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The emerging risk that constitute aggressions and violence that physicians suffer performing their profession: the case of Spain

Mercedes Martínez León

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Abstract. The article presents some considerations on the aggressions within the area of Health Professionals, considering those facts as an international phenomenon which is latent in European countries (Spain, France, Great Britain) as well as in other parts of the world (Latin America, United States, Canada, Australia, New Zealand). In Spain, the studies carried out with medical staff demonstrate that the aggression rate is approximately of 0,2/100.000 medical acts. The objective of this article is to place emphasis on the aggressions and violence suffered by the medical staff in the course of their duties, and since it is a relatively new phenomenon there is not much data on the topic. For this reason I consider important to deepen, investigate and outline possible causes to this serious problem which according to the World Health Organization (WHO) denounces that almost 25 percent of all the incidents of violence at work take place in the health sector.

Key words: Hostility. Violence. Physicians. Health personnel. Risk

Mercedes Martínez León - Medical and Surgeon doctor and university expert in Bioethics from the University of Valladolid. Professor of Legal Medicine at the University of Valladolid. Secretary of the Ethics and Ethical Theory of Valladolid Official Physicians College, Spain

Violence in the working place has become a worldwide problem that, as the International Labor Organization (ILO) and the World Health Organization (WHO) state, crosses borders, working context and professional groups. WHO denounces that almost 25% of all work violence events take place in the sanitary sector. The health sector represents almost one fourth of total violence taking place at work. Aggressions that health workers suffer performing their profession is without any doubt an emerging risk[1].

ILO and the WHO propose a definition of personal violence, adopted by the European Commission, which indicates that are: *All those events in which the individual is subject to mistreatment, threats or attack under circumstances*

related to his work, including commuting from his home to the work place, with the implication that threatens explicitly or implicitly his safety, wellbeing or health[2]. Even though it is considered, generally, aggression and violence are synonyms, since the outcome is the same independently of intention, some authors made differences between both based in the intentionality of causing harm.

Violence at working place encompasses from offensive or threatening language to homicide. The *Occupational Safety and Health Administration* (OSHA) determined, in1998, that aggressions occur with higher frequency in work related to social and sanitary services, particularly in psychiatric, geriatrics, urgencies and waiting room facilities[2].

Physicians have been resigned for years, and they have paid little attention to aggressions suffered from their patients. A situation that seems to worsen if one considers the gradual increment in events of verbal or physical aggressions toward professionals at the health centers.

It is noticed a notable increment in physical and verbal aggressions toward physicians and other health workers performing their work. According to Martinez Pereda, Justice at the Supreme Court of Spain, we went *in a very short time from getting news in different communication means of acknowledgment and homage to our physicians to repeated physical and verbal aggressions to technical staff and other health sector workers while performing their profession.*

It is not isolated events taking place occasionally in a hospital, but rather they repeat with too much frequency at Urgencies and Base Care Units[3].

All these aggressions cause a very important weariness in physicians' health with depression problems and sick leave. The workload and pressure are generating in physician anxiety, emotional stress, or burnout situations. Physician has to assume all his working duties in addition to undertake aggressions from patients or patients' family members. The physician, under such circumstances, may feel unmotivated to perform such vocational profession as the medical one[4].

Thus, one could think that such situation could lead to loss of trust, dialogue, hearing, and mutual comprehension that should chair patient-physician relationship, giving place to a deterioration of this relationship. This deterioration in patient-physician relationship may be due to several causes: loss of the historical respect for the physician, since physician was a profession whose opinion was esteemed, inclusively outside clinical scope, while physician's work is considered now as .a "paid" obligation. Additionally, the progressive and general destructuring of western societies, which are increasingly more individualist and competitive helps in this deterioration. Lack of knowledge of what is a public good, and the gratuity of public health can be mentioned. Moreover, users mix up rights with requirements and intolerance.

The professional practice in a world in permanent change could not be detached from changes that societies experience at an increasingly pace. The social stereotype of the physician's figure dissolves in a universe of unstable situations.

