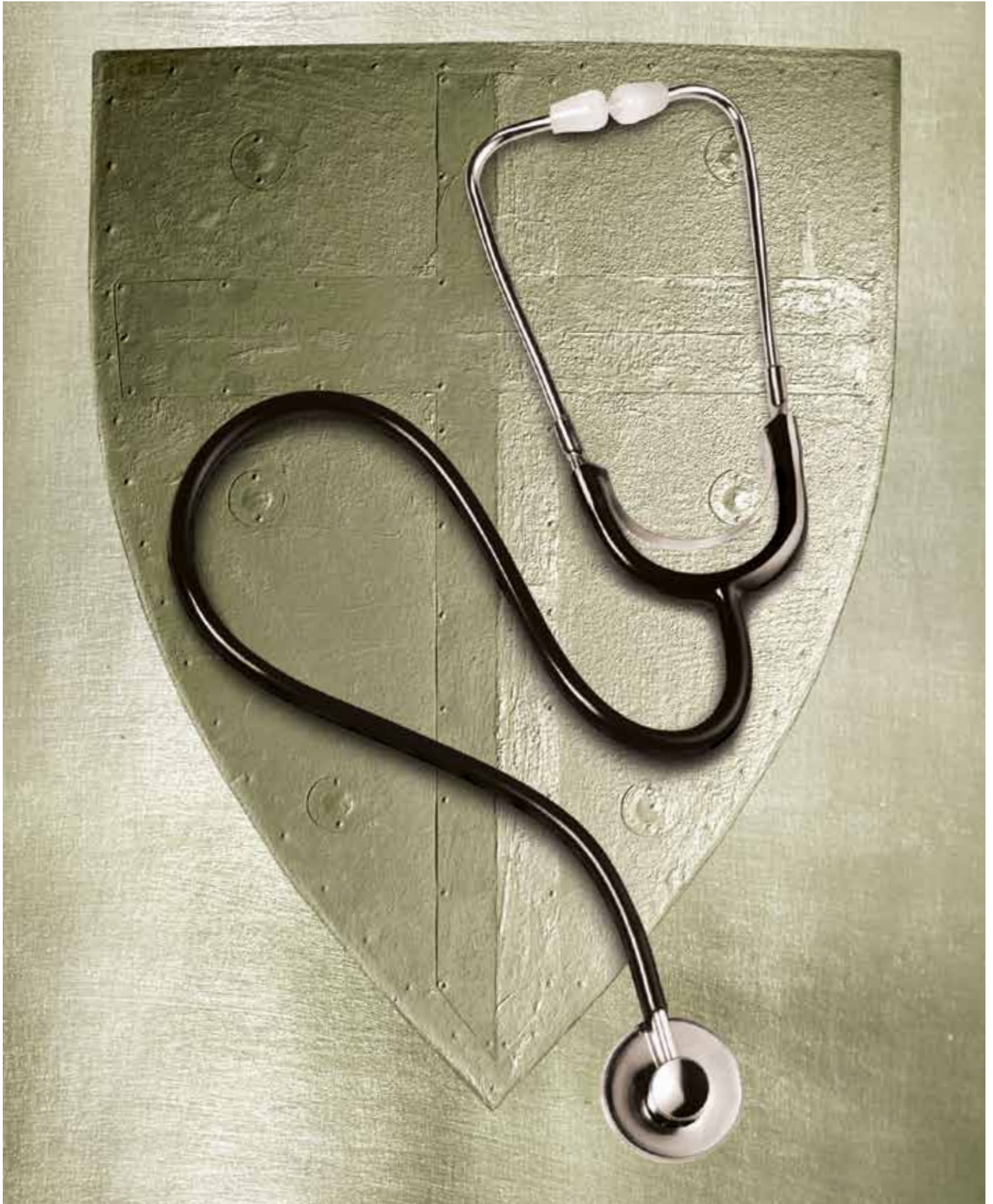




The Royal Australian
College of General
Practitioners

General practice – a safe place

Education module



General practice – a safe place: Education module

Written by Leanne Rowe AM, Bronwyn Morris-Donovan, and Ian Watts in conjunction with
The Royal Australian College of General Practitioners Publications Unit.

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The RACGP National Standing Committee – General Practice Advocacy and Support would like to thank the general practitioners, practice nurses and practice managers who helped refine the material contained in *General practice – a safe place*.

This education module is, in part, a collection and adaptation of the work by prominent people in the field of general practice and occupational violence.

The RACGP wishes to acknowledge the contribution of general practice teams across Australia who have led safety and quality improvements in their practices and openly shared their experiences about managing violent and aggressive patients.

In particular, the RACGP would like to acknowledge Melbourne Medical Locum Service, Associate Professor Moira Sim and her colleagues at the Osborne GP Network Ltd and Edith Cowan University, and the Dandenong Casey General Practice Association who generously worked with the RACGP and contributed their materials.

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The Dandenong Casey General Practice Association Safety and Security Kit for General Practice is available at www.dcgpa.com.au/_misc/Safety%20and%20Security%20Kit%20Sept%202008.pdf.

Foreword

It is clear that general practices need to work both collectively and at the individual practice level to ensure that people in general practice remain safe and secure. *General practice – a safe place* focuses on the prevention and management of patient initiated threats to the personal safety of general practice staff. The evidence demonstrates the multidimensional nature of patient initiated violence and the need for a preventive, multifaceted response to this issue.

A number of studies have reported that about two out of three general practitioners experience some form of occupational violence in a 12 month period. At the most severe end of the spectrum of violence, four Australian GPs have been murdered in the past 12 years. Although it is important not to overreact to these rare instances of major physical assault, a preventive approach is essential as the negative consequences of any potentially violent situation can be severe. As one GP said of such an experience: 'I aged 10 years in 2 seconds'.

Because different types of violence require different responses, a balanced and comprehensive approach to violence in general practice is required. Any form of patient initiated violence should be considered as a 'sentinel event'. Some events need to trigger a 'root cause analysis' of all contributing factors, so as to try and prevent a future incident. This well accepted approach to quality improvement in health care can readily become part of a routine response to aggressive behaviour, threats, or assault in general practice.

Increasing health workplace violence is a symptom of increasing violence in Australian communities. General practitioners have an obligation to protect themselves, their team and the community as a whole if patients display criminal behaviours that pose a risk to the safety of others.

As employers, general practices also have responsibilities under occupational health and safety legislation to protect colleagues, the violent/aggressive patient, other patients, carers and staff by identifying and controlling risks associated with occupational violence. While some practitioners have been resistant to such measures, it must be accepted that security strategies are now part of modern life and routinely implemented by mental health services, drug and alcohol services, locum agencies, hospitals and other businesses.

This education module aims to:

- support practice teams to create a safe working environment
- prevent episodes of patient initiated violence, and
- decrease the impact of violence when it occurs.

In developing this resource, the authors have consulted with many experts in the field, and with practice teams working at the coalface. We recognise the topic is complex and requires different approaches in different situations.

We anticipate that this resource will be used as a tool to encourage discussion within general practice teams about appropriate responses to manage the risk of occupational violence.

The RACGP is keen to have feedback about patient initiated violence, the ways general practice has worked to reduce the incidence of such violence, and about this resource specifically. Feedback can be provided at safety@racgp.org.au.

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Aims of this education module

The aims of this education module are to:

- support practice teams to create a safe working environment
- prevent episodes of patient initiated violence, and
- decrease the impact of violence when it occurs.

Key learning objectives

Key knowledge

This education module will provide general practitioners and the practice team with the following information:

- A definition of patient initiated violence and assault
- The frequency of reported violence in Australian general practice
- Classification of violence, including the cycle of aggression
- Risk factors for violence and aggression in general practice
- Barriers to managing violence effectively
- Warning signs for escalating aggression
- Strategies to de-escalate violence
- The steps required in discontinuing a therapeutic relationship and taking out an intervention order in your state or territory
- An overview of the privacy issues around warning other medical practices about patient initiated violence.

Key skills

At completion of this education module you will have developed skills in:

- Identifying warning signs of escalating aggression
- Using communication and behavioural strategies to de-escalate aggressive behaviour
- Understanding and where appropriate, implementing, crime prevention through environmental design principles
- De-briefing with the practice team following a violent incident
- Managing aggressive patients within the practice and minimising the risk for GPs undertaking home visits
- Implementing whole of practice strategies to improve the safety of the practice and minimise the risks associated with patient initiated violence.

Key attitudes

This education module encourages the following attitudes:

- A willingness to reflect on the many forms of patient initiated violence and how patient initiated violence impacts on practice staff
- An appreciation of the importance of learning practical lessons to ensure ongoing opportunities for improvement
- An appreciation that patient initiated violence is a significant occupational health and safety issue for GPs and the practice team
- An appreciation that threatening, aggressive behaviour is not just 'part of the job'.

Key behaviours

This education module will enable you to:

- Maintain a level of alertness for patients who display signs of escalating frustration that may lead to violence
- Cultivate a culture where practice staff can discuss situations where they feel unsafe
- Review violent incidents (this includes threats, verbal abuse and other nonphysical violence) in your practice to prevent a recurrence
- Routinely monitor practice systems for recurring safety issues.

How to use this education module

This education module is intended for use by the entire practice team, including registrars in vocational training, GPs, practice nurses, practice managers and administration staff. It is also a valuable tool for more experienced GPs.

We strongly encourage participants to read the companion booklet *General practice – a safe place: Tips and tools*. The booklet will assist you to work through the education module and also provides an excellent practice resource.

The education module forms a flexible education package and can be undertaken in one of three ways:

- as a facilitated workshop in active learning module style
- as small group learning, or
- as individual (self directed) learning in active learning module style.

The module is divided into five key parts:

- Part 1:** Predisposing activity
- Part 2:** Five case studies with questions and answers
- Part 3:** Practice based activity
- Part 4:** Community based activity
- Part 5:** Reinforcing activity.

Facilitated workshop

When completed in its entirety, this module forms a 6 hour active learning module for RACGP QA&CPD Category 1 points. Facilitators who do not wish to run the full course may run sections of the course and apply for Category 2 points.

It is anticipated that facilitators who deliver the module will have experience in delivering education. It is recommended that facilitators read the *General practice – a safe place: Tips and tools* booklet in preparation for the module.

