



Abuse of emergency department workers: An inherent career risk or a barometer of the evolving health care system?

Laurie J. Morrison, MD

‡ See related article page 1245

In this issue, Fernandes and colleagues¹ report the results of a survey of health care workers at the Emergency Department of St. Paul's Hospital, in Vancouver. The survey was intended to define violence against health care workers, document the prevalence and rates of reporting, and suggest preventive strategies.

The respondents in this study reported a 1-year prevalence rate of 92% for physical assault and 97% for physical threats, and 66% reported being verbally abused at least once per shift. In a similar survey of 170 directors of emergency departments across the United States with annual volumes greater than 40 000, the directors reported a prevalence of 43% for at least one physical assault a month, 32% for at least one verbal threat a day and 18% for use of weapons to threaten staff at least once a month. Two hostage incidents at knife-point were described, and 7% reported an act of violence within the previous 5 years that had resulted in death.²

The US statistics may reflect a more violent society with easier access to firearms; however, the types of patient presentation most inclined to violence have been documented and are generalizable to all emergency departments. These included intoxicant use, states of withdrawal from drugs, delirium, head injury, psychiatric causes and social factors.² St. Paul's Hospital has a high annual volume of patient visits and an inner-city population. Fernandes and colleagues present data on health care worker abuse that seem credible and troubling. Some readers may view these findings and conclude that the inner-city population accounts for the high level of abuse. I suggest that current changes in health care and the resultant social factors make the results generalizable to all emergency departments and beyond.

The emergency department is the interface between the office, the hospital and the community. It is the barometer of how well the health care system is working. The volume of patients, the acuity of illness, the 24-hour "open-door" policy, the efficiency of health care delivery, the media and the political focus of the day all contribute to the ability of the emergency department staff to meet the patients' expectations. When patients' expectations, or their perceived needs or wants, are not met, violent outbursts and verbal abuse can occur.

What do patients expect? Two previous publications in *CMAJ*^{3,4} and one in the *British Medical Journal*⁵ summarized patients' expectations in the office and in the hospital. The provision of information, accessibility to a wide range of services and after-hours service, good discharge planning, a caring and compassionate approach, the time to listen to the patient, patient involvement in decision-making, and quality, timely medical care were priority items.^{4,5} Additional in-hospital expectations included the need to respect privacy, to provide adequate pain management and to keep the family informed.³

It is a supreme challenge to consistently meet the public's expectations in the highly volatile environment of the emergency department. The waiting times are unpredictable. The staff have divided loyalties among patients with various degrees of need or illness. Therapeutic relationships are hampered by the transitory nature of the care. Some expectations, such as discharge planning, family communication, education and involving patients in decision-making,^{3,5} are limited by the brevity of the encounter. These competing demands challenge the flexibility of the system and the resources, both personal and technical. In the emergency department, they are like dry leaves to a stray spark.

For several reasons, there is a critical shortage of health care workers in the emergency department. This shortage contributes to existing staff fatigue and a "short fuse" when a worker is challenged by an angry patient or a situation that is accelerating out of control. A scarcity of qualified intensive and emergency care nurses has resulted in roster depletion, burnout and increased sick time.⁶⁻⁸ It is becoming increasingly difficult for small and rural communities to recruit and retain physicians.^{8,9} The problems with recruitment in the north have become more apparent since the changes induced by the Barer-Stoddart Report of 1991.¹⁰ Concurrently, academic institutions are struggling to meet their emergency medicine physician supply needs.^{8,11} In addition, the Canadian physician cohort is aging. As physicians age they choose to restrict their working hours and scope of practice for health or family reasons, particularly in high-risk areas: obstetrics and emergency department



services.¹² The shortage in emergency department personnel and the resulting fatigue also compromise the creativity and flexibility that the health care worker needs to deal with the ongoing dramatic changes in health care delivery.

The current fundamental changes in health care delivery are challenging for the public and the professional. Restructuring in the last few years has affected the role the emergency department plays in the community. Resources have been withdrawn without ensuring that alternative means of care provision have been planned for.^{13,14} The emergency department has become the safety net in the system. When the emergency department cannot fulfil expectations and desires, patients and others direct their anger toward those immediately available.