The conditions of work, the pathologies that we daily face, the relationships between individuals who constitute the basis of the medical act, are unchangeable for us, and therefore, they could not be the strategies that physician requires to face this new realities.

An endless series of cultural changes have conformed new scenarios for human relations, and the physician submerges daily into situations for which, often, he was not suitably prepared. Lately, patient has seen himself placed in the core of the health system by the service provider management, when it was not himself that set in said core, claiming for his right to be assisted (with diligence and celerity, since illness does not stop if not treated), and his right to be healed.

These changes in the modalities of care have set, often, patients and physicians as victims of a system over which they do not exercise control. Concerning the role that they perform, the physician results in a visible figure of a health organization over which he does not exercise control. He converts into the person who the closest to receive complaints when directly receiving aggressions from situations experienced as unfair.

The following possible causes may be among those for the increase in aggressiveness and friction against physician:

- overcrowding of the waiting room with disturbed families;
- Shortage of personnel;
- Need that patients and family have for a fast and effective care;
- Absence of security measures;
- Confluence of patients with mental complications, marginality, and drug addiction;
- Patients who receive from physician an answer that they do not want or a unexpected diagnosis;
- Negative of a sick leave grant;
- Sudden death;
- Negative for prescription of a medication;
- Disagreement with physician in urgency ward for considering that ill person problem has less priority than other.

Ethical conflict between patients' rights and duties and health workers rights and duties

The Spanish Medical Ethics Code and Ethical Theory in its Article 9 states that: *When physician accepts to attend a patient, he commits himself in assuring continuity of his services, which he may suspend if he is convinced that there is not needed trust in him.*

He will notify of it with due advance to patient or patient's family, and he will facilitate that other physician take charge of the patient, to whom he will transmit all necessary information (Medical Ethic Code and Ethical Theory. Spain, 1999, Article 9).

Has not such trust ceased to exist in isolated or continued cases of aggression?

Physicians have their rights in the patient-physician relationship without entailing lack of care for the patient as equally it is considered that defensive medical practice should take place in order to avoid possible complaints.

Health care requires, in one hand, that patients' and citizens' rights are respected, and in the other hand, it is necessary that the later comply with their duties by suitably using all provision that health system offers.

Actually, we are in a scenario where health professionals themselves are aware of their obligations and duties toward the health system and its agents, and where patients themselves ignore, almost completely, their obligations with the health system and its professionals.

Nevertheless, this lack of knowledge of obligations and duties that are connected to patients oppose to the extreme knowledge that they have of rights acknowledged to them by different standards, which finds its immediate explanation in the dissemination that different communication means carry out on this broad range of rights that fills us in and that causes in parallel at hospitals among patients a lack of knowledge about the Health Public System own limits and its functioning, among others[5].

The citizen knows already surely that he can demand that he is provided with the best remedy for his illness, he exercises this right, he demands, and he claims for all care.

It has gone in this process from the indolent paternalist posture of the Bioethics Principle of Beneficence to the active attitude of asking in the Bioethics Principle of Autonomy, putting it subtly, the best remedy. User does not allow anymore for any ill caring, but it is evident that he demands it also, Nevertheless, when this process flows into its worst consequences, it reaches at its most undesired effect: the violence toward health profession, mostly toward the physician whom health trust has been deposited, but as well as toward other professionals (administrative, nurses, janitors). Health units are far from being peaceful working places, even if one does not perceive details of the struggle at first sight. Patients complain, and not just because they are ill, but often from the treatment they get both by management and physicians either for not complying to their rights or because they are not assisted as desired. In their turn, technical staff had to withstand,

more and more, impatient users who manifest aggressive and, inclusively, violent behavior in addition to psychological harassment by superiors or from colleagues. Therefore, Medical exercise develops in an ever more hostile environment, dominated many times by mistreatment

Physician should avoid counter aggressiveness by all available means, to show calm and control of the situation by speaking kindly without provoking the patient or issuing an opinion about him, trying to keep both the patient and himself seated. He should avoid getting too close to user, and to avoid keeping eyes fixed or away from the patient. To listen attentively if he starts speaking, particularly patients with personality disorder, that he is able to put himself in his place and to recognize the signs that predispose violence for the patient; his way of walking, repetition of the same word or phrase or any other warning sign.

