

# Physical assault on a medical resident

*Abdullah H. Al-Zayed, MBBS, Anwar A. Jammah, MBBS, Mansour Al-Nozha, FRCP (Lond), FRCP (Edin).*

---

## ABSTRACT

We report a physical assault on a 25-year-old male medical resident who was on-call in the emergency room. Causes of assault on physicians as well as how they can be avoided are discussed.

**Saudi Med J 2003; Vol. 24 (8): 895-897**

---

When we decided to become doctors, none of us thought that our patients might assault us. However, it is very common worldwide to hear about such unfortunate events every now and then. Some studies claim that every 6th colleague is assaulted.<sup>1</sup> This assault can be a slight verbal comment and can progress up to a murder. The 1996 British Crime Survey confirmed that doctors are at greater risk of violence at work than the general population.<sup>2</sup> Sadly, such events are often perceived to be "part of the job". For this, we are presenting a case report from a university hospital in Riyadh, Kingdom of Saudi Arabia of which the victim was one of our residents.

**Case Report.** A 25-year-old male medical resident, who is married, was the medical resident on call in the emergency room. At 12:30 am he was asked by the emergency room physician to evaluate a 27-year-old female patient who is a known diabetic with suspicion of diabetic keto-acidosis. The resident asked one of the nurses to take permission from the patient to examine her. The patient who was fully awake agreed to be seen by him. The resident entered the cubical of the patient with a female nurse. There were 2 female attendants with the patient. After he took the history, he asked the patient if he could examine her, and she agreed. Another female nurse also entered the cubical to set up the intravenous fluid. The resident started examination in the presence of the 2 nurses and 2 of the patient's

relatives. During the examination and all of a sudden the patient's husband who was not present initially, entered the cubical and immediately began hitting the resident on his face repeatedly and then he hit one of the nurses on her head, and shouted "why is a male doctor examining my wife?". He did not previously notify anyone in the emergency room that he wanted a female doctor to examine his wife, the patient neither requested for a female physician or did she refuse to be examined by a male physician. The resident had a deep cut wound in the upper lip, which required suturing. He had severe bleeding from the mouth and nose and dizziness. He was admitted to the intensive care unit, where he was seen by a neurologist who ordered a computerized tomography scan of the brain and to keep him under observation. He was shifted to the ward the next day. He was very anxious and did not sleep well. On the second day, he complained of severe epigastric pain and developed melena. He is known to have peptic ulcer disease, which was exacerbated by severe stress. He stayed in hospital for 6 days.

**Discussion.** Violence in general practice is a growing problem all over the world.<sup>3</sup> Out of all medical staff, residents and nurses form the main target because of the close contact with the patients and their relatives. Emergency room physicians and physicians working in psychiatric service are most commonly subjected to violence, which more frequently occurs in highly

---

From the Department of Medicine, College of Medicine & King Khalid University Hospital, King Saud University, Riyadh, Kingdom of Saudi Arabia.

Received 17th March 2003. Accepted for publication in final form 9th April, 2003.

Address correspondence and reprint request to: Prof. Mansour Al-Nozha, Consultant Cardiologist, Department of Medicine, College of Medicine, King Saud University, PO Box 2925, Riyadh 11461, Kingdom of Saudi Arabia. Tel. +966 (1) 4671934. Fax. +966 (1) 4679476. E-mail: malnozha@ksu.edu.sa

