

Violence against trainee paediatricians

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Abstract

Background—Much research has looked at the extent of violence against doctors, but this has been restricted mainly to psychiatry, general practice, and accident and emergency.

Aims—To assess the level of violence against trainee paediatricians.

Methods—A telephone questionnaire was addressed to 25 specialist registrars/senior registrars/senior SHOs in each of three regions in the UK: Northern Ireland, South Thames, and North West England.

Results—Sixty eight of 75 (90.7%) trainee paediatricians had been exposed in at least one circumstance to a violent incident, 47 of which incidents (62.3%) had occurred in the past year. Thirty one (41%) had suffered threats on at least one occasion. Although only 5.3% of the interviewees had been victims of actual physical assault, more than 10% said that an attempted assault had taken place. Most of the doctors who had experienced a violent episode (41/68) worried about the incident after return from work and yet only one was offered any counselling. Only nine (13.2%) had ever formally reported an incident to hospital management. Less than 10% of those questioned had received any formal training in the management of violent people, although 99% thought this would be a good idea.

Conclusions—Paediatric trainees are involved in high risk situations at work (for example, child protection and casualty) which frequently result in exposure to violence. Very few report these incidents officially, but often underplay them. More attention should be given to the training and counselling needs of paediatric trainees.

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Violence is an escalating problem in our society and more recently violence is being recognised as an increasingly significant problem in the workplace. Between 1991 and 1995 incidents of work related crime doubled in the UK.¹ Examples include the abduction of Suzy Lamplugh, an estate agent, in 1986 and the murder of Frances Bettridge, a social worker, who was killed while making a home visit. Health care professionals have not been spared and the 1996 British Crime Survey confirmed that they are at greater risk of violence at work than the general population. If an individual doctor has not personally been a victim of violence, most doctors will know a colleague who

has suffered from violence at work. To date, the actual extent of the problem has been difficult to ascertain. What constitutes violence has varied in different studies and this, in part, has led to the differing incidences quoted in the literature.² The definition used by the Health and Safety Executive³ is “any incident in which an employee is threatened or assaulted by a member of the public in circumstances arising out of the course of his/her employment”. The European Commission DG-V used a similar definition of “incidents where (staff) are abused, threatened, or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, wellbeing, or health”.⁴ Verbal abuse and threats are often overlooked and are not usually reported to either hospital authorities or the police. Such events are often perceived to be “part of the job”. Many studies have looked at violence and aggression against doctors but have tended to concentrate on areas where the problem is perceived to be greatest—psychiatry, emergency medicine, and general practice.⁵ From personal experience, paediatricians as a group, and junior paediatricians in particular are at significant risk. They undertake duties in accident and emergency departments and are involved in child protection matters where emotions can run high. In addition parents may behave in an uncharacteristic manner when their child is unwell. There was no evidence to be found in the published literature regarding just how great the extent of the problem is in paediatrics.

The aims of this study were to ascertain the incidence, frequency, and severity of violence against paediatricians in training, to ascertain how doctors responded to such episodes and whether they had received any training in the management of violent and aggressive situations.

Methodology

The population studied was middle grade paediatricians (specialist registrars, senior registrars, and experienced senior house officers). Twenty five doctors in each of three health regions of the UK were contacted by telephone. All agreed to participate in the study. A questionnaire was addressed to each doctor looking at whether they had ever been the subject of various forms of abuse or assault. They were also asked if this had happened in the past year. If the individual doctor had been involved in a violent episode, they were asked how they responded to such situations and whether they had reported a violent incident at work to either hospital authorities or the police. Finally they were asked about training

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Table 1 Violence experienced overall and in the past year

Type of violence	Ever	Past year
Verbal abuse	68 (90.7%)	47 (62.7%)
Threats	31 (41.3%)	16 (21.3%)
Attempted physical assault	8 (10.7%)	2 (2.7%)
Actual physical assault	4 (5.3%)	1 (1.3%)

in handling aggression and violence and whether they had ever received any instruction in this field.

Results

Of the 75 doctors questioned, 42 (56%) were female. This reflects the national average at this level of seniority. The mean length of time spent in paediatrics was 5.7 years with a range of 18 months to 15 years.

RATES OF VIOLENCE

Sixty eight of the 75 (90.7%) paediatricians had experienced violent episodes of one kind or another, with 49 (65%) reporting such an incident in the past year (tables 1 and 2). The most common incident was verbal abuse, which more than 90% of doctors had suffered. Threats, which included a death threat and a threat to involve a paramilitary organisation in Northern Ireland, were reported by 31 (41.3%). Four doctors (5.3%) had been physically assaulted during the course of their work and twice this number (10.7%) claimed to have experienced patients' relatives attempting to assault them. There was no statistically significant gender difference in terms of exposure to violence.

REPORTING

Only nine of the 68 (13.2%) who had been involved in a violent incident had formally reported the incident to hospital authorities. Most did not know how to make such a report and many did not know that they should do so. Just four people (5.9%) had reported an incident to the police.

AFTER THE INCIDENT

Most of those questioned did not shrug off the incident. Forty one (60.3%) reported worrying about the episode after work. In this respect men and women were equally affected (60.7% men; 60% women). Only one person (1.5%) was offered counselling after the violent incident.

TRAINING

Only seven of the 75 (9.3%) had received training in how to manage violent or aggressive patients or relatives. For most, this had been part of their undergraduate medical course. Attendance at a course since graduation was rare (2/75). All except one felt that such training would be useful.