In order to attempt solving violence in consultation, physician should express his interest in establishing *a good relationship with patient*, based in mutual respect and tolerance. He must have communication skills to manage this violence in consultation channeling it suitably. Improvement in communication techniques with ill person and learning methods to face violent situations may safeguard health workers integrity. If this was so, there would be, possibly, much less aggressions. But, what happens is that there is an explosive violence that is impossible to manage, and in face of which physician must have legal protection.

Data on the phenomenon at the international level

Aggressions within health professionals scope is an international phenomenon, which is latent in other European countries (France, Great Britain) as well as in other latitudes (the United States, Canada, Australia, New Zealand, and Latin America).

In Europe

The European Agency for Safety and Health at Work includes *violence of the public* among risks factors and health problems for the health care sector. Aggressions against health professionals are happening throughout Europe. Countries such as Sweden and Belgium have adopted the regulation as the way to face the situation. Due to the number of seriousness of cases of violence in France, Holland, Italy, and particularly in France, these countries are adopting concrete action plans[6].

A study undertaken among general practice physicians in England and Wales has expressed that this type of behavior are very frequent out of hospital environment as well. More than half of the physicians who responded to the survey (63%) had

suffered in the previous year some kind of aggression, although fortunately the majority of events were verbal insults[7].

In the English *National Health Service,* in 2006, 11% of hospital professionals, and 6% of those in primary care informed on having suffered physical aggression, while 26% and 21%, respectively, manifested feeling intimidated or harassed by patients or by those accompanying them[8].

The United States and Canada

The United States head the most dramatic list if we take in account that weapons are legal.

According to a study in 170 school hospitals, 43% of workers in emergency units suffer physical attacks once monthly. Around 18% of them are threatened with knives.

Their prevention strategies and plans have a large tradition and they serve as reference for other countries such as Canada [9].

In Latin America

The largest online survey was carried out in Latin America (www.intramed.net) with 30,000 physicians on aggression suffered while performing their profession. Over half of surveyed physicians (54.6%) suffered some kind of aggression, and 52.4% suffered verbal aggressions: 23% from patients, and 29.4% from patients' families.

The most frequent aggression were from age range of 30-39 years old.

The distribution by countries showed more aggression in Argentina (with an increment of 20% regarding the remaining countries), and least aggression in Mexico (with around 32% less). Excess of aggression appeared in urgency medical expertise. The distribution according to gender presented similarity, male 59% and female 41% [10].

Data on the phenomenon in Spain

Studies undertaken in Spain referring to medical staff show that aggression rate is about 0.2/100,000 medical acts approximately. Violent acts against medical technical staff are increasing in worrisome way throughout the Spanish territory. It is a relatively new phenomenon, and thus there are not much data about the issue at national level.

According to physician's unions around 8,000 Spanish physicians suffered pressure from their patients, this corresponds to 4% of the total. 60% of 200,000 medical doctors existing in Spain received threats, while 4% of them developed psychic problems[11].

According to the Medical Colleges, the number of denounces achieved 3,500 from 2004 to 2007. The Barcelona Official Medical College (COMB) also carried out a study showing that one third of

physicians, during their professional careers, suffered some kind of aggressiveness by patients or by patients' families. One fourth of them declared having witnessed mistreatment against colleagues.

The data gotten from a survey with 1,500 physicians reveal that verbal aggressions are the most frequent (44%), followed by physical (28%), and threats (26%). Aggressor over half of cases are patients (52%), 33% are family members or people accompanying patients, while the remnant are psychic ill (11%), and drug addicts (10%).

