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EDITORIAL

Violence in emergency care: can we do better?

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The World Health Organization (WHO) defines aggressiveness as "every use of physical force or power, threat or real, against oneself, another person or against a group or community that may result in or has a high probability of death, psychological harm, developmental changes or deprivation" [1]. Emergency departments (EDs) are workplaces where violence is encountered. Violence that has motivated the consultation of patients, or violence towards health care personnel. Whatever violence we are talking about, this is a daily problem in EDs [2]. Emergency physicians and nurses the world over will care for victims of violence and run the risk of becoming victims themselves. The pooled incidence suggests there are 36 violent patients for every 10,000 presentations to the ED (95% confidence interval 0.0030–0.0043). The instigators of violence in the ED were family members (52%), patients (27%) and other relatives/friends (21%).

Violent acts presenting to, and occurring in, healthcare settings are substantially under-recorded to the police [3]. Indeed, the American College of Emergency Physicians has stated that while 70% of emergency physicians have reported acts of violence against them, only 3% pressed charges. Nurses are more likely to experience violence while performing their duties. The Canadian Association of Emergency Physicians (CAEP) position statement seeks to address this by promoting mandatory reporting of violent incidents among a series of well reasoned recommendations. The factors contributing to these acts of violence are well described[1]; drugs, alcohol or substance abuse, poverty, acute or chronic diseases (i.e. dementia) play a major part in the escalation of aggressive and violent behaviour and are suspected to be responsible for the majority of violent escalations in the ED. Aggression situations may be associated with behavioural changes, namely psychomotor agitation, dementia, previous trauma and other disorders, psychotic and personality disorders, drug, hospital and service rules rejection, socio-cultural situations, the shortage of space or the organization of inpatient facility.

Violence against health workers can take different forms: verbal insults, physical, sexual, or moral aggression. Violence can have direct consequences at personal (i.e. risk of severe injuries, deaths or Post-Traumatic Stress Disorder), staff retention, organizational, and societal levels. CAEP seeks to change this perception and increase ED safety for physicians, hospital staff and patients [2]. They propose an approach to violence based on institutional commitment to providing a safe working space, focusing on the managment violent incidents, and prevention, as is evident in the almost universal training of healthcare workers in de-escalation techniques. Alternatives to physical restraint can reduce the contention rate; these are separate into four categories: medical and nursing approaches with pharmacological restraint, environmental modification, occupational and socio-psychological approach with professional attitudes that can limit the risk by protection mechanisms.

The prevention and management of violence, and the implementation of procedures, requires coordination between hospital administration and regional health authorities for workplace safety.

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Continuing the theme of violence, but now focused on victims, McDonald et al. report a four year retrospective study of non-fatal strangulation injuries [4]. Emergency physicians may not develop much experience in evaluating survivors of strangulation injuries and international guidelines have been issued, such as The Evaluation and Treatment of Non-Fatal Strangulation in Health Care Settings [5]. It is difficult to read this paper without considering the terrifying nature of these assaults. Reassuringly, few survivors suffered serious consequences of injuries. Deciding which patients need further investigation appears to be a matter of clinical judgement, though most people are physically unscathed. It is not enough to manage the injury alone but to provide holistic care for victims of violence.

National bodies have made recommendations about how to best support victims in the ED setting. These patients require ED staff to not only take time and provide a disclosing environment, but also to adapt our language, both verbal and physical approach, to erase any possible interpretation of judgement, intrusive attitude or violence [6]. The detection and accompaniment of victims can be a unique moment to avoid the fatal outcome that could occur months or years after this consultation. It is estimated in the UK that a woman will suffer over 20 assaults from a partner before disclosing to a healthcare professional. Furthermore, victims are much more likely to disclose to healthcare workers than the police. The UK IRIS study proved that training healthcare staff increased referral rates to advocacy services [7]. Furthermore, it is accepted that advocacy services improve the health and well being of victims [8]. It is therefore essential to offer follow-up to victims. In France, a national plan has allowed the creation of a task force for the management of these victims. This task force enables the interaction of health care, psychiatrists, and police's forces, with the victim's agreement. Perhaps it is time for Canada to follow suit.

Dedicated training on violence management, victim identification and support should be organized for all emergency health workers.

Declarations

Conflict of interest None declared.

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