Commentary

When Residents Are Victims of Violence

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Many studies of the relationship of mental illness to violence focus on subsequent arrest rates of individuals already hospitalized with a diagnosed mental illness. The results are equivocal, but generally no clear relationship between mental illness and violence is discovered. These are the studies so often quoted by those who argue that a mentally ill person is no more likely to be violent than anyone else (1).

Practitioners of psychiatry, however, fear that these studies are misleading. First, those labeled mentally ill are unlikely to be subject to arrest if they become violent. Rather, their violence will be viewed as a manifestation of illness, and they will be treated outside the criminal justice system. Thus, the true incidence of violence by the mentally ill cannot be assessed by looking at arrest rates. Second, some of the studies of violence among the mentally ill fail to consider substance abuse disorders as mental disorders. Psychiatric practitioners who treat these patients are well aware of their tendency to be violent while they are intoxicated (2).

Finally, unpublished surveys and anecdotal evidence suggest that violent acts perpetrated by the mentally ill are not uncommon. Surveys of family members of chronic patients by the National Alliance for the Mentally Ill indicate that 60% of those surveyed have been physically assaulted by a mentally ill family member.

Physicians who work in the “trenches” (emergency rooms, public institutions, and walk-in clinics) are also increasingly concerned about their personal safety. Psychiatric residents are at especially high risk of being assaulted. The most dangerous site for psychiatric residents appears to be the emergency room or walk-in clinic. Last year in my own program there were eight completed assaults (physical contact was actually made) on residents in the two emergency rooms through which the residents rotate. There were many more “near misses,” in which a show of force or intervention by security officials prevented a completed assault. On a number of occasions patients were found to have weapons. Data about the frequency of patient violence toward psychiatric personnel are not available, but the
The potential violence of mentally ill patients raises two basic questions for those of us who deal with the training of residents. First, what can we do to prevent physical attacks upon residents? Second, what can we do to help residents who have been victims of attack?

There are certain physical measures that can be taken in most hospitals to increase protection for hospital personnel. The key site where protection is needed is the emergency room or walk-in clinic. One basic need in this type of setting is the ready availability of security people and a warning system that alerts them quickly when violence is imminent. The physical structure of the interviewing room is also important. Many emergency rooms are not designed to provide the resident with sufficient protection. For example, doors open inward rather than outward; the interview room may be too remote from other people; the buzzer system may not function well; and there may not be an easy way for the physician to exit the room quickly. Some of these conditions are surprisingly difficult to remedy because of space requirements, fire ordinances, and perhaps, an insufficient concern by some administrators for the safety of personnel. Once the attention of the administrator is gained, however, these conditions, often can be remedied without great expense.

The decision to use metal detectors in emergency rooms raises serious questions of balancing the dignity of patients with the safety of personnel. Unfortunately, as episodes of violence increase, we may see more and more institutions resort to the use of metal detectors, regardless of its impact on patient morale.

Another major preventive measure is directly relevant to training. It is obviously desirable that each resident who works in the emergency room be highly skilled in dealing with potentially violent patients. Unfortunately, psychiatric training programs traditionally place their least experienced doctors in the most difficult treatment situations. Educators and administrators are not the only ones responsible for this practice. The residents themselves often want to get into the action as quickly as possible, and most of them find that the "baptism of fire" of emergency room work enhances their self-image and sense of competency.

My own belief is that although "macho" on-the-job training fulfills certain psychological needs of the trainee, it provides inferior training and exposes the trainee to too great a risk of danger. Recent medical graduates in nonpsychiatric specialties begin their first year of training with a reasonable degree of experience in managing physical aspects of illness. Beginning psychiatric residents, however, have learned very little about managing psychiatric patients. Until they have been tutored, precepted, and had the chance to watch others handle difficult situations many times over or unless a more advanced resident or attending is physically present, they should never be allowed to manage the most difficult patients in the most difficult situations in psychiatry.

Of particular concern is the residents' involvement in making decisions about involuntary commitment in the emergency room. These decisions require a very high level of clinical and social judgment, and they are made in a setting that carries a high risk of violence. One useful way of diminishing violence toward residents would be to limit their responsibility for emergency room call until they had at least one, and preferably two, years of psychiatric training.

Other educationally related measures can contribute to the process of prevention. Residents can be taught to anticipate and avoid creating situations or actions that the patient may perceive as a confrontation. We need to teach residents how to recognize