Disrespect, harassment, and abuse

All in a day's work for family physicians

Baukje Miedema RN PhD Julie Easley MA Pierrette Fortin PhD Ryan Hamilton MSES Sue Tatemichi MD

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.

EDITOR'S KEY POINTS

- Harassment and abuse of family physicians in the workplace by patients or colleagues is an emerging issue in health care environments; encounters range from disrespectful and demanding behaviour to verbal threats and violence. Little research has been done in Canada regarding this issue, although it is believed that a large number of abusive encounters experienced by physicians remain unreported.
- Younger physicians, female physicians, and physicians working in rural areas are most likely to experience mild to severe forms of workplace abuse.
- Unaddressed workplace issues might lead to family physicians leaving clinical practice prematurely or refusing to work in high-risk settings, such as emergency departments, rural locations, or patients' homes, which are also areas of high need.
- There are currently no national guidelines in place to help family physicians prevent or address workplace violence—policies must be developed to protect family physicians, increase awareness of risk situations, and send a message of zero tolerance.

This article has been peer reviewed.
Can Fam Physician 2009;55:279-85

Manque de respect, harcèlement et grossièreté

Le menu quotidien du médecin de famille

Baukje Miedema RN PhD **Julie Easley** MA **Pierrette Fortin** PhD **Ryan Hamilton** MSES **Sue Tatemichi** MD

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'ÉTUDE 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.

MÉTHODES On a utilisé une approche d'étude de cas regroupés, soit 24 cas comprenant chacun 2 sujets. Ces cas étaient choisis en fonction du sexe, du lieu de pratique (urbain ou rural), de la langue (anglais ou français) et du nombre d'années depuis l'obtention du diplôme (< 10 ans, 10 à 20 ans ou > 20 ans). Les entrevues étaient en anglais ou en français. Les participants ont été recrutés à l'aide de l'annuaire des médecins du Nouveau-Brunswick. D'après les taux de réponse et de participation, certains cas étaient sur-représentés tandis que d'autres n'ont pas été complétés. Toutes les entrevues ont été enregistrées sur bande audio, transcrites mot à mot et analysées de façon thématique par une méthode d'agrégation catégorique. L'équipe de recherche a mis au point un système de codage pour l'analyse thématique avant la transcription des entrevues.

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.

Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2009;55:279-85

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.[1-6] 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 "fallback" doctor when other specialist medical services are not available, they are more vulnerable to abuse than other medical specialists are.[7]

The Canadian Centre for Occupational Health and Safety defines *abuse* as threatening behaviour, harassment, verbal abuse, physical attacks and grave physical or psychological harm.[1] 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.[7] 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.[7-11] 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.[9]

The most frequently cited perpetrators of disrespectful, harassing, or abusive behaviour are patients and their relatives.[12-14] 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.[15] A recent New Zealand study concluded that two-thirds of medical students experienced at least 1 negative encounter, such as humiliation, with their superiors.[4] 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.[16] 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.[6,8,17,18]

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.[10,19] 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."[20]

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.[21] We created a New Brunswick family physician profile based on the 2007 National Physician Survey results,[22] 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.[22]

A qualitative case study methodology was used to explore the "bounded system" through in-depth interviews.[23] Time and place are the prevailing characteristics of a bounded system; in this case, the work environment of family physicians was the parameter studied.[23] 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."[23] 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.[23] 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**.

Table 1. Distribution of participant characteristics: *N* = 48.

CHARACTERISTICS	N (%)*
Sex	
• Female	29 (60)
• Male	19 (40)
Location	
• Urban	27 (56)
• Rural	21 (44)
Language	
• French	25 (52)
• English	23 (48)
Years in practice	
• < 10 years	18 (38)
• 10–20 years	18 (38)
• > 20 years	12 (25)

*Not all values add up to 100% owing to rounding.

