**Source:** *The Straits Times,* pA16
**Date:** 5 January 2022

ByInvitation

# *The doctor's dilemma when patients turn violent*

It's no simple matter making police reports against patients who assault healthcare professionals, especially when the patients suffer from mental disorders

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For The Straits Times

According to the World Health Organisation, healthcare workers throughout the world are at high risk of violence, and between 8 per cent and 38 per cent of them suffer physical violence at some point in their working lives. Studies have shown that medical staff in settings such as the emergency department of a hospital or psychiatric facility are particularly vulnerable to patient or visitor violence. PHOTO: BLOOMBERG

A patient whom I had known and treated for almost a decade barged into my consultation room one morning while I was talking to my first patient of the day. He flung the door open and blurted to me and my startled patient that he was hearing voices, and just as abruptly and before I could respond, he shut the door on us.

In all these years, this patient, fairly big and in his 30s, had been unfailingly polite, soft-spoken, and mild-mannered to the point of meekness, but that morning I knew with dismay that he had suffered a relapse of his schizophrenic illness and was in the grip of some distressing psychotic experiences.

I finished my consultation with the first patient and almost immediately after she left the room, there was a commotion in the waiting area. Opening the door, I saw my long-time patient shouting and beating his father who had, as always, accompanied him to the clinic.

Calling out his name and without really thinking, I stepped forward. He wheeled around and charged at me. Swinging his arms wildly, he started raining blows on me. As I stumbled backwards, I pulled him down with me, and somehow managed to push him to the floor. His father came to my rescue – victims now united as subduers – and in a tangle of limbs, we managed to pin him down.

Shortly after, with the assistance of nurses and security personnel, we strapped him to a gurney, injected him with a sedative antipsychotic medication, and moved him to the ward.

**A TINDERBOX**

According to the World Health Organisation, healthcare workers throughout the world are at high risk of violence, and between 8 per cent and 38 per cent of them suffer physical violence at some point in their working lives, with many more at the receiving end of verbal threats and aggression. As reported in The Straits Times, figures from the Ministry of Health showed a steady increase in the number of abuses (verbal abuse and physical assaults) towards healthcare workers here – from 1,080 cases in 2018 to 1,300 cases in 2020.

Most of the violence is perpetrated by patients and visitors, for whom the hospital setting is already an unsettling and alien place. Add to that the inevitable anxiety of help-seeking, the pent-up helplessness and frustration of waiting to be seen (long waiting time is apparently one of the common causes of aggression), the subsequent rushed consultation, the uncertain outcome of medical treatments and their occasional failings – what we could have in hand is a potential tinderbox.

And studies have shown that medical staff in settings such as the emergency department of a hospital or psychiatric facility are particularly vulnerable to patient or visitor violence.

For any of us who work in a public healthcare setting and have been assaulted, a few things would follow. The most immediate, of course, is to check for any injuries that require medical attention. That morning, I did so under the worried gaze of my clinic nurse and felt that no real damage had been done. Despite the flurry of blows, my patient didn't seem to have had his heart in inflicting any serious injury on me or his father.

If anything, I was somewhat chastened by this attack. This was the first time in my long years of practice that I had been roughed up by a patient – there were a few close shaves but never anything like this.

Thinking about it, it was nobody's fault but mine: I had let my guard down and not seen the warning signs and taken the precautionary measures that I often drilled into my junior doctors. I was probably blinded by hubris arising from assuming that my experience as well as longstanding relationship with and knowledge of my patient were enough for me to step forward without first calling for security.

The second thing to do is an administrative task – of going through that necessary tedium of filing a report of the incident: detailing the who, when, how and why in an online system called the Incident Reporting Information System. The report is routed to a higher level and this would often occasion a concerned call from the reporting officer to ask if the staff member is all right or needs to talk to someone (we have in-house counsellors for such things).

If the incident is deemed serious enough, there would be an inquiry by an appointed committee, which would carry out a root cause analysis to dissect the incident, and the findings might be brought to the attention of the hospital clinical leadership to consider if any subsequent measures ought to be taken.

**CULTURE OF CAREGIVING**

And there is a more complicated question: Should the victim, who is a medical staff member involved in the care of the patient, make a complaint with the police?

This course of action is not so much exacting our pound of flesh as one of deterrence. It is also to demonstrate the official policy of "zero tolerance" towards any violence against medical staff, driving home the message that assailants could face punishment under the law. As violent patients may sometimes assault not only staff but also other patients, pressing criminal charges would also protect these other patients from harm.

But taking this course of action is very much the exception rather than the norm. The reason could be a feeling that the incident was not serious enough, or fear of the assailant, or pressure from the patient's family not to make a police report, or just wanting to avoid the hassle of going to the police station and later to court.

There is a more noble reason – if a conflicting one. Choosing to press criminal charges against patients can be a difficult decision for healthcare professionals who work in a culture of caregiving and where hospitals and clinics are supposed to be places of healing, rather than punishment.

For us to move into that very different role of complainant in a criminal case is something else entirely – a switch of role that is usually riven with ambivalence and even guilt.

It is especially so in the mental healthcare context where it is often unclear whether violent patients should or deserve to be prosecuted for their actions. It can be really hard to say if a mentally unwell patient had knowingly and intentionally assaulted someone, and even if he did, it could be because he was under the malevolent influence of some psychotic or manic disorder.

My patient was hallucinating; he heard frightening voices who told him that the Devil and the people around him or known to him were out to get him. He told me this when I went to see him in the ward a couple of days later. He was subdued, tearful and horrified that he had assaulted his father and me and asked for forgiveness. By the time of his discharge two weeks later, he was his usual placid and gentle self.

**PREVENTION OF VIOLENCE**

The notion of making it a police case had never entered my mind – in a way, he was as much a victim as his father and I were of his mental illness. But if he were a psychopath who had been repeatedly and wilfully violent in order to intimidate, I would have had no qualms in lodging a police report.

Prevention of such violence is, of course, better, and there are various measures to this end: teaching of de-escalation techniques and better communication skills; having a transparent reporting system with a framework for learning and for implementing changes that would improve workplace safety; the availability and rapid deployment of security personnel; and developing hospital protocols to determine when prosecution may be appropriate and, if possible, enabling hospital administrators to pursue legal action on behalf of staff.

But it is impossible to completely eradicate such violence, and for those of us in the mental health profession, we know that this is our occupational hazard.

But this is an awareness that we have subconsciously pushed to the back of our minds. The fear would be crippling otherwise, and it would not be possible to get on with our work, let alone provide good and empathetic care, if we were to constantly feel at risk and endangered.

I still see my patient. After many years of not working, he has found a job and he tells me that he is happy and feels better about himself, though that episode still haunts him.

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