deprived areas.<sup>4,6</sup> Interns, sub-interns and even medical students are also in possible danger for patients' violence and insult. This might prevent doctors from choosing the clinical practice as their future career and, furthermore, they might prefer office work and research to avoid from such risks. Undoubtedly, the emergency room is the place where many violent and aggressive patients are seen. A study carried out on accident and emergency departments in Kuwait City revealed that surveyed physicians reported rates of violence against them to vary from 54%-79%. Eighty-seven percent (86%) out of 101 of the included doctors reported having experienced verbal insults or imminent threat of violence; in addition, 28% had also experienced physical attacks, and 7% had experienced physical assaults likely to cause serious or fatal injury. Similarly, out of a total of 781 violent incidents reported by the doctors, 73 involved physical attacks, and 8 involved physical assaults likely to cause serious or fatal injury.<sup>7</sup> It appears that there is an international increase of violence in the emergency department (ED) which threatens medical staff daily. In some studies, the main reason for violence was prolonged waiting in the ED. While other causes such as dissatisfaction with treatment, refusal to leave the ED, and language that displeased the patient were also encountered.<sup>8</sup> These events are most commonly associated with patients who are intoxicated or who have psychiatric histories.<sup>9</sup> Although there was no clear reason for what happened in our case, the most likely cause for the violence is that the attacker misunderstood the resident, others include psychiatric illness or drug abuse, however, it is possible that he did this for the purely religious reason that he does not want his wife to be examined by a male physician.

On the other hand, it is so frequent for nurses, especially those working in emergency room, to be assaulted. In a Canadian study involving 8,780 registered nurses practicing in 210 hospitals, nearly half (46%) of those surveyed had experienced one or more types of violence in the last 5 shifts worked.<sup>10</sup> Our nurse was no different in this regard. She was hit repeatedly by the patient's husband before the staff in the ED intervened. These events usually result in many adverse sequelae on the morale of medical staff. Many of these residents will have varied psychological disturbances and changes in behavior such as increased prescribing, ongoing fear of violence at work, depression, insomnia, flashbacks and taking 'time off'.<sup>11</sup> However, body injuries can also happen in physical assaults as happened to our resident. It can also result in exacerbation of previous morbid conditions such as exacerbation of the peptic ulcer in our resident.

We need to work very hard to minimize these incidents. One important way is to analyze each event alone to ascertain the reason for violence. Reporting such events will help to create awareness among members of the health community about the real size of the problem, which in turn will help in suggesting solutions for such violence. A Canadian study suggested

that we should work in 3 directions to improve the climate of residency training programs including behavioral initiatives, structural initiatives and educational initiatives.<sup>6</sup> Behavioral initiatives, for example, promotion of contemporary inclusive language, labeling and addressing discriminatory and abusive events and issuing corporate policies concerning all type of harassment and human rights, can be useful in decreasing these misbehaviors. Structural initiatives like appointing a residency-program ombudsperson, offering accessible confidential counseling, encouraging support groups for residents and establishing and promoting an institutional office to deal with all the reported cases will be a good start in abolishing these headaches. One of the solutions that can be suggested is to strengthen the security system in our hospitals possibly by providing armed security officers in the high-risk areas of the hospital.

Also, we can improve the residents' response to violence by providing a special program on how to deal with, or even avoid, the aggressive or embarrassing situations like those, which occur daily in the ED. This program should be started from the sub-internship in the form of multiple courses. Also, incorporation of the resident's association will be very helpful in solving the recurrent nature of these occasions. Most of the developed countries have their own associations for residents, interns and even the medical students. These associations are mainly concerned with promotion of humanitarian ideals among medical students, interns or residents and so seeking to contribute to the creation of responsible and highly qualified future physicians. They help in educating residents on issues concerning graduate medical education, national health policies and, more concerning us, what to do if the resident has a problem with the ancillary staff, another resident or patients. They give valuable advice on how to address the issue in a timely fashion to a senior resident or to the program director if they could not resolve the issue on their own.

We believe that the Saudi Council for Health Specialties has an important role to play, first by acting as the residents advocate protecting the residents and second by encouraging physicians to report these incidents to the council. The council should formulate strong protocols, and policies in handling such situations and we, as physicians, should put our hands together to abort these events. We think that all residents should be supplied with a forum discussing topics related to resident insult varieties and the ideal response for each. This will lead to a systematic manner in solving each emergent incident and finally in creating a safe and comfortable weather for the residents to produce.

