CORRESPONDENCE

Aggression and Violence Against Primary Care Physicians —a Nationwide Questionnaire Survey

by Dr. med. Florian Vorderwülbecke, Maximilian Feistle, Dr. med. Michael Mehring, Prof. Dr. med. Antonius Schneider, Prof. Dr. med. Klaus Linde in volume 10/2015

Violence Against Medical Assistants

Having practiced as an office-based dermatologist in a socially disadvantaged area in Hamburg for 31 years, I would like to widen the perspective of the article beyond “threats to doctors.” As other doctors, I was physically attacked by patients in my office room, the entrance door to my office was smashed because it had not been opened to a patient arriving late, and I was seriously threatened when I did not issue the certificates of incapacity for work demanded by some patients.

However, violence—mostly in the form of verbal attacks—against my medical assistants has been much more common. My practice nurses and receptionists were shouted at, insulted and threatened every week when they had to defer appointments to the next day because of overcrowding or when they only handed over prescriptions requested by patients after these patients had been seen by me or when they asked for patience when waiting times were long. In some cases, I had to intervene personally at the counter of my office to protect my staff. At some occasions, I had to take members of my staff along in my car out of the underground car park as they had been threatened to be attacked after work.

Violence in physicians’ offices is a problem kept secret out of shame. Many doctors are reluctant to talk about conflicts with violent patients, fearing this could harm their offices’ reputation. It is essential to break this taboo to facilitate a public discussion aimed at developing strategies to solve this problem that work in the real world.

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Legal Uncertainties

The article of Vorderwülbecke et al. deals with the important topic of prevention of violence. It arrives at the conclusion that severe types of aggression are of concern, especially at house/home visits during on-call

duty. The authors hold the view that in this respect a comparison with the experiences made by the emergency medical services may be warranted. (1) This comparison could reveal further strategies for the prevention of violence.

For the emergency medical services of the city of Braunschweig, Germany, severe violence was defined as violence resulting in several days of incapacity for work after a physically violent attack. Three such cases were identified during the period of one year (2). This is in line with the quality and frequency reported by Vorderwülbecke et al. (1). Uncertainties and misunderstandings with regard to the legal basis of coercive measures have been identified as a main source of violence in the healthcare professional–patient relationship (2). This applies to the use, and, more so, omission of coercive measures. At times, an obligation to render assistance is perceived despite the fact that such assistance cannot be reasonably expected, even when taking into account the guarantor status. Typically, a legal obligation to enforce certain measures against the patient’s will is assumed, even though the patient has the right to reject such measures. These errors in judgment promote violence. They occur among both paramedics and emergency physicians.

I believe it is likely that legal uncertainties regarding the use and omission of coercive measures do exist and contribute to the occurrence of avoidable violence for physicians during on-call duty as well. Future research into this topic should include the connection between legal uncertainty and violence. This could help to identify strategies to increase the safety during house/home visits made while on on-call duty.

A pragmatic interpretation of the relevant legislation and consistent respect for patient rights may contribute to the prevention of violence in the healthcare professional–patient relationship.

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In Reply:

We like to thank our colleagues Weiß and Günther for their contributions. The account of Weiß shows that the issue of aggression and violence is definitely not

limited to primary care physicians, but also affects medical assistant staff.

The uncertainties and errors of judgement with regard to the legal basis for coercive measures as an important source of violence in the healthcare professional–patient relationship does certainly apply to the interface between primary care physicians and paramedics as these measure are frequently a cooperative effort. However, as coercive measures are rarely taken in a primary care setting, the overall impact of other factors is likely to be critical. It is unfortunate that there is still a lack of research into what actually triggers aggression and violence against primary care physicians in Germany, making it impossible to draw any scientifically based conclusions.

The data from Braunschweig provided by Günther (1) in combination with the study by Schmidt (2) and our own survey show that aggression and violence against paramedics and primary care physicians represent a problem which has received little scientific and organizational attention despite the fact that it regularly occurs. Therefore, we support the view of Weiß that the issue should not be “kept secret out of shame“. Instead,

further research (e.g. into the causes, triggers) is desirable, and strategies to tackle the problem (e.g. as part of continuous medical education and advanced training or by providing drivers for on-call duty call-outs) are urgently required. DOI: 10.3238/arztebl.2015.0736c

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Conflict of interest statement

The authors of all contributions declare that no conflict of interest exists.