If participants attend a workshop as the main educational element of the module, it is suggested you ask participants to complete Part 1 (predisposing activity) and the recommended readings for each case study to prepare for the workshop. It would also be beneficial for participants to refer to the *General practice – a safe place: Tips and tools* booklet, available at www.racgp.org.au/gpandpracticeteamsafety.

Workshop format

Part 2 is completed in the workshop environment. It is suggested that participants break into small working groups of 4–8 participants. Each group is requested to progressively work through an assigned case study and attempt to answer each question. Each group then presents the case study and answers back to the main group. Depending on group size, each working group may choose to work through only one case study or all five, followed by group discussion.

Parts 3 and 4 are designed to be undertaken individually at your own practice. To assist participants in selecting two appropriate activities, you may wish to discuss the activities in Parts 3 and 4 within the workshop.

Suggested active learning module structure

	ALM component	Time allocation (approximately)	Location for participants to complete activity
1	Predisposing activity	30 minutes	At home/practice
2	Five case studies	3 hours	Workshop
3	Practice based activity	2 hours	At home/practice
4	Community based activity	2 hours	At home/practice
5	Reinforcing activity	15 minutes	At home/practice

Small group learning

If you undertake this module as part of a small group it is suggested you complete Part 1 (the predisposing activity) and the recommended readings for each case study. Participants are encouraged to access the 'Tips and tools' booklet available at www.racgp.org.au/gpandpracticeteamsafety.

Part 2 can be completed in a small group learning environment. You may wish to break the small group learning across two sessions, however group meetings are best undertaken in a short timeframe to enable discussion of the case studies.

Parts 3 and 4 are designed to be undertaken individually at your own practice. You may wish to discuss the activities in Parts 3 and 4 within the group, to assist you in selecting two appropriate activities.

Individual (self directed) learning

This module can be completed by individual (self directed) learners. When completed in its entirety it forms a 6 hour active learning module for RACGP QA&CPD Category 1 points. You can apply for quality assurance points as an individual GP by completing an 'Individual GP' application form (a completed individual GP application form is available at www.racgp.org.au/gpandpracticeteamsafety).

If you do not wish to complete the full module you may complete sections of the module and apply for Category 2 QA&CPD points.

In order to qualify for 40 Category 1 QA&CPD points for this active learning module you need to:

1. Undertake the predisposing activity
2. Read and complete the answers to the case studies. You do not need to send in your answers to the case studies (these can be retained for your future reference)
3. Undertake one practice based activity of at least 2 hours duration
4. Undertake one community based activity of at least 2 hours duration
5. Complete the reinforcing activity.

If you complete the module individually, it is recommended you complete the predisposing activity. Work through each case study progressively, using the pre-readings to assist you, and complete the questions as you progress. The answers provided at the end of each case study are there to guide you and direct your learning.

Part 4 is designed to be undertaken individually at your own practice. To enhance your learning opportunities, we strongly encourage you to share the practice based activity and community activity with your practice colleagues.

It is suggested you download the 'Tips and tools' booklet from www.racgp.org.au/gpandpracticeteamsafety to assist you.

Resources, reading and references

All recommended pre-reading material is available from the RACGP John Murtagh Library. A reading list is available at www.racgp.org.au/gpandpracticeteamsafety.

College members will need to log on to the website using your username and password to activate the web links on the reading list.

For nonmembers, the reading list can be accessed through the RACGP John Murtagh Library at a charge. (See www.racgp.org.au/library/nonmembers for charges.)

The 'Tips and tools' booklet is available to download from the RACGP website at www.racgp.org.au/gpandpracticeteamsafety.

Hard copies are available to borrow through the John Murtagh Library.

A full list of additional resources and references are provided at the end of this module.

Introduction

Internationally, there has been increasing interest in occupational violence in the health care sector. In Australia, there has been heightened interest in the safety of general practice and primary health care teams since the killing of Dr Khulod Maarouf-Hassan in 2006.

The increase in violence in the workplace is symptomatic of the overall increase of major violence in Australia.^{1,2} Workplace violence is not an isolated incident with a simple solution. It is a dynamic and multidimensional event.

The literature suggests that occupational violence requires a multifaceted response, as it is a structural problem rooted in social, economic, organisational, and cultural factors. However, initiatives to address risks of violence in general practice in the past have tended to be largely ad hoc and are seldom the result of considered or coordinated strategies.^{3,4}

The booklet *General practice – a safe place: Tips and tools* focuses on threats to personal safety rather than the clinical management of 'difficult' patient interactions, anger management or conflict resolution. Clearly, early management of patient frustration and other feelings is vitally important to preventing violence. Other resources on these topics are included in the Resources section on page 41 of the booklet. The strategies in the booklet are related to imminent or actual patient initiated violence and effective risk control measures, which are:

- inclusive of the whole practice team, including reception staff, practice nurses, the practice manager and GPs
- pre-planned and preventive in approach, and
- multi-dimensional, encompassing physical environmental, patient directed and practice team directed strategies.

Classification of workplace violence

A widely accepted classification divides workplace violence into three broad categories:

- 'External' violence, which is perpetrated by persons outside the organisation such as during an armed hold-up
- 'Patient initiated' violence, which is inflicted on workers by their clients, such as a patient who verbally abuses a practice nurse, and
- 'Internal' violence (or bullying) such as between supervisor and employee.^{5,6}

The booklet only considers patient initiated violence in Australian general practice.

The prevalence of patient initiated violence

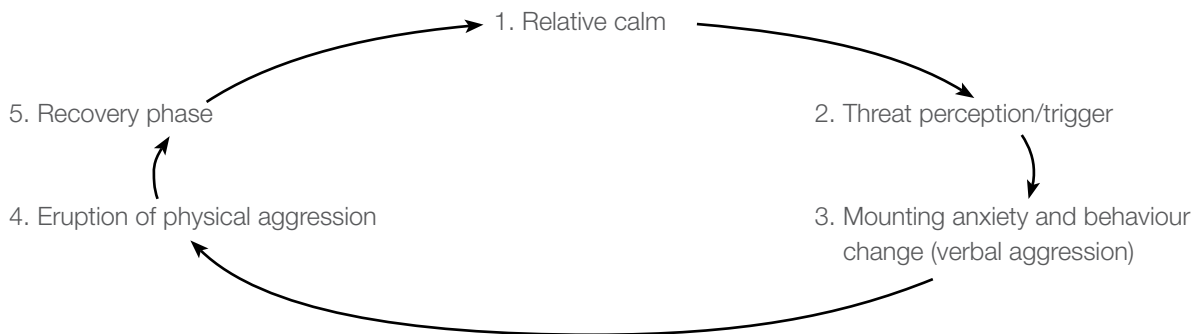
There are very few studies on the prevalence or circumstances of violence against GPs and their teams. One study reported that about 20% of GPs have experienced physical abuse during their careers.⁷ A 2003 Australian study found that 63.7% of GPs had experienced at least one episode of violence over the previous 12 months, with the likelihood of having experienced violence declining with increasing years of experience as a GP.⁸

Younger, female GPs appear most at risk of physical violence, including sexual violence, and have been shown to experience greater fear and implement more changes to the way they practise due to their apprehension of violence.^{3,4}

Geographical variations in experiences of violence in general practice have not been extensively studied. Both GPs working in metropolitan and rural areas appear to be at risk of medical workplace violence.^{3,9}

The cycle of aggression

It is important to recognise the different stages of aggressive behaviour. Retrospective reviews of incidents of aggression reveal a pattern of sequential events. It is useful to consider this pattern as it may assist in recognising and evaluating both perceived and real threats.¹⁰ The pattern of events is represented schematically as a repeating cycle with distinct stages.



Stage 1: The individual is at rest. There may be a heightened state of alertness.

Stage 2: The individual perceives internal and external cues as threatening – this could be a cue from the environment, staff or other patients. The person may misperceive internal cues, such as their own anxiety surrounding a medical condition.

Stage 3: There is a significant increase in central nervous system activity as anxiety escalates. Attempts to relieve anxiety are displayed as restlessness, hypervigilance, and verbal abuse.

Stage 4: The individual feels increasingly threatened and vulnerable. High anxiety and discomfort are released through physical aggression.

Stage 5: Recovery phase. An individual's physical and emotional response may be below his/her normal baseline calm.

A patient in stage 1, 2, 3 or 5 may continue to be very dangerous but may be amenable to negotiation. It is imperative the threat continues to be treated seriously, even when the patient's aggression has settled.¹⁰

Part 1. Predisposing activity

Please write answers to the following questions:

1. How would you define patient initiated violence?

2. Do you consider the risk of patient initiated violence to be 'part of the job'?

3. What would you do if a patient became aggressive during a consultation?

4. How would you manage the situation of a patient requesting benzodiazepines or other drugs of addiction?

5. Under what circumstances would you undertake a home visit for a new patient, or a patient requesting specific analgesia, or a patient previously known to behave aggressively?

6. Would you refuse to treat a patient who became aggressive?

7. If so, how would you go about terminating the therapeutic relationship?

8. What features of consulting room and practice design may improve the physical safety of staff?

9. Please reflect on the learning objectives and set your own.

Recommended pre-reading

Magin P, Adams J, Joy E. Occupational violence in general practice. *Aust Fam Physician* 2007;36:955–7.

Rowe L, Kidd M. Increasing violence in Australian general practice is a public health issue. *Med J Aust* 2007;187:118–9.

Part 2. Case studies

The next section works through five case studies. Each case study is based on practical scenarios and encourages you to consider how your practice could respond in a similar situation.

Each case study has recommended pre-reading to establish a context for the case study.

The case studies are followed by a series of questions, many of which are challenging and complex. For this reason, the answers are provided following each case study.

Given the complexity of the topic, much of your learning will come from working through the answers.

Case study 1 – Jack

Recommended pre-reading

Anderson L, Clarke J. De-escalating verbal aggression in primary care settings. *Nurse Practitioner* 1996;21:95.

Del Bel J. De-escalating workplace aggression. *Nursing Management* 2003;34:30.

Jack, aged 18 years, is brought to your practice by his parents who are extremely concerned about their son's sudden deterioration in behaviour and recent physical assault on a fellow university student. They report he has been hearing voices. Today Jack appears agitated. He is pacing the room, and is withdrawn and noncommunicative with his parents. When the receptionist asks Jack to wait in a GP consulting room, he swears and pushes her against a wall.