The perceived needs of the patient may be legitimate or excessive. Unjustified demands may be fuelled by the political and media focus on the scenario of decreasing quality of health care, which contributes to a "learned" expectation of compromised care and access. In addition, a well-informed public believes that technology is the only way to be sure that the doctor has made the correct diagnosis, and so it demands access to technology and specialty consultation, putting unnecessary stress on the system. The perception that government cutbacks have limited access to specialists and subspecialists leads some people to present to the emergency department, particularly in urban and academic settings, to expedite consultations and gain access to advanced technology.^{13,14} Unfortunately, some physicians advise their patients to present to the emergency department to obtain access to these resources, thus reinforcing this perception.

This focus on the risk of violence and abuse in the health care setting is not isolated to the emergency department. The College of Physicians and Surgeons of Ontario recently highlighted its concern about a "number of very disturbing, unfortunate and even tragic incidents in which physicians, their staff and their patients have been put at risk or assaulted by disruptive and even violent outbursts and attacks by distraught persons entering their offices and other places of practice."¹⁵ The college, the Ontario Medical Association, other medical groups and public authorities are seeking conjoint solutions.

Aggression is fuelled by perception, intolerance, misunderstanding and lack of control. The emergency department and the health care system are under pressure to continue to provide quality service at a time of transformational change in health care delivery. This is a challenging situation in which perceived and real needs may not be met consistently. The risk of violence and abuse of health care professionals has been documented. Responsible physician practices, public education, ethical journalism, a health institutional focus on problem-solving and well-informed government decisions with timely implementation may douse the "emotional fire" in the emergency department and beyond.

Dr. Morrison is with the Division of Emergency Medicine, De-

partment of Medicine, University of Toronto, and the Department of Emergency Services, Sunnybrook & Women's College Health Sciences Centre, Toronto, Ont.

Competing interests: None declared.

References

1. Fernandes CMB, 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.
2. Lavoie F, Carter G, Danzl D, Berg R. Emergency department violence in United States teaching hospitals. *Ann Emerg Med* 1988;17:1227-33.
3. Gauld C, Chambers M, O'Brien B, Haynes R, Labelle R. How was your hospital stay? Patients' responses about their care in Canadian hospitals. *CMAJ* 1994;150:1813-22.
4. Stigglebout A. A role for the sick role: patient preferences regarding information and participation in clinical decision-making. *CMAJ* 1997;157:383-9.
5. Neuberger J. Primary care: core values: patients' priorities. *BMJ* 1998;317:260-2.
6. Rytan E. *A statistical picture of the past, present and future of nursing in Canada*. Ottawa: Canadian Nurses Association; 1997. p. 16.
7. Lancot A, Nield S. *Nursing employment cross country checkup: January 1998-June 1998*. Ottawa: Canadian Nurses Association; 1998. Available: www.can-nurses.ca.
8. OHA Region Three Emergency Services Working Group. *Final report April 1998*. Toronto: Ontario Hospital Association and Ontario Ministry of Health; 1998.
9. Wexler H. Joint alternate funding arrangement targets urgent small hospital emergency coverage issues. *Ontario Medical Association* 1999;13(4).
10. Bonn J. Are there enough doctors in Ontario? *Members' Dialogue* [College of Physicians and Surgeons of Ontario] 1999;May/June:20-1.
11. Beveridge R, Lloyd S. CAEP manpower survey: work standards and remuneration. *CAEP Communiqué* 1996;Winter:15-8.
12. Chan B, Anderson GM, Thériault ME. Patterns of practice among older physicians in Ontario. *CMAJ* 1998;159:1101-6.
13. McLellan B. Merger, acquisitions, and trauma care in the 1990's. *J Trauma* 1998;44:575-9.
14. Baer N. As hospitals shrink, consolidate or close, physicians are swept up in the turmoil. *CMAJ* 1996;155:1166-9.
15. Carlisle J. Safety issues in your practice. *Members' Dialogue* (College of Physicians and Surgeons of Ontario) 1999;May/June:33-7.



More Canadian physicians subscribe to *CMAJ* than to any other professional medical journal. One of the secrets behind our success is Classified information.

CMAJ Classifieds

reaching almost 60 000 physicians every 2 weeks

tel 800 663-7336 or
613 731-8610 x2127