These are patients with a determined profile wanting something they believe that the professional can or should provide them, and they consider aggression as the fastest and most effective mean to get it. In summary, *they search in the physician immediate and preferred assistance, medication at their will, a determined diagnosis to get a sick leave or retirement, a revenge because a relative has deceased or a sadist pleasure in humiliating the physician* [12].

Urgency units are the places where most often aggression happens in 45% of cases, followed by Primary Health Care units in 28%, and in the Hospitalization Rooms in 13.7%.

However, violence is not just in Catalan consultations. Medical Colleges of Madrid, Valencia, Castile-La Mancha, Andalucía, and Baleares had to start aggression recording due this new irrational way, and not civilized, that patients have to require assistance from their physicians. Aggression against physicians is increasing also, mostly in primary care consultations and urgency units at hospitals.

As reference, one should just look over the figures about violent events recorded in the Community of Madrid in different years: four in 2002; 36 in 2003, 45 in 2004, 50 in 2005, and 68 in 2006. As one sees, this increase is terrific since the number of aggression increased 17 fold during the period. According to recent data, in 2003 (although there is no data published for 2004), only at the Community of Madrid almost 50,000 complaints were processed, a very high figure that represents just 0.083 percent over 60 million medical procedures that take place yearly at this community. Complaints about ineffective Health assistance reached 606, and out of these, 108 were due to physicians' degrading treatment. The majority of professional Colleges are carrying out a large campaign for legal protection in face of aggressions[13].

The College of Physicians of Valencia recorded, up to December 2009, 30 aggressions against physicians, a similar figure recorded in 2008, with 31 aggressions. What calls attention is the increment of physical aggression of 75%, that is, going from four to seven the more serious cases.

Regarding origin of aggressions, it stands out that majority of aggressions comes from the health units in opposition to what took place a few years before. Thus, en 2009, 65% of denounces correspond to primary care units, particularly, the increment of aggressions in the primary urgencies[14].

In Andalusia, according to data collected in the Aggression Records at the Andalusian Health Service (SAS), between January and November 2009, there were 712 aggressions to health and non-health professionals, 183 were physical [15].

The Official College of Physicians of Valladolid has carried out a zero tolerance campaign against these aggressions with assistance of its lawyer through programmed and systematic denouncing of every aggression. This reduced in 60% physical aggressions, threats and insults at the health units and public hospital in that locality [16].

In 2007, out of the nine aggressions endured by health professionals, one was verbal (insults), threat and coercion against a female physician, and eight were physical aggressions on male physicians, three of them on the same physician who works in 112, in drug addiction programs, and five were physical aggressions. The decrease in aggressions in face of the growing trend related to 2005 with an average of two aggressions is due to: i) Legal and social pressure against this kind of attitudes; ii) Campaign carried out against aggressions; iii) Promotion of legal denounces; iv) Demanding the Public Attorney's Office a commitment related to the issue; v) Sensitization and information of aggression through communication means; and vi) Public health user realization that these event are punishable.

The Public Prosecutor's Office of the Superior Court of Justice of the Autonomous Community of Castile and Leon jointly with main Prosecutors of the Community agreed that legal qualification of violence against health personnel would be *attempt offense*. Therefore, violence against health professional while performing their profession would be considered a *serious offense and not as lesion offense*. The consideration of attempt offense will suppose:

- Imprisonment penalties;
- Larger indemnifications;
- Aggressor will have criminal records, more exemplary and with a positive dissuasion effect;
- Public attorney's office in Castile and Leon has qualified already during instructions, despite there is not any sentencing until now in Castile and Leon.

Since the end of 2009 until April 2010, there was not any denounce of physical aggression, no humiliation, threat or insult.

Final considerations

In order to avoid aggression on health staff a series of preventive measure should be adopted:

1. Control of the environmental factors that may cause these events such as long waiting time, uncomfortable waiting rooms, poor communication between patient-health staff, and the way of setting rules of the unit.
2. Establishing or incrementing security staff mostly at the urgency areas.
3. Setting a TV close circuit and anti-panic alarms to control the building,.
4. Establishing an education and help program to improve resident physicians' life (MIR), and of personnel in units where disruptive behavior take place.