One of the other staff members informs you of Jack's outburst. You note from Jack's patient file that he was also seen at your practice 2 weeks ago, at which time Jack slammed his fist on your colleague's desk after being advised of a 3 month wait for an appointment with the local mental health service.

Question 1

What actions would you take to de-escalate Jack's violent behaviour?

Question 2

What are the risk factors for violent behaviour?

Question 3

What are the important questions to ask when eliciting Jack's history?

Question 4

What are some of the early or prodromal signs of psychosis?

Comment

It is very important to recognise psychosis early, as the patient is more likely to respond to treatment with anti-psychotic medication and to have a better prognosis in the long term.

Question 5

What are the criteria for admission of an involuntary patient to a psychiatric facility in your state or territory?

Comment

Jack's behaviour fulfils these criteria as he does not consent to treatment and is at risk of harming others.

Question 6

How would you conduct a debriefing session for your receptionist and other practice staff?

Further history

The practice team discusses the possibility of discontinuing a therapeutic relationship with Jack due to his aggressive behaviour. The team decides to continue care after he is discharged from hospital as he is unlikely to be at risk of violent behaviour after he has responded to treatment. They have discussed discharge planning with the mental health team. However, for their safety, they choose to insert an electronic warning flag in Jack's file. The warning flag appears on the screen each time an appointment is requested for Jack and the call is then managed by the principle GP. The practice implements a policy that indicates two staff must be present in the room during all future consultations.

Note: Discontinuing patient care will be covered in *Case study 3*.

File flagging systems

As a general rule, practices should flag the file of patients who demonstrate aggressive or violent behaviour, or who are at risk of violent behaviour, because a history of violent behaviour remains the single best predictor of future violence. However, in the health care setting, information about past history of violence is not always readily available, limiting the capacity to which staff can be forewarned about a potentially violent encounter.⁶

Question 7

What are the restrictions around flagging patient files when there has been a history of violence?

Additional resource

Friedman R. Violence and mental illness – How strong is the link? *N Engl J Med* 2006;355:2064–6.

Answers Case study 1 – Jack

Answer 1

If you feel in danger at any time, do not continue the consultation, leave the room, warn your staff and other patients, and stay in a safe place until the police (and in this case, the mental health crisis assessment team) arrive.

If you believe you are not in immediate danger, you may find the following steps helpful in de-escalating violence:

- Appear calm, respectful, self controlled and confident – think ‘stay cool and professional’. This may be easier said than done, especially when an individual is screaming at you or using abusive language
- Use reflective questioning where you can. Put the person’s statements into your own words and then check to see that you have understood. By repeating or reflecting a person’s message in the form of a question, you will give him/her the opportunity to clarify the message. Engage in conversation; acknowledge concerns and feelings – let the patient know you are listening. For example ‘You need to see a GP as soon as possible, is that correct?’
- Watch the way you speak. If you are not in immediate danger, be clear and direct in your language – clearly explain your intentions. Avoid jargon and complicated choices. A person who is losing control cannot process complex information. Complex questions will increase anxiety and can make behaviour more difficult to manage. For example, ‘I’d like to help you’
- Watch your body language. As the person becomes increasingly agitated he or she will pay less attention to your words and more attention to your body language. Be aware of your space – maintain as much physical space as possible. Avoid too much eye contact as this can promote excessive outbursts in some people
- Embrace silence. Surprisingly, silence can be a very effective nonverbal intervention. Silence on your part allows the individual time to clarify his or her thoughts. It can provide valuable time to reassess the situation.

If the patient is amenable to reason, try these communication techniques to attempt to de-escalate conflict:

- Portray your actions as being in the patient’s best interest. Portraying your reason for the need for action or change as being in your or the practice’s best interest to a patient who is building their level of anger can be inflammatory. By portraying your suggestions or actions as being in their best interests, an angry patient is more likely to undertake a ‘cost-benefit’ analysis of your suggested change rather than automatically dismiss your suggestions as oppositional or unacceptable
- Use a sequence of ‘yes’ questions. It is very hard to remain angry with someone who you keep agreeing with. An effective technique to attempt to de-escalate aggression is to ask a sequence of questions that the patient can only answer ‘yes’ to.

The most effective way to undertake this technique is to do short summaries of the patient’s perceptions and views as expressed to you with questions at the end such as: ‘Have I got that right? Or: ‘Is that what you mean?’ A sequence of 5–6 questions where the patient is answering ‘yes’ is a powerful way to increase the likelihood that that an aggressive patient will see you as being on their side, even if they remain angry with the issue.

- Maintain a solution focus. This technique involves asking the aggressive patient to problem solve the issue they are concerned about by seeking as many options as they can think of for their problem. By simply listing the options they generate rather than arguing about the pros and cons of each option, there is the potential to stretch the person to develop hybrid or compromise options that are more acceptable to both parties. Anger is usually associated with ‘black and white/all or nothing’ thinking and the skill of nonresponding to the initial ‘black and white’ options and respectfully pushing the patient for more (often greyer) options can be very effective. By calmly acknowledging that everything is an option, and stretching the patient for alternatives, a different conversation can be moulded. It is very difficult to remain in an aggressive frame of mind if you are engaged in a process of basic problem solving.

Answer 2

- Past history of violence
- Alcohol or drug intoxication or withdrawal
- Poorly treated or untreated mental illness such as psychosis associated with disordered and persecutory thinking⁹
- Cumulative stress (eg. grief, fear, distress, anxiety, pain) combined with other unanticipated events such as long waiting times.

Violence rarely 'comes out of the blue'. It is commonly preceded by behaviour that indicates a potential for violence. In addition to the above risk factors, there are many reasons why a patient may be angry, including a patient who:

- is dealing with acute or chronic pain
- is anxious about a serious diagnosis or report
- is seeking drugs of addiction or prescription shopping, and
- has had difficult past encounters with GPs or practice staff.¹¹

An appreciation of the underlying origins of a patient's escalating frustration and agitation can assist in:

- effectively de-escalating the situation, and
- identifying the most effective and appropriate clinical and medicolegal risk management strategies to deal with the problem and prevent its recurrence.

Answer 3

Jack is likely to have a serious mental illness given the sudden deterioration of his behaviour. Some of these questions may be helpful in eliciting psychotic symptoms if Jack's aggressive behaviour settles:

- Have you been feeling especially nervous or fearful?
- Have you been feeling sad or 'down in the dumps' recently, not enjoying activities as much as before?
- Have you been feeling especially good in yourself, more cheerful than usual and full of life?
- Do you hear voices of people talking to you, even when there is no-one nearby?
- Have you ever felt that thoughts are being put into your mind? Do you experience telepathy?
- Have you experienced thoughts being taken out of your mind?
- Have you felt that other people are aware of your thoughts?
- Have you experienced voices or people echoing your thoughts?
- Have you felt under the control or influence of an outside force?
- Do programs on the TV or radio hold special meaning for you?
- Do you feel you are being singled out for special treatment? Is there a conspiracy against you?
- Do you feel special with unusual abilities or power?
- Do you believe you have sinned or have done something deserving punishment?¹²

Answer 4

- Reduced concentration, attention
- Deterioration in role functioning
- Irritability
- Suspiciousness
- Reduced drive and motivation, anergia
- Anxiety
- Social withdrawal
- Sleep disturbance
- Depressed mood.¹²

Answer 5

The objective of mental health legislation is to provide for the care, treatment and protection of mentally ill people who do not or cannot consent to that care, treatment or protection. Legislation (including the criteria for involuntary treatment of patients and the procedures for involuntary admission) differs from state to state and territory.

Police and/or ambulance officers in attendance at a scene requiring the care or treatment of a mentally ill person will generally be able to reassure a practitioner of the appropriate action as the situation requires.

The following website provides access to relevant parliamentary sites, and through them, access to the current version of the mental health legislation for each jurisdiction: www.scaleplus.law.gov.au/othersites.htm.

Answer 6

The effects of violence in the workplace are serious. When there is an incident involving patient initiated violence, it is valuable to provide staff with the opportunity to debrief. Debriefing serves two primary functions:

- it provides staff with an opportunity to take care of the 'person' aspect of patient initiated violence. It allows for an opportunity to seek emotional support and resolve personal issues that may have arisen from the incident, and
- it provides an opportunity for the whole practice to 'intellectualise' the situation and review what happened from a quality improvement perspective.

Depending on the severity of the violence and cohesion of the practice team, debriefing may be provided by an external psychologist or a member of the practice team. The opportunity to consult an appropriate health professional, external to the practice, needs to be offered to all staff members.

Questions to consider in the debriefing session may include:

- What happened?
- What factors may have triggered the violence?
- Could the incident have been prevented?
- What safeguards or barriers can be put in place to minimise a recurrence?

In particular, the practice team could discuss:

- management of agitated patients in the waiting room
- staff training in de-escalating aggression
- systems for flagging patient files
- relationship with the CAT of your local mental health service
- chaperoning during consultations, and
- protocols around the use of duress alarms.¹³

Answer 7

A history of violent behaviour remains the single best predictor of future violence. However, in the health care setting information about history of violence is not always readily available, limiting the capacity to which staff can be forewarned about a potentially violent encounter.¹⁴

As a general rule, practices should flag the health records of patients who demonstrate aggressive or violent behaviour or who are at risk of violent behaviour. Practices need to have a policy in place outlining the criteria for file flagging. The policy should include:

- a clearly defined purpose for the flag, eg. to protect the health and safety of treating staff
- a standard mechanism for flagging patient health records which makes the information readily available to those who need it
- clearly defined scope of who has access to the information, eg. treating practitioner only, restricting access to the staff on a 'need to know' principle

- readily accessible information on managing patient initiated violence, eg. how to manage the patient so that violence is minimised
- a mechanism to review flagged files to ensure ongoing relevance.¹⁵

There are both formal and informal means of flagging patient files.

Some practices flag the computer based appointment program with notes such as 'patient at risk of aggressive or violent behaviour' or 'care for this patient discontinued on [insert date] due to violent behaviour'. In paper based systems, some practices use 'Post-it' notes at front reception to flag patient names. However, this system is open to error for patients with the same name, or where the note becomes inadvertently attached to another file.