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

> going to come in and get what I want and I don't really care what you have to say because you are only a GP" ... sometimes people are a bit disrespectful, and their expectations are unreasonable and then they get angry at you. (Interview 32)

Some disrespectful behaviour is completely a result of gender bias. A few female physicians reported receiving derogatory comments from both patients and colleagues 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 disrespectful work environment caused the physician to leave the community. As one female physician described,

> [T]he nurses would talk behind your back ... questioning 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 experience 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 encounters 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 conversation. (Interview 6)

Abusive encounters with patients were more common. One female physician was threatened with violence 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 making 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 problems 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 literature, disrespectful, harassing, and abusive encounters are not uncommon in the workplace of the family

physician.[1] 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.[24] This trend is consistent with other studies that found women to be at higher risk than their male counterparts for abuse and harassment.[6,9,17] 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."[25,26] 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.[27]

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.[28] 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.

Dr Miedema is Director of Research at the Dalhousie University Family Medicine Teaching Unit (FMTU) in Fredericton, NB. **Dr Tatemichi** is Unit Director at the FMTU and a part-time family physician in a First Nations community in Fredericton, NB. **Ms Easley** and **Mr Hamilton** are doctoral students at the University of New Brunswick in Fredericton and part-time research assistants at the FMTU. **Dr Fortin** is Chair of the Secteur des sciences humaines at the Université de Moncton in Edmundston, NB.

Contributors

Dr Miedema was the principal investigator for this study and contributed to all parts of the project, from conception to the final manuscript. **Dr Fortin** was a coinvestigator. **Ms Easley** and **Mr Hamilton** contributed to the study design, data collection and analysis, and writing the manuscript. **Dr Tatemichi** was a coinvestigator and contributed to the study design and to writing up the results.

Competing interests

None declared

Correspondence

Dr Baukje Miedema, Family Medicine Teaching Unit, Dr Everett Chalmers Hospital, PO Box 9000, Priestman St, Fredericton, NB E3B 5N5; telephone 506 452-5714; fax 506 452-5710; e-mail **bo.miedema@rvh.nb.ca**

References

1. Violence in the workplace [website]. Ottawa, ON: Canadian Centre for Occupational Health and Safety; 2008. Available from: **www.ccohs.ca/oshanswers/psychosocial/violence.html.** Accessed 2009 Jan 20.
2. Magin P, Adams J, Ireland M, Joy E, Heaney S, Darab S. The response of general practitioners to the threat of violence in their practices: results from a qualitative study. *Fam Pract* 2006;23(3):273-8. Epub 2006 Feb 3.
3. Luck L, Jackson D, Usher K. Innocent or culpable? Meanings that emergency department nurses ascribe to individual acts of violence. *J Clin Nurs* 2008;17(8):273-8. Epub 2007 Apr 5.
4. Wilkinson TJ, Gill DJ, Fitzjohn J, Palmer CL, Mulder RT. The impact on students of adverse experiences during medical school. *Med Teach* 2006;28(2):129-35.
5. Purcell R, Pathé M, Mullen PE. The prevalence and nature of stalking in the Australian community. *Aust N Z J Psychiatry* 2002;36(1):114-20.
6. Magin PJ, Adams J, Sibbritt DW, Joy E, Ireland MC. Experiences of occupational violence in Australian urban general practice: a cross-sectional study of GPs. *Med J Aust* 2005;183(7):352-6.
7. Magin PJ, Adams J, Ireland M, Heaney S, Darab S. After hours care—a qualitative study of GPs' perceptions of risk of violence and effect on service provision. *Aust Fam Physician* 2005;34(1-2):91-2.
8. Fernandes CM, Bouthillette F, Raboud JM, Bullock L, Moore CF, Christenson JM, et al. Violence in the emergency department: a survey of health care workers. *CMAJ* 1999;161(10):1245-8.
9. Kowalenko T, Walters BL, Khare RK, Compton S; Michigan College of Emergency Physicians Workplace Violence Task Force. Workplace violence: a survey of emergency physicians in the state of Michigan. *Ann Emerg Med* 2005;46(2):142-7.
10. Erdos BZ, Hughes DH. Emergency psychiatry: a review of assaults by patients against staff at psychiatric emergency centers. *Psychiatr Serv* 2001;52(9):1175-7.
11. Galeazzi GM, Elkins K, Curci P. The stalking of mental health professionals by patients. *Psychiatr Serv* 2005;56(2):137-8.
12. Harding K. What doctors won't say: they're living in fear. *Globe and Mail* 2006 Feb 15;Sect. A:3.
13. Walsh A. Our white coats are not armour. Protecting physicians in the doctor-patient relationship. *Can Fam Physician* 2005;51:1604-5 (Eng), 1609-11 (Fr).
14. Anderson C. Workplace violence: are some nurses more vulnerable? *Issues Ment Health Nurs* 2002;23(4):351-66.
15. Gold J, Ross P, Seeley J. Harassment and intimidation in Canadian faculties of medicine: what Canadian graduates are telling us. Paper presented at: 2001 Annual Conference of the Royal College of Physicians and Surgeons of Canada; September 2001; Ottawa, ON.

