors recognize and manage the violence they may encounter.

90% prevention, 10% management

"Confronting a violent patient is one area where doctors do need training," says Dr. Jim Lane, the BCMA president. "Most of us confront this periodically." Noone, who says preventing violence is 90% prevention, 10% management, would like to see security training provided at medical school.

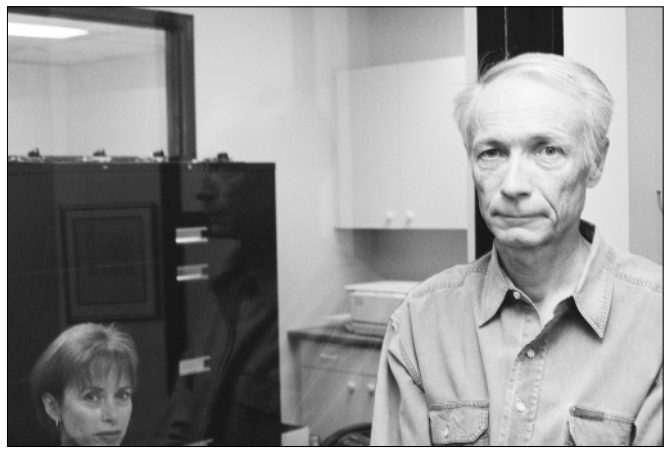
But even when training is available many physicians appear reluctant to take it. Noone offers a course at the Vancouver General and UBC hospitals, and only half of the psychiatry residents wanted to take it. Likewise, it was "hard to get emergency physicians to see it as a problem."

He suspects that many doctors are in denial — they don't think it will happen to them — or they feel it's just part of dealing with sick and unhappy people. "We have to separate the person from the behaviour," he says. "Staff do not go to work to be assaulted."

Noone differentiates between mood aggression and the less prevalent predatory aggression. "Predatory violence is very frightening," he says. "You can see mood aggression coming, but the predatory variety is impossible to predict and therefore much harder to prevent."

According to the Alberta College of Physician and Surgeons (see "What to do when you are threatened!", *The Messenger*, July 1998, **www.cpsa.ab.ca**), only about 25% of threats against doctors are made by strangers; a very small percentage of attacks involve terrorists with political or ideological motivation.

Zoltan Varadi



Dr. Bill Campbell sits in front of new waiting room window that was installed after he was attacked; office manager Pat Penney sits behind window.

So what can physicians do to protect themselves? Inspector Dave Bowen of the Hamilton-Wentworth Police Service recommends a multipronged approach. The first step, he says, is to form a strong relationship with the local police force. "Contact them so they know the concerns of doctors. The police want to help."

Noone, meanwhile, advises physicians to remember the "3 As" of personal safety: awareness, assessment and action.

The following is a synthesis of information provided by Noone, Bowen, the Winnipeg Police Services *CounterAction* handbook, the Alberta college article and other sources. Indeed, the amount of information now available is one indication of how serious this problem has become.

A safe workplace

Physicians' first step should be to ask police to conduct a security audit of their office, clinic or hospital. The resulting recommendations may include ID checks, restricted after-hours access, improved lighting at entrances and in parking areas, security cameras, panic buzzers, mirrors and deadbolts or electronic locks.

Other recommendations:

- Remove potential weapons (letter openers, scissors, staplers, etc.) from public areas.
- Lock all doors other than the main entrance, keep track of who has keys and retrieve them when employees leave the practice.
- Preprogram 911 into all phones.
- Install an alarm and place alarm buttons in strategic locations.
- Enclose and secure the reception areas.

"Be prepared for the worst"

As a GP specializing in addiction treatment, Dr. Bill Campbell is used to dealing with disturbed patients. However, nothing prepared him for the psychotic visitor who barged into his office in 1996.

The patient, who Campbell had sent away because he wasn't willing to quit taking drugs, walked past Campbell's receptionist and into the doctor's office, demanding that he "take this thing out of his rectum." Campbell says he had no previous indication that the man was psychotic, so at first he thought he'd missed diagnosing bowel cancer. The patient soon clarified that: he said Campbell had planted a radio receiver in his rectum.

He then grabbed the phone from Campbell, who was in the midst of a call, slammed it down and punched Campbell in the face. "He kept saying 'I'm going to kill you.' "

Campbell had a back door to his office. "I asked him to come with me to get the receiver out, and we went out the back door into the main hallway. When he realized he'd been tricked he hit me again and knocked me out briefly. I came too and saw his boot and I thought he was going to kick me, but another guy came along and he took off."

The receptionist had called 911 immediately and the police arrived. By the time they arrested the man, he had a knife. He was convicted of assault and later committed suicide.

Campbell needed a couple of stitches in his lip and a week off work to recover. When he returned to work he spent some money on a tempered glass window that allows his receptionist to see into the waiting area. He also installed locks on her door, allowing her to control access to his office.

Campbell recommends a 3-level approach to preventing violence in the workplace. First, don't let it happen: be aware of the possibility of danger and do what you can to prevent it. Second, make sure you have control. Finally, be prepared to act quickly.

"Patients I deal with can be threatening, but when they're psychotic and threatening there's not much you can do, so be prepared for the worst.

"I'm more careful now," says Campbell. "It's not going to happen to me again."

Physicians can also take steps to protect themselves and staff members:

- Ask the police to hold a personal safety seminar for all staff.
- Leave the examining-room door open if concerned about a patient.
- If a person is encountered while you are working late or alone, indicate that someone else is nearby: "My partner will be right with you."
- Always escort visitors to their destination, and consider introducing a visitor logbook and name tags. If a stranger is wandering about, offer assistance.
- Review your emergency plan and ensure everyone knows what to do if there is an incident.
- Do not allow staff to give out names, role, home phone numbers or addresses over the phone.
- Develop code words for alerting one another to danger.

Experts warn that all threats of violence should be taken seriously. Those being threatened should stay as calm as possible and watch for signs of anger, such as clenched fists, while keeping their own hands in view, above the waist and with palms open. They should keep their distance by staying about a leg-length away, and they should never block a person's exit route or try to take a weapon from him.

After the incident, police should be informed immediately and post-traumatic counselling should be offered. Written or recorded messages should be kept as evidence and a note should be made in the person's medical record. Witnesses should be asked to make notes about the incident and the patient should be dismissed from the practice in writing. If applicable, the referring physician should be informed.

Security at home

Danger can follow physicians home. Several Canadian physicians have been murdered in their homes in the last 10 years, including at least one who was killed by an ex-patient. The police, who will conduct a home-safety audit if asked, say physicians should not list their home phone number and they should ensure that it is removed from phone Web sites.

They should also carry a cell phone, avoid being alone in a parking lot or garage, and avoid travelling alone after hours.

In light of the shootings that have wounded 3 physicians in their homes since 1994, they should also be wary of unfamiliar cars or "out-of-the-ordinary" people or incidents anywhere near their home. ❦