

Let's talk about violence – more!

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Everywhere in Switzerland, there are people whose lives are permeated by violence. Interpersonal violence is a complex problem, closely interwoven with mind-sets, and individual and social customs, as formed by many different influences in families and communities [1]. Interpersonal violence can be defined as a conscious physical attack, with the intention to cause physical and psychological harm

In comparison to other countries in Europe, Switzerland is fortunate in that only a few people lose their lives to violence each year, but many people suffer physical or psychological harm – or indeed both [2]. Interpersonal violence leads to high costs for a medical system, as many injury patterns require expensive diagnostic workups (e.g., cranial computed tomography) or need to be treated with surgery and require hospitalisation.

Therefore, intensified research on interpersonal violence in Switzerland is important. We must question our own notions about what is acceptable, and abandon the illusory conviction that acts of violence are simply an internal matter between two “unlucky” parties, an individual choice for handling arguments, or an inevitable aspect of daily life in a violent world. In cooperation with a variety of partners, medical research must develop scientifically based and comprehensive measures to work against these forces, which are slowly poisoning our society – as violence is often predictable and *more importantly* preventable.

We have the research instruments and we have the knowledge we need to translate our research results into practice. We have already used these research instruments thousands of times to solve other medical problems.

Douet et al. determined the prevalence of self-reported interpersonal violence among adult emergency department (ED) patients and found alarming numbers: in 2002, for only every fortieth consultation in the ED of Lausanne University Hospital had the patient experienced violence in the preceding year; 17 years later it was every fifth [3]. This comparison might be biased through selection – only about 20% of all ED patients were included in the current study – or bias in detection and reporting, but the trend is frightening and the absolute numbers are impossible to ignore. Five percent of all ED consultations included were solely caused by interpersonal violence. It is particularly grave that violence disproportionately affects young patients. Furthermore, physical assault and community violence more often affected males; females more often suf-

fered domestic violence and one can wonder whether “widowed” is the marital status most protective against violence.

From the epidemiological standpoint, research on this topic is demanding, as there are different definitions of violence – especially in different cultures – and evaluating the effectiveness of preventive strategies is challenging [4]. Epidemiological studies focussing on particular subgroups are desirable in future and these should employ standardised, less subjective measures, as well as socioeconomic evaluations.

In any case, the extremely high participation rate of 86% (!) makes it clear how important this issue is for future studies and preventive interventions. However, only 17% of patients discussed this problem with their family doctor or any other physician. Hannah Arendt's fundamental statement that “Violence begins where speech ends” could be applied to our clinical work [5]. A conversation about the chief complaint is then simply not enough. If we are to detect and prevent physical and psychological violence, we must discuss the problems intensively with our patients.

Even modest investment might lead to consistent and sustainable changes. But the endeavours must be supported by the complete spectrum of partners in healthcare and in private, and supported by rigid legislation.

We must be determined to fulfil our role in the fight against violence.

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