It is important to establish an agreed and standardised mechanism for flagging patient files within the practice team. This mechanism needs to be included in the orientation process, as well as in practice policies.

Flagging patient health records and anti-discrimination laws

While anti-discrimination laws may sometimes influence the steps that can and should be taken to deal with patient initiated violence, they do not specifically prohibit the flagging of health records. These anti-discrimination laws also do not require GPs and their practices to tolerate or accept criminal acts.

To comply with anti-discrimination laws, GPs and their teams, need to take a commonsense and proportionate response to perceived or actual threats, taking into account the relevant factors for the patient, the practice and other people involved.

Legal advice provided to the RACGP on the impact of anti-discrimination laws on management of patient initiated violence can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal.

Medicolegal tip

Some patient initiated violence occurs because the patient has a disability. When it does, discrimination laws come into play. Those laws make it unlawful to discriminate on the grounds of disability, and this can extend to behaviours resulting from, or caused by, that disability.

Flagging patient health records and defamation laws

Whatever form of flagging patient records is used, the information contained in the records needs to be clinically and factually accurate. This is particularly important given that patients have statutory rights of access to 'their' health records, and some patients may seek to argue that the flagging in some way has unlawfully defamed them.

Legal advice provided to the RACGP on the impact of defamation laws on the management of patient initiated violence can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal.

Flagging patient health records and privacy/confidentiality issues

The flagging system, and any communications about the patient either within the practice or beyond it, also needs to comply with confidentiality and privacy laws.

Legal advice provided to the RACGP on the impact of confidentiality and privacy laws on the management of patient initiated violence can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal.

Case study 2 – Tania

Recommended pre-reading

Sim M, Hulse G, Khong E. Acute pain and opioid seeking behaviour. *Aust Fam Physician* 2004;33:1009–12.

Tania, aged 28 years, is holidaying with her extended family and is new to your practice. Apparently you have been recommended as the best GP in the area. Tania says she has run out of her prescription for diazepam and oxycodone for her chronic back pain due to secondary cancer in her spine. You do not have any medical records, her solo GP in New South Wales is currently on long service leave, and you cannot contact him. When you begin to take a history, Tania starts to cry and says she can't sleep and will hurt herself 'unless you prescribe the benzos'. You begin to feel uncomfortable in the consulting room alone with Tania because of her assertive body language and the aggressive tone of her voice.

Origins of patient initiated violence

Violence rarely 'comes out of the blue'. It is commonly preceded by behaviour that indicates a potential for violence. In addition to the above risk factors, there are many reasons why a patient may be angry, including a patient who:

- is dealing with acute or chronic pain
- is anxious about a serious diagnosis or report
- is seeking drugs of addiction or prescription shopping, and
- has had difficult past encounters with GPs or practice staff.

When responding to the patient or perpetrator, it is important to consider that rudeness and signals of impending violence might have their genesis in treatable health problems.

An appreciation of the underlying origins of a patient's escalating frustration and agitation can assist in:

- effectively de-escalating the situation, and
- identifying the most effective and appropriate clinical and medicolegal risk management strategies to deal with the problem and prevent its recurrence.

Sometimes patients are more likely to exhibit violent behaviour if there is a history of the practice tolerating or ignoring inappropriate behaviour from patients. Patients may come to believe this is acceptable behaviour in the practice, and learn to use their violent behaviour as a means of receiving what they want.⁹

Question 1

What are some of the warning signs of escalating aggression?

Question 2

How could you respond to Tania's request for drugs of addiction in view of her escalating aggression, and in the absence of any other knowledge about her?

Question 3

Tania calms down as you call your practice nurse to the consulting room. What are the features of your history and examination?

Comment

Do not provide drugs of addiction to new patients unless you are able to confirm the history with the patient's usual GP or specialist. If in any doubt, consult with the drugs and poisons unit in your state or territory, or with specialist colleagues at a pain clinic or palliative care unit.

Question 4

How can you identify or report a patient who you suspect is prescription shopping?

Question 5

What would you do if you were physically threatened by Tania for drugs?

Question 6

How would you define patient initiated violence?

Question 7

How would you define assault?

Question 8

What steps can be taken to minimise the risk of patients obtaining access to Schedule 8 drugs, prescription pads and letterhead paper?

Note: Schedule 8 refers to Schedule 8 of the Australia wide Standard for the Uniform Scheduling of Drugs and Poisons. Schedule 8 (S8) drugs (or controlled drugs) are 'substances which should be available for use, but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence'. (Department of Health and Ageing, Therapeutic Goods Administration, Poisons Standard 2007, page 10). Examples of S8 drugs include methadone and morphine. See RACGP *Standards for general practices* for further information on storage of S8 drugs. Criterion 5.3.1. Available at www.racgp.org.au/standards/531

Additional resources

Sim M, Khong E, Choy W, Casey W. Substance abuse. **check** Program of self assessment, Unit 428. 2007. November. The Royal Australian College of General Practitioners.

Mayhew C. Preventing client-initiated violence – a practice handbook. Australian Institute of Criminology, 2000.

Isle of Wight Primary Care Trust NHS. Policy on violence and aggression in general practice: Isle of Wight NHS; 2003.

Answers Case study 2 – Tania

Answer 1

- Veiled and overt threats to GPs, staff or other patients
- Outbursts of irrational anger
- Violent gestures such as pointing, swearing, verbal abuse, slamming objects (eg. doors, chairs)
- Either intense staring at you or avoiding looking at you (this often depends on cultural background)
- Increased psychomotor activity – restlessness, repetitive movements, pacing, arousal, and inability to sit still
- Refusal to communicate, withdrawn
- Harmful, violent thoughts and disordered thinking about violence
- Warning signs from early episodes of violence, past history of violence.^{10,16,17}

Answer 2

Always acknowledge your 'gut' feeling when you feel unsafe and act on it by leaving the room immediately and alerting other staff. If you do not feel you are in immediate danger, you can unobtrusively indicate you need support to other staff in the practice. For example, other staff can be alerted by a speaker phone or by dialling one number or a computer pop up message at the press of one key.

Some practices have a key word that when used out of context is a signal that the staff member needs assistance.

Answer 3

Chronic pain requires a comprehensive assessment including:

- History of pain condition and contributing factors
- Past medical and psychiatric history
- Past and current treatment
- Past and current medication use
- Physical examination in relation to the site of the pain
- Physical examination of other relevant sites
- Assessment of the mental state including response to pain and consistency of behaviours
- Signs of intoxication and withdrawal
- Signs of intravenous and intramuscular injections
- Previous investigations in relation to the cause of the pain.¹⁸

Answer 4

Patients who are prescription shopping for drugs of addiction often provide false histories of cancer or fabricate stories of other misfortune. If patients have genuine histories of chronic pain, they usually readily agree to have their details checked with the Prescription Shopping Program. Patients who are prescription shopping will usually leave your practice at the suggestion of having their details checked.

Special legislative provisions are in place in relation to the Prescription Shopping Program to protect doctors who report 'prescription shoppers'. Once the doctor is registered with the program, he or she can call the service 24 hours a day, 7 days a week on 1800 631 181 to find out if the patient has been identified under the program.

More information on the Prescription Shopping Program can be accessed at www.medicareaustralia.gov.au/provider/pbs/prescription-shopping/index.shtml.

Answer 5

Alcohol or drug intoxication or withdrawal is a risk factor for patient initiated violence.

Drug seeking behaviour is also a risk factor of patient initiated violence. General practitioners and practice staff should exercise extreme care with 'prescription shoppers'. Patients who are intoxicated or have a known drug dependency and try to obtain licit drugs should be reported to the relevant state/territory drugs and poisons unit.

If GPs and staff feel threatened by a patient, especially someone who is affected by drugs and seeking a prescription, they should consider giving the patient what they want and asking them to leave immediately, to avoid a possible violent incident. Always call the police and your state/territory drugs and poisons unit in this situation. Do not confront the patient.

However, if you perceive there is no danger, GPs should not provide small amounts of medication to 'prescription shoppers' just to 'get rid of patients'. If you suspect a patient of requesting medicine in excess of medical need, you can call Medicare Australia's Prescription Shopping Information Service (1800 631 181).

Adverse drug reactions have resulted from the provision of drugs of addiction to patients with a known addiction problem. Prescribing to prescription shoppers has been the subject of numerous Coroners' inquests, and resulted in several investigations by state and territory medical boards.

There is a useful website for GPs and other health professionals on issues associated with alcohol and other drugs, which has information on:

- screening and early recognition
- assessment
- brief interventions
- motivational interviewing
- treatment options and efficacy
- challenging behaviours (including drug seeking behaviour)
- comorbidity
- pain management
- polydrug use
- pregnancy
- referral and shared care, and
- surgery.

See www.aodgp.gov.au/internet/aodgp/publishing.nsf/Content/resource-kit-3.

Answer 6

A good definition for patient initiated violence is: 'Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, wellbeing or health'.¹

Patient initiated violence covers a wide spectrum and can include:

- threatening or inappropriate body language
- intimidation and threats
- verbal aggression (rudeness, yelling, inappropriately swearing)
- abusive letters/phone calls/emails
- assault
- forcible confinement/false imprisonment
- acts of indecency
- sexual harassment (including innuendo, 'accidentally' touching or overt sexual advances)

- sexual assault
- destruction of property/possessions
- stalking, loitering
- armed assault
- a hostage situation.⁹

Answer 7

Assault is a threat or a physical attack on personal safety. Assault has a different statutory definition in each Australian state. A general definition of assault is: 'The intentional use of force or intimidation by one person against another, without that other person's consent or other lawful reason, which causes that other person to fear an immediate threat of physical violence or harm'.

The definition of assault has been extended to include acts that technically constitute battery such as:

- pushing
- shoving
- smacking
- holding, or
- touching of a person's body or clothes so as to cause the victim discomfort.

