INTERNATIONAL JOURNAL OF STUDENTS' RESEARCH
Volume 6 Issue 1 Year 2016 **www.ijsronline.net**

EDITORIAL

Violence against healthcare professionals: are we looking for the peaceful truce?

M. M. Aarif Syed

Way back in 1981, Dublin WR had discussed about evaluating and managing violent patients [1]. He was concerned about such patients attending the emergency rooms. Jacobs D, 2 years later, talked about aggressive patients in psychiatry emergency [2]. They at that time may not have had an idea that we will someday require such discourses on managing violent patients' relatives as well. Medical fraternity has been the target of aggression and violence across the globe, perpetuated not only by patients but also by their companions or escorts. In fact, the problem has now reached pandemic levels.

Feldmann et. al. in 1997 reviewed 40 incidences of workplace violence in medical facilities [3]. He concluded that the risk factors for violence in medical setting differed from other work environments. A year later, Morrison et. al., using data from Bureau of Labor Statistics, US Department of Labor, highlighted the fact that more acts that are violent occur in healthcare and social service industries than in any other [4]. This was alarming. The reasons for aggression may be multifactorial. If we leave aside the medical cause of such violence, which is often the case with psychiatric patients, several socio-geo-political factors have roles to play. The reasons may differ significantly in the western part of the world as compared to the east. Employment status, educational level, and deficiency in services may not be the significant risk factors in the west [4]. While in the developing nations, mistrust, low economic and educational status, and poor managerial arrangements in the hospitals are more strong risk factors. Long wait for appointments, overburdened staffs, delay in attending patients, prescribing investigations that the patients or their relatives may think to be unnecessary, asking for advance payments, inadequate communication with patients of poor prognosis, and withholding deceased body are important instigating points [5,6]. Young residents, nurses, emergency personnel, and inexperienced staffs are other risk factors. In fact, nurses have been found to be the more common recipient of violence than the treating physicians.

In developing countries like India, the proportion of violence and aggression has resulted into multidimensional consequences. In March 2017 in Mumbai and Delhi, nearly 40,000 doctors from public and private sectors did not return to work for 5 days to protest a series of violence against doctors by patient's relatives. Such a step threatened to completely jeopardize the healthcare services. However, this was not one odd incidence of doctors taking such extreme step. Several instances of peaceful bunking as well as agitations have taken place in the past around the world. A survey from Turkey last year revealed that almost three-fourths of the respondents have been exposed to some form of violence [7]. China too has its own share of the pie. In a survey of 11 tertiary care hospital in China, the incidence of physical violence ranged from 8% to 35%, while nonphysical violence was documented between 68% and 76% [8]. The National Ministry of Health in China has reported a rapid increase in violent incidences, being 10,000 in 2005 to more than 17,000 in 2010 [9]. The numbers are increasing across the world. Pakistan and Nepal are also not immune to these problems [10,11].

Workplace violence is a global phenomenon. Several safety measures are in place. However, tackling violence in healthcare setting needs a different approach. Just installing security personnel may not yield long-lasting results. First, a more comprehensive approach through public and private partnership is required. The government must ensure that the perpetrators of violence are immediately booked and law must not delay its course of action. Second, the heavy workload on doctors could always be a precipitating factor for violent spats. Reducing the work burden on doctors, nurses, or supporting staffs will require an exhaustive policy to overhaul the healthcare infrastructure of the country. Furthermore, developing nations are struggling with heavy patient load per doctor. This heavy work pressure along with long working hours threatens the effective health services that a doctor can provide. Third, effective communication skills and showing empathy with compassion must be taught as an enforced part of the medical curriculum, so that the young residents who join the hospitals could explain the prognosis and the requisites of the treatment and medications. This will also turn a doctor into an educator to the patient. Fourth, the public must be taught about the doctors' rights as well, through proper display boards and noncommercial advertisements. Fifth, tackle the mistrust that has developed between doctors and patients, where patients are often suspicious of the ulterior motives of treating physicians. Building trust is equally a challenging task and can only be achieved through ethical practice from the medical fraternity.

Finally, this all may be a challenging job to address the issue of workplace violence; however, an optimistic approach can always be expected to yield positive results. Those trying to defend your life cannot be forced into a situation where they

Department of Dermatology and Venereology, Institute of Medicine, Tribhuvan University, Kathmandu, Nepal. E-mail: syedmmaarif@gmail.com

have to defend their own lives. Let the fight be against the diseases, not against the doctors.

References

1. Dubin WR. Evaluating and managing the violent patient. *Ann Emerg Med* 1981;10(9):481-4.
2. Jacobs D. Evaluation and management of the violent patient in emergency settings. *Psychiatr Clin North Am* 1983;6(2):259-69.
3. Feldmann TB, Holt J, Hellard S. Violence in medical facilities: a review of 40 incidents. *J Ky Med Assoc* 1997;95(5):183-9.
4. Morrison JL, Lantos JD, Levinson W. Aggression and violence directed toward physicians. *J Gen Intern Med* 1998;13(8):556-61.
5. Bawaskar HS. Violence against doctors in India. *Lancet* 2014;384(9947):955-6.
6. Violence against doctors: why China? Why now? What next? *Lancet* 2014;383(9922):1013.
7. Kaya S, Bilgin Demir İ, Karsavuran S, et. al. Violence against doctors and nurses in hospitals in Turkey. *J Forensic Nurs* 2016;12(1):26-34.
8. Liu H, Zhao S, Jiao M, et. al. Extent, nature, and risk factors of workplace violence in public tertiary hospitals in China: a cross-sectional survey. *Int J Environ Res Public Health* 2015;12(6):6801-17.
9. Violence against doctors: heartless attacks. The Economist; 21 July, 2012. Available from: http://www.economist.com/node/21559377. [Last accessed on 2013 Nov 02].
10. Khawaja A, Irfan H. Violence against doctors in government hospitals and the role of media. *J Pak Med Assoc* 2011;61(11):1163-4.
11. Magar A. Violence against doctors in Nepal. *J Nepal Med Assoc* 2013;52(190):I-II.

Competing Interest

The authors declare that they have no competing interests.

Funding

Sources of Funding: None.

Please cite this paper as: Syed MMA. Violence against healthcare professionals: are we looking for the peaceful truce?. *Int J Stud Res* 2016;6(1):1-2.

Access this article online	
Quick Response Code:	**Website:** www.ijsronline.net
	DOI: 10.4103/ijsr.Int_J_Stud_Res_8_17