The existence of socio-educational policies for users regarding health personnel, rational use of health resources, and knowledge of their limitation. This will help to minimize and to control risk of violence, and to create a safe environment for the public and for professionals. To avoid economic costs related to the increment of absenteeism, and low morale of team, to avoid possible legal actions and to help hiring and keeping staff, as well as to avoid unobserved abuse of patient by staff [17].

Management should ensure physicians' safety at the health centers. Last but not the least, it is very important that professionals denounce aggressions that they may endure while performing their work.

Resumen

El riesgo emergente que constituyen las agresiones y violencia que sufren los médicos en el ejercicio de su profesión: el caso de España

El artículo presenta consideraciones sobre las agresiones en el ámbito de los profesionales de la sanidad, considerando esos hechos como un fenómeno internacional, que están latentes en otros países tanto del entorno europeo (España, Francia, Gran Bretaña) como en otras latitudes (América Latina, Estados Unidos, Canadá, Australia, Nueva Zelanda). Se refiere a estudios que se han realizado en España con personal médico, que demuestran que la tasa de agresión es de 0,2/100.000 actos médicos aproximadamente. El objetivo de este artículo es resaltar estas agresiones y violencia que cada vez con más frecuencia sufren los profesionales médicos en el ejercicio de su profesión y que por tratarse de un fenómeno relativamente nuevo no hay muchos datos sobre el tema. Por este motivo pienso que es importante profundizar, investigar y analizar las posibles causas de este gravísimo problema, que según la Organización mundial de la Salud

(OMS) denuncia que casi un 25 por ciento de todos los incidentes de violencia en el trabajo se producen en el sector sanitario.

Palabras-clave: Hostilidad. Violencia. Médicos. Personal de salud. Riesgo.

Resumo

O risco emergente que constituem as agressões e violência que sofrem os médicos no exercício de sua profissão: o caso da Espanha

O artigo analisa dados sobres as agressões na área da saúde, considerando esse fato como um fenômeno internacional que se manifesta tanto em países europeus (Espanha, França, Grã-Bretanha) quanto em outras latitudes (América Latina, Estados Unidos, Canadá, Austrália e Nova Zelândia). A discussão se reporta a estudos realizados na Espanha com pessoal médico, os quais demonstram que a taxa de agressão é de 0,2/100.000 atos médicos, aproximadamente. O objetivo do artigo é ressaltar essas agressões e violência, que os profissionais de saúde vêm sofrendo com frequência cada vez maior, no exercício de sua profissão. Por tratar-se de fenômeno relativamente novo não há muitos dados sobre o tema. Por esse motivo, é importante aprofundar as pesquisas e análises sobre as possíveis causas deste gravíssimo problema que, segundo denuncia a Organização Mundial da Saúde (OMS), corresponde a quase 25% de todos os incidentes de trabalho no setor sanitário.

Palavras-chave: Hostilidade. Violência. Médicos. Pessoal de saúde. Risco

References

1. Villar M, Aranaz JM. Violencia en el medio hospitalario por pacientes con enfermedad mental. Arch Prev Riesgos Labor 2005;9(1):20-7.
2. Occupational Safety and Health Administration. OSHA. Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. Washington: U.S. Department of Labor; Occupational Safety and Health Administration; 1998.
3. Martínez Pereda JM. Los profesionales sanitarios ante el problema de las agresiones. 12º Congreso Nacional de Derecho Sanitario; 20-21 Octubre 2005; Madrid. Madrid: Asociación Española de Derecho Sanitario; 2005.
4. Alarcón Vena MJ, Adana Bellido JL. Las agresiones al personal médico de los servicios de salud. 12º Congreso Nacional de Derecho Sanitario; 20-21 Octubre 2005; Madrid. Madrid: Asociación Española de Derecho Sanitario; 2005.
5. Pinedo García I. Las agresiones al personal sanitario y el delito de atentado. Aspectos prácticos y legales. In: Adroher Biosca S, Montalvo Jääskeläinen F, Corripio Gil-Delgado MR, Veiga

Copo AB. Los avances del Derecho ante los avances de la Medicina. Navarra: Aranzadi; 2008. p.421-34.