If a patient threatens another person using a weapon such as a dirty syringe by waving it in front of that person's face, or by some other intimidating gesture, this constitutes an assault if it is done intentionally and the act evokes fear in the person threatened. Conduct which is threatening and intimidating, but falls short of an overt act of aggression is capable of constituting an assault.^{19,20}

Answer 8

- Keep supplies of prescription pads and letterhead paper locked up, except for the minimum required for the day. Both computer generated and hand written prescriptions are easily reproduced with today's technology
- Keep additional stationary supplies locked up in an area inaccessible to patients
- Avoid leaving patients unattended in the consulting room or at reception where prescription pads and letterhead paper is accessible
- Store Schedule 8 drugs in a locked cupboard in an area inaccessible to patients
- Don't store Schedule 8 drugs in the consulting room
- Ensure the source of the medication supplied is not visible
- Avoid leaving patients unattended in the treatment room where Schedule 8 drugs may be accessed by the patient.

Further information is available from the RACGP *Standards for general practices*. Available at www.racgp.org.au/standards/531.

Case study 3 – Jonathon

Recommended pre-reading

Manca D. Woman physician stalked. *Can Fam Physician* 2005;51:1640–5.

Jonathon, aged 38 years, has visited the practice only twice before. He presents to you requesting a letter of good character for an upcoming court appearance for drink driving. You see from his medical record that he has a past history of alcohol and illicit drug abuse. When you ask about his current use, Jonathon answers irrationally and becomes highly agitated. He throws his chair at you and storms out of the consulting room, knocking down an elderly patient.

The practice team decides, for their safety, to discontinue a therapeutic relationship with Jonathon as his previous acceptable behaviour agreement has clearly failed (see *Appendix 1*).

Question 1

Outline the process of discontinuing care with a patient.

Further history

Despite your letter to Jonathon discontinuing care, over the next 3 weeks he contacts your practice by phone, abusing the reception staff several times a day. He tries to persuade the reception staff to schedule another appointment.

Question 2

When is it deemed appropriate to contact the police or a neighbouring practice about a person at risk of violent behaviour, and what information should be conveyed in the disclosure?

Comment

The assault on the GP and the elderly patient should be reported to the police. The general practice may wish to seek the advice from local police in relation to Jonathon's potential risk to other practices.

Further history

Two weeks later Jonathon is seen by reception staff waiting in your practice car park. The next day Jonathon is again in the car park, leaning against your car door. Jonathon shouts out to the reception staff that he'll wait for you in the car park all day if necessary.

Question 3

What should you do after being informed Jonathon is waiting in the car park?

Question 4

Stalking is a common form of violence against GPs and requires early intervention and special attention. What safeguards could be put in place to manage Jonathon's stalking behaviour?

Question 5

How do you take out an intervention order in your state or territory?

Additional resources

Pathé M, Mullen P, Purcell R. Patients who stalk doctors: Their motives and management. *Med J Aust* 2002;176:335–8.

Meloy DR. Commentary: Stalking, threatening, and harassing behaviour by patients: The risk-management response. *Journal of the American Academy of Psychiatry and the Law* 2002;30:230.

Answers Case study 3 – Jonathon

Answer 1

A practice may consider discontinuing care to a patient where genuine safety concerns exist as these concerns may prevent GPs and practice nurses from providing ongoing high quality care. If a practice is considering discontinuing care to a patient it needs to reflect on the situation of the GPs, their practice team, and on the patient.

A practitioner is not compelled to continue a treating relationship with a patient where the practitioner is unwilling to do so. In terminating the relationship, caution should be exercised in emphasising to the patient the need for continuing care, if there is such a need.

To consider what is reasonable under these circumstances, it may be useful to:

- ask yourself the question: ‘What would my peers say and do in this situation?’ Would your peers understand and support your choice to discontinue care if they were in the same situation? If you believe they would, then this supports your decision
- reflect on the patient’s situation, especially any short term risks to their health by discontinuing care. It can be useful to consider what action your peers would consider appropriate to meet the patient’s health needs.

If a delay in treatment would harm the patient, then, if practicable, it is important to explain this to the patient.

You may need to:

- Advise the patient of an appropriate place to get care other than your practice
- Advise the patient of the importance of getting care
- Act to reduce imminent harm to the patient (eg. treating them in an emergency and/or call an ambulance).

The doctor has an ethical responsibility to ensure that administrative staff do not turn away patients with urgent medical problems without reference to the doctor. Furthermore, the doctor has an ethical duty to assure him/herself that the patient does not have a life threatening emergency before the patient is declined immediate attention or referred to another practice or hospital.²¹

You may need to consider the risks to other people (eg. other patients who come to the practice) and factor this into your decision.

In a nonemergency situation where the relationship with the patient is terminated, the doctor must:

- ensure the patient understands that the relationship has been terminated. This decision can be conveyed face-to-face or via a letter
- propose a realistic way for the patient to seek continuing general practice care, where possible.²²

If it is appropriate to talk with the patient face-to-face, carefully consider the way you tackle the discussion and ensure the practice is prepared for the discussion.

It may be more appropriate to send the patient a letter advising him/her that you are discontinuing his/her care. In the letter:

- outline the boundaries you are setting (eg. the patient is not to call the practice or attend the practice), and
- with the patient’s permission make an offer to transfer a copy of the patient’s health information to a new practice.²³

General practitioners and practice staff need to be mindful of anti-discrimination laws when discontinuing care. Patients cannot be excluded on the grounds of illness (including mental illness) or disability. Anti-discrimination laws do not require GPs and their practices to tolerate or accept criminal acts.

Legal advice provided to the RACGP about the risk of discrimination in circumstances of patient initiated violence can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal.

What else do you need to do?

- Keep a detailed factual report in the patient's health record at the time of the incident, including a copy of any letter sent to the patient. This should be completed contemporaneously
- Agree on the practice's response to a violation of the boundaries you have set (eg. what the practice will do if the patient calls or attends)
- Be aware that you are legally and ethically bound only to treat a person in an emergency situation
- If you hold any concerns regarding the process of discontinuing care, notify your medical indemnity insurer.²³

Terminating a relationship can sometimes generate difficult ethical and legal questions. The Medical Practitioners Board of Victoria provides advice at <http://medicalboardvic.org.au/content.php?sec=149>.

Occasionally, a medicolegal challenge can arise when seeking to terminate a relationship in a way that still discharges the duty of care owed to the patient. When in doubt as to your rights and duties, you should contact your medical defence insurer.

Legal advice provided to the RACGP on duty of care issues relevant to patient initiated violence can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal.

Answer 2

Warning others about the risk of patient initiated violence

The welfare of other health professionals and patients, especially those in nearby practices, has been consistently discussed within general practice following the killing of GP, Dr Khulod Maarouf-Hassan in 2006.

Decision making surrounding notification to a range of third persons can sometimes pose difficult legal (and occasionally ethical) questions. To help work through these medicolegal issues, a decision making checklist is included at the end of this section.

The patient's right to privacy and confidentiality (often a bar to disclosing information about patients) is not absolute and must be balanced against other important social interests that compete with privacy. It is important to first satisfy yourself that the disclosure is not only lawful, but also a proper and responsible option taking into account the interests of your patient, your staff, your colleagues and yourself.

A useful principle is that any disclosure of information, even if legally permitted, needs to involve the minimum necessary amount of information being disclosed to the smallest group of people in order to effectively manage the risk.

The RACGP *Handbook for the management of health information in private medical practice* provides guidance for general practices about privacy issues. Available at www.racgp.org.au/privacy/handbook.

While recognising that there are many different scenarios that can arise (these are discussed in the checklist), this resource focuses on two discrete situations:

- notifying other professionals when you fear the patient may harm them, and
- notifying/reporting to the police.

The right to disclose information outside the practice

Because it is confidential and covered by privacy law, information about patients is treated differently to information about other people. A common theme in privacy law is that information should not be shared about a patient except with the patient's consent. However, these laws also recognise that the public interest in maintaining confidentiality must sometimes be outweighed by other competing public interests aimed at protecting individuals or the broader community. Because of these exceptions, in some circumstances the law makes it possible to share information about the patient with others, even when the patient does not consent, or where it is impracticable to seek that consent.

The rights of doctors to notify other persons about patient initiated violence are constrained by these laws. An outline of ways to make a decision about when to disclose information follows.

Legal advice provided to the RACGP on the impact of confidentiality and privacy laws on management of patient initiated violence can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal.

Duty to disclose information about patient initiated violence outside the practice

It is possible, that under the law of negligence, a doctor may actually owe a duty – as opposed to simply have a right – to notify third persons that those third parties (eg. other doctors) are at risk of patient initiated violence.

Legal advice provided to the RACGP on the impact of negligence law and duty of care issues surrounding notifications about violent/abusive patients can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal. General practitioners and their team members may also wish to seek advice of their medical indemnity insurer, where the need for disclosure is not urgent.

Where risk to other people is serious and imminent, call the police

If you form the view, reasonably based, that the perpetrator of violence (patient or not) presents a serious and imminent threat to the life, health or safety of other medical practitioners or other health professionals in the area (eg. you think that they have ‘targeted’ a doctor, person or practice), the police should be called without delay.

You should tell the police that their assistance in warning neighbouring practices is necessary. The privacy principles are relevant to what you tell the police.

It is paramount that you form a view, reasonably, of imminent and serious danger or threat of harm to a person or the public. In these circumstances, the privacy principles do permit disclosure of personal information. In considering what is ‘reasonable’ in forming a view, the following are relevant factors, however the list is not exhaustive:

- the patient has a documented history of anger management or uncontrolled aggression
- the patient’s capacity for violence or aggression is associated with drug/alcohol dependency or mental illness such that speculation as to escalation of violence poses an unacceptable risk
- the patient’s behaviour prompting the report to police is sufficiently serious to cause alarm or fear to the safety of those witnessing the incident.

The disclosure to police of personal information about the patient is also justifiable under privacy legislation as being necessary for law enforcement in the circumstances outlined in this section.

Where there is no time to use the police and the risk to others is serious and imminent

Police assistance in contacting neighbouring practices may not be practicable in all instances, such as where a neighbouring practice needs to be urgently alerted to an imminent threat. If you have just encountered a patient/individual who presents a serious and imminent threat, and you are genuinely afraid for the safety of another practitioner or neighbouring practice (eg. you believe that the patient has ‘targeted’ a specific doctor, person or practice), the following factors are relevant to consider:

- Is the danger imminent? Is it serious? By this, we do not mean credible, but rather that there is a risk of serious harm. If so, identify which practitioners are particularly vulnerable and prioritise contact accordingly
- Telephone or email the other practitioner/s and:
 - advise that you have just experienced a violent episode in your practice involving the named person who is the perpetrator

- if applicable, advise that the person was demanding drugs with violence or is under the influence of drugs or alcohol. This conveys a lot of information and, unless you indicate a relationship with your practice, does not breach any doctor-patient confidence
- advise that you have called the police to remove the person from the premises or to report a violent incident
- advise the practitioner you have contacted that they may need to consider taking preventive measures such as locking the front door.