Table 2 Violence experienced according to region

Type of violence	Northern Ireland	South Thames	North West	Total
Verbal abuse	23	22	23	68 (90.7%)
Threats	11	9	11	31 (41.3%)
Attempted physical abuse	5	2	1	8 (10.7%)
Actual physical abuse	2	1	1	4 (5.3%)

Discussion

In this study, most junior paediatricians were exposed to violent episodes during their career, with more than 60% having experienced violence during the past year. Most of these incidents were verbal insults or threats, with less than 6% suffering physical assault. Studies looking at junior doctors working in the fields of accident and emergency, psychiatry, and general practice,^{6,7} have reported an incidence of 63.6% for verbal insults, 41% for physical violence, and 36.3% for physical injuries. In 1995 the British Medical Association surveyed 250 doctors and found that 55% had been exposed to violence in the course of their work.⁸ I found physical injury to be less common than reported in some other specialties, but the nature of paediatrics is such that paediatricians may attract more verbal abuse from highly stressed parents. Should we worry about this? The old aphorism of "sticks and stones may break my bones but names will never harm me" is often quoted, but verbal abuse can be both menacing and harmful. In addition to the psychological problems⁹ faced by the recipient, abuse can interfere with clinical decision making. When faced with an angry parent it can be difficult to make decisions which may inflame matters. This applies particularly in the field of child protection.

How can we improve this situation? There are several ways in which we can reduce the risk of such incidents. It has been shown that formal training in how to avoid violent situations and how to manage them if they occur can lead to a decrease in the number of such incidents.¹⁰ Presently many NHS trusts run such courses, although few of the doctors I surveyed had attended, even though almost all said they would find such a course helpful. Should training in dealing with aggression and violence become a mandatory element of general professional training? At the very least, hospital induction programmes should include information regarding the local availability of training in this topic. I believe a good training programme should cover four areas:

- (1) Theory—understanding aggression in the workplace
- (2) Prevention—assessing danger and taking precautions
- (3) Interaction—with aggressive people
- (4) Post incident action—reporting, investigation, counselling, and other follow up.

Increasingly, government policy is to encourage and enable patients to complain about the health services they receive. Paediatricians should ensure that they deliver a service in an environment that is safe for both patients and staff. In addition, we should be more concerned about the after effects of violent incidents and ensure that our colleagues receive the help and support they need in the aftermath of workplace violence.

1 Home Office Research Group. *British crime study*. London: Home Office, 1996.

2 Hobbs FDR, Keane UM. Aggression against doctors: a review. *J R Soc Med* 1996;**89**:69–72.

- 3 Poyner B, Warne C. (1986) Report by the Tavistock Institute of Human Relations for HSE. *Violence to staff: a basis for assessment and prevention*. London: HMSO, 1986.
- 4 Wynne R, Clarkin N, Cox T, Griffiths A. *Guidance on the prevention of violence at work*. Luxembourg: European Commission, DG-V, 1997.
- 5 Zahid MA, Al-Sahlawi KS, Shahid AA, et al. Violence towards doctors: prevalence and effects. *Hosp Med* 1999;50:414–18.
- 6 Schneiden V. Violence at work. *Arch Emerg Med* 1993;10:79–85.
- 7 Schneiden V. Violence against doctors. *Br J Hosp Med* 1993;50:6–9.
- 8 Coulsdon J. Doctors demand training in dealing with attackers. *BMA News Review* 1995;21:17.
- 9 Schneiden V, Maguire J. *A report on violence at work and its impact on the medical profession within hospitals and the community*. London: BMA, 1993.
- 10 Health Services Advisory Committee. *Violence and aggression to staff in health services*. London: HMSO, 1997.

Commentary

Paediatricians of all grades work in perhaps the most emotionally charged atmosphere of all specialties. Verbal abuse is a common occurrence, and tends to be ignored or forgiven because of the fraught situations the parents or carers are in. But is this the right attitude? Mackin's paper highlights the high frequency of verbal and physical abuse directed against trainee paediatricians. He emphasises that verbal abuse is both harmful and menacing and may interfere with clinical decision making. The staff of the department within which I work were subjected to prolonged (over a period of weeks) verbal abuse and threats of physical violence. This culminated in an actual physical attack on two consultants, resulting, personally, in post-traumatic stress disorder and permanent physical damage.

Prevention is better than cure, and Mackin is right when he states that training in this area is now, unfortunately, essential. However, avoidance of conflict with carers, and on occasions patients, is not always feasible. It may be possible to recognise a pattern of escalation and for this reason all incidents of violence, verbal or physical, should be reported, recorded, and acted on. There should be no tolerance of vio-

lent threats or incidents. In retrospect the warning signs in my own case were clear. Verbal abuse had become routine and was being ignored. The spirit of cooperation that usually exists between medical (and nursing) staff and carers had broken down and it had become increasingly difficult to manage the patient. Where conflict over care seems inevitable despite all efforts at negotiation there may come a time when further action needs to be taken in order to continue to provide care. At this stage, legal opinion is essential. My personal experience would suggest that it might be necessary to obtain specialist legal advice—hospital lawyers may not be *au fait* with such situations, and their advice inadequate.

If an assault occurs should criminal charges be brought? My attackers were brought to Court, tried, convicted and jailed. The defence lawyers seemed aggressive and confrontational and the media coverage sensation seeking and inaccurate. The experience was unpleasant and isolating. The profession should consider how best to support doctors in this position. How can victims of violence be helped? Mackin suggests "reporting, investigation, counselling, and other follow up". I would agree but would suggest caution in the use of generic counselling. Counselling may be of no benefit,¹ and from my own experience can worsen matters. Seek expert help and give yourself time to process what has happened. It does get better.

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¹ Carlier IV, Voerman AE, Gersons BP. The influence of occupational debriefing on post traumatic stress symptomatology in traumatized police officers. *Br J Med Psychol* 2000;73(Pt 1):87–98.