6. Junta de Castilla y León. Gerencia Regional de Salud. Plan Integral de Seguridad de la Gerencia Regional de Salud [Internet]. Castilla y León/ES: Gerencia Regional de Salud de Castilla y León; publication date n. a. [accessed March 6, 2008]. Available at: http://www.enfermeriaysalud.es/GRAFICOS/PLAN_DE_SEGURIDAD_COMPLETO[1].pdf 7. Pane G.A. Preventing and controlling violence in emergency departments. West J Med 1991;155(3):285-6.
7. Organización Médica Colegial de España. Libro de Agresiones 2009 [Internet]. Madrid: Organización Médica Colegial de España; 2009 [accessed May 25, 2010]. Available at: http://www.cgcom.org/sites/default/files/Libro_agresiones_2009.pdf.
8. Hobbs FD. Violence in general practice: a survey of general practitioners views. Br Med J 1991;302(6772):329-32.
9. Agresiones contra médicos: que he hecho yo para merecer esto? [Internet]. Investigaciones Intramed 22 ago. 2005 [accessed August 22, 2005]. Available at: http://www.intramed.net/contenidover.asp?contenidoID=36397.
10. Cozar A. 8.000 médicos españoles han sufrido agresiones de sus pacientes [Internet]. El País.com 9 maio 2007 [accessed July 7, 2010]. Available at: http://www.elpais.com/articulo/sociedad/8000/medicos/espanoles/han/sufrido/agresiones/pacientes/elpepusoc/20070509elpepisoc_2/Tes .
11. Asociación Internacional de Médicos Progresistas. Agresiones contra médicos [Internet]. Valencia (ES): Asociación Internacional de Médicos Progressistas; 2005 [accessed August 14, 2005]. Available at: http://www.medicos-progresistas.org/modules.php?name=News&file=a rticle&sid=17.
12. Fundación del Ilustre Colegio Oficial de Médicos de Madrid. El problema de las agresiones al médico [Internet]. Madrid: Sergio Montiel García, fdo; [accessed March 1, 2008]. Available at: http://www.fundacion-icomem.org/index.php/articulos-de-interes/perspectiva-juridica/39-el- problema-de-las-agresiones-al-medico
13. Mezquita E. Aumentan las agresiones en la Atención Primaria de Valencia [Online]. Diario Medico.com 9 dez. 2009 [acessed May 25, 2010]. Available at: http://www.diariomedico.com/2009/12/09/area-profesional/normativa/aumentan-las-agresiones-en-la-ap-de-valencia.
14. Servicio Andaluz de Salud. El Servicio Andaluz de Salud registra 712 agresiones a los profesionales entre enero y noviembre de 2009 [Internet]. Diario Medico.com 19 fev. 2010 [acessed May 25, 2010]. Available at: http://www.diariomedico.com/2010/02/19/area-profesional/normativa/el-servicio-andaluz-de-salud-registra-712-agresiones-a-los-profesionales-entre-enero-y-noviembre-de-2009.
15. La presión judicial reduce en el 60 % las agresiones contra el personal sanitario en Valladolid [Internet]. El Norte de Castilla 2007 Mar 25 [accessed March 25, 2007]. Available at:http://www.

nortecastilla.es/prensa/20070325/portada/presion-judicial-reduce-agresiones_20070325.html.

16. Montes Martínez A, Romaní Lestón M, Gestal Otero JJ. Agresiones al personal de salud. In: Gestal Otero JJ. Riesgos laborales del personal sanitario. 3ª ed. Madrid: Mc-Graw Hill; 2003. p.665-71.

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Contact

Mercedes Martínez León - *legal@med.uva.es*
Calle María de Molina 6-4 Izda. 47001.Valladolid, España.