It is desirable for neighbouring practices to co-operate in formulating the most effective means of communication and to discuss concerns.

Consider taking the proactive step of telephoning local practice principals or medical directors and discussing the way practices in your area would respond.

Consider safeguards such as ensuring you have the mobile phone number and email address of local practitioners who may need to act with you in a coordinated manner.

Giving nonidentifying information in other circumstances

Sometimes you may want to notify police or others about a pattern or a risk of violence/abuse, but that pattern/risk does not trigger any of the disclosures permitted under privacy law. In these situations, there are still some options available to you. For example, if you do no more than state the facts as observed and as they have occurred (ie. the threat of imminent danger and the report to the police), you have not breached any patient–doctor confidentiality. This is because the account of the situation described above does not identify the perpetrator as a patient of your clinic. It does not disclose any diagnosis or treatment. Nor does the above account breach any privacy principle.

This form of communication should involve no more than the absolute minimum amount of information necessary.

Checklist for disclosure

This checklist is not intended for use at the time an episode of violence occurs. It is intended to be used for educative purposes for less experienced doctors and practice staff who may find it useful to have an overview of the factors to be considered when choosing to make a disclosure.

Step 1: Identify the risk

Is this a case of patient initiated violence/abuse?

- If it IS NOT, proceed as you would for any other violent incident
- If it IS, continue down the checklist.

Step 2: Assess the risk

A. Consider the most likely cause(s) of the violence/abuse

- In pain
- In need of care/attention
- Desperate for help
- Afraid, anxious
- Expecting early attention
- Confused
- Inarticulate
- On medication
- Psychotic
- Drunk
- Drugged
- Volatile
- Try to address the underlying causes of the violence in your response.

B. Consider the severity of the episode

- The nature of the violence/abuse which the patient might commit/has committed, and how serious or potentially harmful it is
- Severity is not only 'objective' (eg. the patient threw something) but also 'subjective' (eg. the way staff feel about the incident)
- Call the police where you need to
- Address any clinical issues that are safe to manage at the clinic
- Agree on a way of managing the patient should the situation re-occur
- Discuss this with the patient as soon as appropriate.

C. Consider the likelihood the episode will recur

Where the episode is likely to be a one-off event

- Notify the police where you believe it is sufficiently serious (but do not notify others).

Where there is the likelihood (as opposed to a theoretical possibility) that the patient will in fact commit these acts in the future

- Take steps to proactively prevent or minimise the risk of recurrence or the problems that led to it
- Ask yourself whether there is still a risk that the violence/abuse will re-occur and that others outside of the practice will be exposed to it
- If it is likely to re-occur, is the person to whom you want to communicate information a potential victim? (Ignore this question when considering notifications to police). If so, would the giving of information to them help them prepare for and possibly avoid or minimise the violence/abuse or its effects?

If it would help the other person, proceed to Step 3.

If it wouldn't help them to avoid or minimise the violence, do not notify them (Ignore this question when considering notifications to police).

Step 3: Notify others of the risk

If you are still at the point where the notification is, on balance, appropriate, you need to think through some specific issues relevant to the various communications:

- Is it practicable to obtain the consent of the patient? If so, get it.
- Am I disclosing patient identifiable information only because it is absolutely necessary?
- Am I using the minimum necessary patient identifiable information?

Notifying the police

You could involve the police at different times and for different reasons:

- Where you want to report a crime committed by the patient against you or your practice team
- Where you want to invoke mental health laws permitting involuntary detention, and want the help of the police to transfer the patient to psychiatric care
- Where you want to notify them about the risk of future violent/abuse against you, your team or others.

A. Identifying the offence

- Is the potential violence/abuse the type that would justify notification to the police?

Remember, not all forms of violence/abuse are crimes. Even when they are, there is a spectrum of criminal activity; and at one end of that spectrum the offence is relatively minor. For example, 'kicking furniture' (technically, criminal damage) and 'spitting at staff' (technically, an assault).

B. Weighing up the situation

- Are there any mitigating factors that would argue against notification? For example, can the issue be dealt with through risk management initiatives?
- Assuming you want the relationship to continue (and sometimes you might not), would notification either harm or end the clinical relationship, reduce the level of trust in the medical profession generally, or potentially impair the capacity or willingness of the patient to seek treatment (possibly treatment that may help to control the violence/abuse)?
- Even if these mitigating factors exist, remember that you also have separate and independent duties to your staff under occupational health and safety laws.

Notifying health care professionals outside of the practice

A. Identifying the need

- Why does this health care professional need this information?
- How might they benefit from receiving the information? Would it help them to avoid or minimise the risk of violence/abuse, and if so how?
- How might the failure to share this information harm their ability to avoid or minimise the risk of violence/abuse?

B. Identifying whether there is a lawful way of disclosing the information to another health professional outside of the practice

Privacy laws recognise that it is in the public interest to permit certain forms of notification, even where the patient does not consent to them.

The following laws are potentially relevant to notifications to other health professionals outside of the practice.

1. The 'serious and imminent harm' exception

For this exception to operate, you need to have reasonable grounds to believe that:

- the risk of harm to life, health or safety of the recipient of information is serious
- the risk of harm to their life, health or safety is imminent
- the nature of the harm may be either to the person themselves or to the health or safety of the public
- the information must be given to someone who can act to prevent or lessen the harm
- only the information necessary to prevent the harm should be given, which may not involve disclosing all information.

2. The 'threat to public health or public safety' exception

Similarly, the second exception here also permits disclosure by members when they have a reasonable view about certain threats. The threat in the second situation is where there is a serious (but not necessarily 'imminent') threat to public health or public safety.

The two key elements are that:

- the threat is serious, and that
- it is a threat not necessarily to an identified individual or group of individuals, but to 'public health or public safety'.

Where this exception applies, the first question should be: Is there any reason the police (rather than the health professionals) should not be the first point of contact? If there is no justification for bypassing the police, contact the police.

And in situations where you are uncertain of your position, your rights or your obligations, contact your medical defence adviser.

Answer 3

Call the police on 000 to request immediate assistance. Do not call the local police station for immediate assistance. Dialling 000 will provide a more immediate response.

Answer 4

Stalking is a common form of violence against GPs and requires early intervention and special attention.

Legal definitions of stalking vary in Australian states and territories. Some jurisdictions require the accused to have engaged in a course of conduct before an offence is considered to have occurred. Some jurisdictions have expansive, but nonexhaustive, lists of the type of conduct that will amount to stalking or harassment, including:

- following, loitering near, or approaching a person
- loitering near, watching, approaching or entering a place where the victim lives, works or visits
- keeping the victim under surveillance
- telephoning, sending electronic messages to, or otherwise contacting, the victim or any other person
- interfering with, threatening or hiding property in the possession of the victim
- giving offensive material to the victim or any other person, or leaving it where it will be found by, given to, or brought to the attention of, the victim or another person
- stopping, confronting or accosting a person in a public place, or
- forcibly hindering or preventing any person from working at or exercising any lawful trade, business or occupation.

Consider these suggestions:

- document every contact with the stalker, including telephone calls, emails, letters and deliverables
- record all cases of being followed by car, on foot, or being watched. The documentation provides evidence that you have been stalked
- have a practice telephone with a caller identification screen. Log all calls from the stalker, recording the time, date and nature of the call (eg. 'heavy breathing')
- contact the police every time the stalker makes contact. The police should also keep documentation. Ask for a copy of the police log
- request that the local police assess the security of your practice
- change your home phone number to an unlisted number and only provide it to people who need to know
- advise your co-workers, friends, family and neighbours of the situation and ask them to watch for any unusual activity near your home, workplace or vehicle
- keep the outside of your practice and home well lit and free of too many bushes that might provide a stalker with a place to hide
- install extra locks, deadlocks, window security, floodlights, security screens and door alarms in your practice and at home
- file a restraining/intervention order against the stalker through your solicitor
- never enter into a conversation with the stalker. Most stalkers are very personable and persuasive and are able to solicit a reply
- consider enrolling in a self defence course
- vary your routine. For example, go home by different routes at different times and arrive at work at different times
- if you travel by public transport, plan your trip to avoid excessive waiting times at bus/train stops. When leaving your vehicle ensure you are not being followed
- support from the practice is crucial if the stalking occurs at or near work.^{9,15,24}

Answer 5

If there is a continuing threat of violence or intimidation against persons or property damage, you may need to consider seeking an intervention or restraining order. The purpose of an intervention order is to protect the safety of the victim. Its effect is to restrict the perpetrator's behaviour in relation to the victim. In some circumstances the order may also restrict the perpetrator's ability to go near the vicinity of the victim's place of work or residence. Orders can be obtained without disclosing the victim's address.

The legislation governing intervention orders varies from state to state and territory.

Generally, if you have a concern about continuing threatened violence this should be raised with the police and their assistance sought in obtaining an intervention order at the time of the complaint and followed up if necessary.

Intervention orders are generally granted only if a Court is satisfied that it is necessary to restrict the defendant's future behaviour in relation to the aggrieved person.

An intervention order limits certain types of behaviour, eg. what a person can do or where they can go. An intervention order may prohibit or restrict a person from:

- behaving offensively toward the aggrieved person
- approaching (or going near) an aggrieved person
- attending a premises where an aggrieved person lives, works or frequents
- being at a particular location
- contacting, harassing, assaulting, stalking, threatening or intimidating an aggrieved person
- damaging property owned by an aggrieved person, and
- causing another person to engage in conduct that is prohibited by the intervention order.

It is beyond the scope of this resource to provide advice in relation to the law in each state and territory. Information and forms of protection vary from state to state and territory, and are detailed below.

Australian Capital Territory

In the ACT, it is necessary to apply for a Personal Protection Order under the *Protection Orders Act, 2001* as amended by the *Domestic Violence and Protection Orders Amendment Act, 2005*. This is done through a local Magistrate's Court.