## References

1. Maulen B. Violence against physicians, every 6th colleague is assaulted. *MMW Fortschr Med* 2000; 142: 4-6.
2. Mackin JG. Violence against trainee pediatricians. *Arch Dis Child* 2001; 84: 106-108.

3. O'Connell P, Bury G. Assaults against general practitioners in Ireland. *Fam Med* 1997; 29: 340-343.
4. Coverdale J, Gale C, Weeks S, Turbott S. A survey of threats and violent acts by patients against training physicians. *Med Educ* 2001; 35: 154-159.
5. Ness GJ, House A, Ness AR. Aggression and violent behavior in general practice: population based survey in the north of England. *BMJ* 2000; 320: 1447-1448.
6. Cook DJ, Liutkus JF, Risdon CL. Residents' experiences of abuse, discrimination and sexual harassment during residency training. McMaster University Residency Training Programs. *CMAJ* 1996; 154: 1657-1665.
7. Al-Sahlawi KS, Zahid MA, Shahid AA, Hatim, Al-Bader M. Violence against doctors: 1. A study of violence against doctors in accident and emergency departments. *Eur J Emerg Med* 1999; 6: 301-304.
8. Derazon H, Nissimian S, Yosefy C, Peled R, Hay E. Violence in the emergency department. *Harefuah* 1999; 137: 95-101.
9. Paola F, Malik T, Qureshi A. Violence against physicians. *J Gen Intern Med* 1994; 9: 503-506.
10. 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: 57-78.
11. Zahid MA, Al-Sahlawi KS, Shahid AA, Awadh JA, Abu-Shammah H. Violence against doctors: 2. Effects of violence on doctors working in accident and emergency departments. *Eur J Emerg Med* 1999; 6: 305-309.

Related Abstract  
Source: Saudi MedBase



Saudi MedBase CD-ROM contains all medical literature published in all medical journals in the Kingdom of Saudi Arabia. This is an electronic format with a massive database file containing useful medical facts that can be used for reference. Saudi Medbase is a prime selection of abstracts that are useful in clinical practice and in writing papers for publication.

**Search Word: Assault**

**Authors:** Abdul-Wahed N. Meshikhes, Ahmed A. Ali, Qassim Al-Dollah, Fouad Al-Kawai, Ahmed Al-Aithan, Mohammed Al-Mubarek  
**Institute:** Dammam Central Hospital, Dammam, Kingdom of Saudi Arabia  
**Title:** The safety of pediatric blunt abdominal trauma in the hands of general surgeons  
**Source:** Saudi Med J 1998; 1: 52-54

**Abstract**

**Objective:** To determine the safety of management of pediatric blunt abdominal trauma in a general surgical ward by general surgeons with no experience in pediatric surgery. **Design:** Retrospective review of the case notes of all children under 13 years admitted with blunt abdominal trauma over 3-year period (January 1988-December 1990). **Setting:** Department of Surgery, Dammam Central Hospital, Dammam, Kingdom of Saudi Arabia. **Methods:** The case notes of 56 children (46 boys, 10 girls) with blunt abdominal trauma were reviewed. Initial clinical examination, associated with surgery were recorded. **Result:** The cause of trauma were: road traffic accident in 27 (48%), fall from height in 20 (36%), blow to abdomen in 5 and assault in 4. Additional injuries were present in 27 (48%) patients: head injury (13), chest (7), pelvis (3), upper limb (3) and lower limb (one). Plain abdominal radiographs were performed in all children. Ultrasound and CT scan were requested selectively and none of the children had peritoneal lavage. All were treated conservatively with good outcome except 5 (9%) who underwent exploratory laparotomy for worsening general and abdominal signs (n=2) and signs of peritonitis on admission (n=3). There was one postoperative morbidity and one mortality. **Conclusion:** Majority of blunt abdominal trauma in children can be managed conservatively with minimal morbidity and mortality in non-pediatric surgical units even in the hand of general surgeons. However, in presence of pediatric surgical service, management of such children should be undertaken by pediatric surgeons.