



Violence against doctors: a wound as old as medicine

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There is something deeply contradictory about a civilization that claims to hold its healers in the highest regard yet tolerates violence against them as a routine occupational hazard. Violence directed at physicians is not a recent social pathology; it is a wound as old as medicine itself, and one that has widened with each passing decade. The Code of Hammurabi, inscribed around 1754 BCE, mandated the cutting off of a surgeon's hands if his patient died or lost an eye.¹ This was institutionalised retribution, the earliest formal codification of the idea that a physician's failure merited physical punishment. Civilizations change; this impulse, it appears, does not.

The historical record is unambiguous. During the Black Death, when the plague killed at least a third of Europe's population between 1347 and 1351, plague doctors contracted by municipalities to treat the dying were attacked, defamed, and abandoned to the disease they were expected to cure.² The fourteenth-century surgeon Guy de Chauliac, who served as papal physician in Avignon during the outbreak, recorded that physicians felt useless and ashamed, many refusing to visit the sick out of fear of infection, while those who did faced fury from bereaved and desperate families.² In nineteenth-century Edinburgh, the Burke and Hare murders exposed how public contempt for the methods of medicine could erupt into mob violence directed at anatomists and their institutions.³ These are not isolated historical curiosities; they are the deep roots of a problem that continues to grow. Contemporary data confirm

that violence against doctors is a global crisis of considerable magnitude. Between 8 and 38 percent of health workers worldwide suffer physical violence at some point in their careers, with many more experiencing threats or verbal aggression.⁴ A systematic review and meta-analysis of 253 studies involving more than 331,000 healthcare workers found that 61.9 percent had been exposed to some form of workplace violence in the preceding year, with verbal abuse accounting for 57.6 percent of incidents and physical violence affecting 24.4 percent.⁵ From 2002 to 2013, the rate of serious violent incidents in healthcare settings was more than four times greater than in private industry as a whole, with healthcare accounting for nearly as many serious violent injuries as all other industries combined.⁶ The 2023 CDC Vital Signs report documented that harassment at work among healthcare workers more than doubled between 2018 and 2022, rising from 6 to 13 percent.⁷ In China, the Ministry of Health recorded approximately 10,000 violent incidents against medical staff in 2005, a figure that rose to more than 17,000 by 2010.⁸ In March 2012, a seventeen-year-old patient at the First Affiliated Hospital of Harbin Medical University fatally stabbed Wang Hao, a junior doctor uninvolved in his case, and injured three other physicians; an online poll found that 65 percent of respondents selected happiness as their reaction to the killing.⁸ Between 2003 and 2013, 101 serious incidents of medical violence in China resulted in 24 deaths among healthcare workers.⁹ In India, three quarters of doctors report facing verbal or physical abuse,

with relatives initiating violence in 70 percent of cases.¹⁰

Pakistan demands particular attention from this journal's readership. Earlier data from a public teaching hospital in Lahore documented that 73.8 percent of healthcare workers had experienced violence in the preceding year, with patients' relatives identified as the most common assailants.¹¹ A more recent nationwide survey across Pakistan found that 77.6 percent of Pakistani doctors had been exposed to violence in the preceding ten months, with patient attendants responsible in 87 percent of cases and 67.8 percent of physicians reporting that they felt unsafe at work.¹² Doctors in Khyber Pakhtunkhwa were specifically identified as more likely to experience workplace violence than those in any other province of Pakistan.¹² The Khyber Pakhtunkhwa Healthcare Service Providers and Facilities (Prevention of Violence and Damage to Property) Act was enacted in 2020, yet remained largely unimplemented as late as 2024, prompting repeated strikes by the Young Doctors Association and the Provincial Doctors Association, who described hospital staff working in fear while the government dragged its feet on enforcement.¹³ The recent murder of a female doctor in Kohat, shot while returning home from duty, and the subsequent suspension of healthcare services across the province, brought these failures into sharp and tragic relief.¹⁴ That our own province leads the country in this grim statistic is not merely a public health failure; it is a governance failure of the most consequential kind.

The causes of this crisis are structural, cultural, and psychological in equal measure. Overcrowded hospitals, long waiting times, inadequate resources, and the absence of effective grievance redressal mechanisms create environments in which the fear and grief of patients' relatives are directed at the most visible available target.^{4,5} Mental illness, alcohol or drug use, and a history of volatile behaviour in patients or their companions are recognised risk factors, as are emergency and psychiatric settings, which consistently carry the highest burden of violence globally.^{5,6} Media narratives that default to blaming doctors when patients die, unrealistic public expectations of medicine's power, and near-total impunity for perpetrators together degrade the social covenant that once protected the physician's person. Under-reporting compounds the problem; studies indicate that only a minority of incidents are formally recorded, in part because physicians have correctly concluded that reporting changes nothing.⁴ In Khyber Pakhtunkhwa, a law exists on paper that could change this calculus. Its non-implementation is an institutional abdication that has already cost lives.^{13,14}

The consequences extend far beyond the individual harmed. Healthcare workers who experience violence suffer posttraumatic stress disorder, depression, anxiety, and burnout at rates substantially higher than the general population, and the organisational costs include lost wages, staff replacement, reduced patient satisfaction, and preventable errors in care.⁵ Physicians who feel unsafe withdraw from the public sector, reduce clinical engagement, practise defensive medicine, or emigrate. The healthcare system injures itself through the very act of attacking those who sustain it.

Addressing this crisis requires more than legislation, though legislation that is actually implemented is an essential beginning. Comprehensive prevention

frameworks built on management commitment, hazard identification, engineering controls, training, and robust post-incident support have been shown to reduce violence in healthcare settings and are strongly recommended by occupational safety authorities.⁶ Global medical bodies and leading journals have called on governments and institutions alike to treat violence against doctors not as an occupational inevitability but as a preventable public health emergency requiring urgent, coordinated action.^{13,14} These frameworks require institutional leadership that supports rather than abandons its clinical workforce, media that bring the same nuance to death in hospitals that they would bring to any other complex human tragedy, and a social recognition that the hospital is not an arena for the settlement of grievances, but a sanctuary where the shared work of healing takes precedence over every other claim. The historical record, stretching from Hammurabi to the streets of Kohat, has been making this argument for nearly four thousand years. It is time the argument was finally heard.

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