Applicants will need to complete an application form and affidavit, and a further confidential form. The Magistrate can grant interim orders until a hearing is held and a final order granted. These forms are available at www.racgp.org.au/gpissues/restrainingorders#bottom.

The assistance of the police should be enlisted for the purpose of seeking an order. Further information is available at www.victimsupport.act.gov.au/content.php?id=14 and www.legalaid.canberra.net.au.

New South Wales

A GP or member of their practice staff needs to obtain an Apprehended Personal Violence Order (APVO), as opposed to a Domestic Violence Order.

There are two pathways to obtaining the order:

- go to the local court, report the incident and then ask to have the case heard to obtain the order
- go to a police station, ask to speak to the domestic violence officer and they will get the process under way.

If a threat is imminent (eg. a patient is in the practice or consulting room) contact the police in the first instance. The police can remove the offending party and then, if there are grounds, the GP can apply for an APVO.

Further information is available at www.legalaid.nsw.gov.au/asp/index.asp?pgid=484.

Northern Territory

In 2008, new legislation came into force in the Northern Territory providing for the creation of a Personal Violence Restraining Order.

Further information (including the relevant forms) is available at www.nt.gov.au/justice/ntmc/index.shtml (search 'personal violence').

Queensland

General practitioners can access a Restraining Order under the *Peace and Good Behaviour Act*. General practitioners (and/or their staff) need to file a complaint with their local court under this Act – cost: approximately \$60 which generally covers the summons fee.

If the complaint is substantiated the court issues a summons (the GP can serve the summons but it is more likely a Bailiff or the GP's solicitor will do this). Once the summons is served a court date is set and both parties should attend (although the GP could opt to be represented, eg. by their solicitor). At the court hearing the Magistrate can issue a Peace and Good Behaviour Order (or request a mediation process) – any number of recommendations can be made on this order; generally for 12 months.

The police can't actually do anything unless an offence is committed – but they can act if the Peace and Good Behaviour Order is violated.

Further information is available at www.courts.qld.gov.au/Factsheets/M-FactSheet-PeaceAndGoodBehaviour.pdf.

South Australia

The complainant (either GP or staff member) needs to provide details of two occasions in the past 6 months where the individual acted in a threatening manner, harassed, assaulted, was verbally abusive, intimidating, left offensive material, entered private property, or kept the property under surveillance.

It is not necessary to prove past behaviour, as an application for a restraining order is based on the person having a reasonable apprehension of fear. It is also possible for the police to obtain a restraining order by telephone in urgent situations.

A complaint should be made to the police, who will apply to the court on behalf of the complainant. In urgent situations applications can be made by telephone.

Restraining orders made interstate may be registered in South Australia giving the order the same effect as an order made in South Australia.

Further information is available at www.lawhandbook.sa.gov.au/ch19s06s02.php (search 'restraining').

Tasmania

People who want a restraining order in Tasmania need to apply to the Clerk of Petty Sessions at the Magistrates Court. If an urgent restraining order is needed, you will need to explain why.

A restraining order can issue made against a person who has:

- caused personal injury or damage to property; and unless restrained, is likely to do this again
- threatened to cause personal injury or damage to property; and unless restrained, likely to carry out that threat
- behaved in a provocative or offensive manner; likely to lead to a breach of the peace; and, unless restrained, is likely to do this again
- stalked the applicant; or has stalked someone else, causing the applicant apprehension or fear.

The Justices must consider the protection and welfare of the applicant to be of paramount importance.

The types of orders that can be made include:

- an order directing the person to vacate premises, restraining that person from entering premises, or limiting that person's access to premises; whether or not that person has a legal or equitable interest in the premises
- an order prohibiting or restricting the possession by the person against whom the order is made of all or any firearms or directing the forfeiture or disposal of any firearms in their possession
- an order prohibiting the person against whom the order is made from stalking the applicant.

Further information is available at www.magistratescourt.tas.gov.au/__data/assets/word_doc/0017/46250/form_48a_restraint_order_app.doc.

Victoria

To obtain an Intervention Order in Victoria takes three steps:

- The person seeking the Intervention Order contacts the closest magistrates office, speaks with a court registrar and fills in an application form
- The police notify the defendant about the complaint
- The magistrate has a court hearing and decides whether to make the order.

Further information is available at www.magistratescourt.vic.gov.au (search 'intervention order').

Victoria Legal Aid and the Victoria Law Foundation have produced a detailed booklet on intervention orders. This gives a practical overview of the issues and contact details. Available at www.victorialaw.org.au/_download_Pdf.asp?pdf=Applying_for_intervention.pdf.

Western Australia

An intervention/restraining order can be obtained through the police, who may apply to a Magistrate for an order by telephone in exceptional circumstances.

Local police can also issue a 24 hour 'temporary' restraining order in extraordinary cases while the main application is being processed. The application is then lodged through the courts and is usually approved within 48 hours; the police serve the restraining order. There is no need to get a lawyer if the application is straightforward, unless there are doctor-patient confidentiality issues involved.

Further information is available at www.police.wa.gov.au/YOURSAFETY/FamilyViolence/tabid/895/Default.aspx#rorder and www.justice.wa.gov.au/.

Case study 4 – Louise

Recommended pre-reading

Magin P, Adams J, Ireland M, Heaney S, Darab S. After hours care – A qualitative study of GPs' perceptions of risk of violence and effect on service provision. *Aust Fam Physician* 2005;34:91–2.

You work in a nine doctor practice that rotates the after hours work, and this evening you are the on-call GP. Late in the afternoon you receive a call from Louise, aged 46 years, requesting a home visit. Louise is known to you, however she usually comes into the practice. Louise tells you she has a severe muscle spasm in her back after an accident at work. After speaking with Louise you agree to visit her early in the evening.

Question 1

What factors should you consider when triaging a patient for a home visit?

Question 2

What systems could the practice put in place to maximise your safety and security before attending a home visit?

Question 3

What personal safeguards could be put in place to maximise your safety and security on a home visit?

Further history

When you arrive at the house, Louise's 15 year old son lets you in and directs you to the bedroom. Louise does not appear to be in pain.

While you are in the bedroom with Louise, her husband enters and verbally abuses you for taking so long to arrive. You feel threatened by his outburst and irrational reaction and notice he is blocking the doorway.

Question 4

What should you do immediately?

Answers Case study 4 – Louise

Answer 1

- Do not agree to provide a home visit before triaging the patient to assess their need for a home visit
- Do not accept calls from patients threatening suicide or domestic violence, who are aggressive in their own language, or who are not known to the practice. It is advisable to request new patients come into the practice where possible
- Do not visit patients requesting specific pain relief medication or repeat prescriptions if they are not known to you. Advise them to come to the practice or a hospital emergency department.

Answer 2

Practices need to have effective mechanisms in place to ensure the safety and security of staff providing home visits and after hours care.

Practice related strategies for safe home visits include:

- Where possible, flag patient files to ensure staff are warned if they are likely to be unwelcome at the home, or if the patient (or their family) has a known history of violence. This gives you the opportunity to alert police before making the visit or choose not to attend (and make alternative care arrangements such as an ambulance)
- Keep a record at the practice of the registration numbers, makes, models and colour of each staff member's car
- Ensure procedures are in place and followed if staff cannot be contacted or do not return/check in as expected
- Education is very important, make sure all the practice team understand the guidelines and include safety as part of the induction process
- Ensure all staff are routinely offered the use of a chaperone for home visits.^{9,25}

Answer 3

Personal safeguards for safe home visits include:

- If your practice engages a deputising service it is essential you alert the service regarding high risk patients
- Do not agree to provide a home visit before triaging the patient to assess their need for a home visit
- Always think in advance about the situation you may be walking into – you can effectively manage a good percentage of potential personal safety problems just by anticipating and being mindful
- When speaking to the patient, ask them about parking – can you use the driveway, could someone move their car to make room for yours?
- If it is dark when you arrive at the house, call while you are in the safety of your car and ask to have the outside lights turned on. If you can hear a dog barking make sure it is secured
- Always park your car so it is pointing in the direction of the exit, so you can leave quickly if you need to
- Always walk on the light side of the street, stay away from bushes; check the back seat before unlocking your car on return
- If you have to use a lift, make sure to stand by the control panel so you can control the lift and get out if you need to
- Keep your bag close to you at all times, do not leave it unattended
- Never become complacent, be alert.^{9,25}

Answer 4

It is helpful to have pre-prepared 'get out' phrases such as: 'My phone is vibrating – it'll be the service switchboard operators' or 'My phone is vibrating – it'll be the receptionist back at the practice (or whatever phrase is appropriate to your after hours/home visit arrangements).

- Once you have left the house it is inadvisable to go back in. What made you take this action in the first place is unlikely to have changed appreciably
- Do not go and retrieve your doctor's bag. These are replaceable items which can be retrieved at a later date with a police escort
- Immediately call your contact, second on call or employer (whichever is appropriate) and inform them of the situation
- Consider whether an offence (physical violence) has occurred? Offences should be reported to the police.²⁵

Case study 5 – Liz

Recommended pre-reading

Mayhew C, Chappell D. Prevention of occupational violence in the health workplace: The University of New South Wales, 2001.

While you are away at a house call, 35 year old Liz unexpectedly attends your practice and demands to see you immediately. Your receptionist, Kathleen, is alone except for an elderly patient in the waiting room. The receptionist explains to Liz there are no available appointments this afternoon. Liz turns to the other patient and angrily demands the elderly lady give up her appointment. The elderly lady is frightened and doesn't answer Liz, which escalates her aggravation.

When the receptionist approaches Liz in the waiting room in order to protect the elderly lady from further verbal abuse, Liz swears and spits in her face. Liz proceeds to a consulting room, refusing to leave until you arrive back from your home visit.

The next morning Kathleen calls to say she is stressed and frightened, and cannot return to work until you provide a safe working environment. She intends to make a WorkCover claim and take at least 4 weeks sick leave.

Question 1

What role do employers play in providing a safe work environment for employees?

Question 2

What could you do in your practice to be 'proactive' about providing a safe working environment for staff?

Question 3

What are the common sequelae of patient initiated violence for practice staff?

Question 4

What are some of the features of a safe physical environment?