16. Frank E, Carrera JS, Stratton T, Bickel J, Nora LM. Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey. *BMJ* 2006;333(7570):682. Epub 2006 Sep 6.
17. Gale C, Arroll B, Coverdale J. Aggressive acts by patients against general practitioners in New Zealand: one-year prevalence. *N Z Med J* 2006;119(1237):U2050.
18. King LA, McInerney PA. Hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban metropolitan area. *Curationis* 2006;29(4):70-81.
19. Duncan SM, Hyndman K, Estabrooks CA, Hesketh K, Humphrey CK, Wong JS, et al. Nurses' experience of violence in Alberta and British Columbia hospitals. *Can J Nurs Res* 2001;32(4):57-78.
20. Royal College of Physicians and Surgeons, College of Family Physicians of Canada. *Accreditation and the issue of intimidation and harassment in postgraduate medical education: guidelines for surveyors and programs.* Mississauga, ON: College of Family Physicians of Canada; 2004. Available from: **www.cfpc.ca/local/files/education/intimidation_and_harassment_en.pdf**. Accessed 2009 Jan 20.
21. Membership directory [website]. Rothesay, NB: College of Physicians and Surgeons of New Brunswick; 2008. Available from: **www.cpsnb.org/webdata/drdbase_form.shtml.** Accessed 2009 Jan 20.
22. College of Family Physicians of Canada, Canadian Medical Association, Royal College of Physicians and Surgeons of Canada. *National physician survey 2007. National results by province and Canada.* Mississauga, ON: College of Family Physicians of Canada; 2007. Available from: **www.nationalphysiciansurvey.ca/nps/2007_Survey/Results/physician2_can-e.asp.** Accessed 2009 Jan 21.
23. Creswell JW. *Qualitative inquiry and research design: choosing among five traditions.* Thousand Oaks, CA: Sage Publications; 1997.
24. Canadian Resident Matching Service [website]. *Timetable for the first iteration of the 2008 R-1 match.* Ottawa, ON: Canadian Resident Matching Service; 2008. Available from: **www.carms.ca/eng/r1_1stIteration_e.shtml.** Accessed 2009 Jan 21.
25. Department of Health. *Withholding treatment from violent and abusive patients in NHS trusts.* London, UK: Health Service Circular; 2001. Available from: **www.dh.gov.uk/en/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/DH_4003624.** Accessed 2009 Jan 21.
26. United States Department of Labor. Guidelines for preventing workplace violence for health care and social service workers. Washington, DC: United States Department of Labor; 2004. Available from: **www.osha.gov/Publications/OSHA3148/osha3148.html.** Accessed 2009 Jan 21.
27. Nachreiner NM, Gerberich SG, McGovern PM, Church TR, Hansen HE, Geisser MS, et al. Relation between policies and work related assault: Minnesota nurses' study. *Occup Environ Med* 2005;62(10):675-81.
28. College of Family Physicians of Canada. *Family medicine in Canada. Vision for the future.* Mississauga, ON: College of Family Physicians of Canada; 2004. Available from: **www.cfpc.ca/local/files/Communications/Health%20Policy/FAMILY_MEDICINE_IN_CANADA_English.pdf.** Accessed 2009 Jan 21.