Question 5

What changes could be made to the physical practice environment to minimise a future incident in the waiting area?

Additional resources

Geason S, Wilson P. Designing out crime – Crime prevention through environmental design. In: Australian Institute of Criminology, 1989.

Caple D. Reduction of occupational violence through architectural controls and work procedures. Journal of Occupational Health & Safety – Australia and New Zealand 2000;16:437.

Answers Case study 5 – Liz

Answer 1

The potential exposure to patient initiated violence in a general practice poses an occupational health and safety (OH&S) risk.

Employers are required by law to adhere to OH&S legislation. Although legislation varies from state to state and territory, it is uniform in its purpose and employer obligations.

This OH&S legislation imposes statutory obligations on employers to take steps to minimise and to protect the health, safety and welfare of their:

- employees, and
- other people at or near the workplace (eg. other patients at the practice).

The OH&S legislation also imposes obligations on the employer to inform, instruct, train and supervise employees to ensure their safety and to eliminate, as far as is reasonably practicable, risk to health or from work related injury.

To determine what is 'reasonably practical' it is necessary to balance the likelihood of the risk occurring against the cost, time and trouble necessary to avert that risk.

Employers are obliged to consult with employees in formulating strategies to minimise the risk. Occupational health and safety issues can be managed by identifying:

- the extent and nature of the risk
- the factors that contribute to the risk
- the changes necessary to eliminate or control the risks, and
- monitoring and evaluation of the risk control process.

This could include, in some practices, formal training for practice doctors and staff by persons qualified in handling high risk aggression or other threatening behaviours which pose a risk to employee health and safety.

All employees have a duty to comply with organisational policy and procedures and to report violent incidents. Such incidents appear to be reported less frequently in the medical setting than in other workplace settings. Empirical evidence suggests that health care workers are tolerant of such behaviour because they have a natural empathy with people suffering from illness or conditions that affect their behaviour.

Where an employer is aware of the potential for occupational violence, and the risk of harm to an employee or another patient or patients is foreseeable, it would be expected that a risk mitigation program is implemented. If there is a physical assault, the incident becomes a police matter and the relevant criminal codes apply.

Each state and territory has its own government organisation responsible for these issues. Information about the OH&S requirements in each jurisdiction can be found at the following websites:

WorkSafe Victoria
www.workcover.vic.gov.au/wps/wcm/connect/WorkSafe

WorkCover Authority of New South Wales
www.workcover.nsw.gov.au

WorkCover Western Australia
www.workcover.wa.gov.au/Default.htm

WorkCover Queensland
www.workcover.qld.gov.au/

WorkCover South Australia
www.workcover.com/

Workplace Standards Tasmania
www.wst.tas.gov.au/

ACT WorkCover
www.workcover.act.gov.au/docs/legohs.htm

Northern Territory WorkSafe
www.worksafe.nt.gov.au/

Legal advice provided to the RACGP concerning the OH&S implications of patient initiated violence can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal.

Answer 2

Create a culture where staff:

- Feel confident expressing their anxieties regarding patients and feel assured that their anxieties will be acknowledged. This allows for the early recognition of patients who may be potentially violent and validates the concerns of staff
- Do not accept threatening behaviour as a 'normal' way of working or 'just part of the job'¹⁴
- have adequate breaks to attend to physical needs (eg. lunch) so their ability to notice and respond to threatening behaviour is not compromised.
- Practices need to have an agreed and planned process by which they can escalate the way in which they address patients who are, or have a propensity to be, violent.
- Are confident to raise waiting times or other issues that may increase concern or agitation among patients, so that these issues can be managed proactively.

Develop practice policies for a safe environment

- If you have a duress alarm, ensure all staff are trained and (re-trained as appropriate) in using the alarm, and are aware of procedures for getting assistance
- Staff response to the alarm needs to be practised and standardised as far as possible to reduce confusion
- Use clinical meetings and case conferences to discuss a practice wide approach to patients who are complex to manage and present a safety risk
- Recognise that reception staff are often on the receiving end of patient impatience, annoyance and escalating aggravation. The receptionist plays an important intermediary role between the patient and GP
- Use consulting rooms that are close to reception after hours and on weekends. It might mean using a room you do not normally consult in
- Ensure practice security arrangements are covered in the induction of all new GPs, practice staff and medical students
- Develop a clear policy that encourages practice staff not to go into a consulting room with someone they have concerns about
- At least one staff member, in addition to the GP, is present when the practice is open for routine consulting – this includes on site after hours consulting.

See RACGP *Standards for general practices* for further information. Criterion 4.1.2. Available at www.racgp.org.au/standards/412.

Answer 3

Patient initiated violence can have a serious and widespread impact on the staff member(s) involved, and the broader practice team.

The physical severity of a violent incident does not necessarily correlate with the extent of the emotional impact on the recipient. Rather, it is the presence or absence of malice by the perpetrator that correlates with impact.¹⁸ The emotional cost from both perceived and real threats can be considerable and cumulative.⁴

The effects of patient initiated violence are primarily psychological, social and professional, and include:

- high levels of anxiety
- poor concentration
- difficulty listening to patients
- depression
- stress related illness
- social withdrawal
- absenteeism, including avoiding patient types or sites
- high staff turnover
- difficulty recruiting
- diminished productivity
- diminished staff satisfaction, and
- reduced participation in the medical workforce.⁹

Workplace culture is an important determinant of how individuals and the practice as a whole respond to the consequences of workplace violence. On one hand, the adverse consequences may be exacerbated by a lack of support by the practice team. On the other hand, the emotional cost of violence can be alleviated by the presence of a supportive and communicative environment.

Practice environment

Every aspect of the practice environment has a significant influence on the behaviour of patients, staff and others. In order to prevent and manage aggression, practice staff need to work in a well designed, carefully considered practice environment.

However, environmental design as an isolated approach is not sufficient to address all security issues, and due consideration should be given to the vital role of practice staff in preventing and responding to aggression.

A balance needs to be created between maintaining a relaxed and inviting environment and facilitating smooth delivery of services while ensuring the safety of staff and patients. This balance will be different for every practice depending on the nature and degree of risk.

Crime prevention through environmental design (CPTED) is a formally recognised, criminological construct aimed at enhancing those aspects of building design that discourage violence and aggression in the workplace. CPTED involves identifying conditions in the physical and social environment that allow an opportunity for violence to occur in the workplace. Risks are minimised through design (or redesign) of a practice and its immediate surrounds in ways that reduce the opportunity to commit violence.^{26–28}

Environmental strategies are most effective when they are tailored to site specific risks in an individual practice or health care centre.

Answer 4

- Physical barriers in place to prevent access by patients to working areas – patients cannot readily gain access to consulting rooms without passing reception
- Patient waiting area is comfortable, spacious and well lit
- Security locks on all windows and access doorways
- No obstacles to good visibility on the ground, such as bushes near the entrance and tall hedges around the perimeter of the building
- Effective lighting in corridors, car parks, walkways and external surrounds of the building
- If appropriate, curved mirrors placed at hall intersections where a patient can conceal his or her presence
- Glass in windows and doors are shatter proof
- Waiting room and consulting room signs are prominently displayed that notify the public that limited cash is kept on site, drugs of addiction are not prescribed by the practice (as appropriate), and violent behaviour will not be tolerated

- Chairs in consulting rooms are arranged so that the GP or practice nurse is sitting closest to the door. Where possible, consulting suites have two exit doors
- Locks on cupboards where 'hot products' are stored, such as S8 drugs. The RACGP *Standards for general practices* require that S8 medicines are stored in a locked cabinet or safe that is itself fixed to an immovable structure. Criterion 5.3.1. Available at www.racgp.org.au/standards/531
- Fencing to prevent practice grounds and car park being used as a public thoroughfare
- Duress alarms are installed (where practicable).^{1,18}

Answer 5

Refer to *Case study 1, Answer 6* on how to review an incident and offer debriefing to staff.

Site specific strategies could include:

- furniture should be robust enough that it cannot be thrown or used as a weapon
- lock all vacant consulting rooms
- consider installing a physical barrier between the waiting room and consulting rooms to prevent patient access to certain areas
- maintain a practice policy of never allowing a staff member to be alone when the practice is open to patients
- consider the design of the reception counter. Wider and higher counters at reception minimise the capacity of patients leaning over and physically harming a receptionist.^{1,26}

Parts 3 and 4 – Practice and community based activities

The next section encourages you to undertake one **practice based** activity and one **community based** activity. You are encouraged to use the 'Tips and tools' booklet, the resource section of this module, and engage with your colleagues to complete these activities.

When selecting an activity, consider the learning objectives you developed in the predisposing activity and choose an activity that assists you in meeting your learning needs.

Part 3. Practice based activity

Choose one practice based activity from the following:

- Summarise what you have learned from this education module and give a presentation at a lunch time practice meeting or journal club
- Meet with reception, practice management staff and GPs in your practice. Share an incidence of patient initiated violence or patient aggression that you experienced while working at the practice. Using *Case study 5* as a guide, use this session to brainstorm whole of practice strategies for minimising the risks of patient initiated violence
- Write a patient education article for your practice newsletter on practice safety or a related issue. You could explain why it is that patients may be asked a number of questions before being able to obtain a home visit, or explain the practice policy on prescriptions for Schedule 8 drugs
- Review the patient education material you have in your practice on any topic relating to this education module. Develop a resource folder of quality information and useful referral contacts in your local community, such as contact numbers of:
 - local emergency mental health services
 - drug and alcohol service
 - crisis assessment and treatment (CAT) services
 - local hospital, and
 - telephone number and email address of neighbouring medical practices and allied health services.

This activity must involve at least 2 hours time commitment and details must be submitted with your evaluation.

Part 4. Community based activity

Choose one community based activity from the following:

- Contact another general practice in your area and find out (preferably by visiting their practice) what strategies, protocols and practice design features they use to minimise the risks associated with patient initiated violence. Share your strategies, protocols and practice design features
- Consider the principles of crime prevention through environmental design (CPTED). Invite local police officers or members of the police crime prevention unit to your practice to discuss security of the practice environment and identify areas for improvement. Use *Case study 5, question 4* and *5* to assist you
- Facilitate a QA&CPD meeting for your local division of general practice on patient initiated violence using the case studies and 'Tips and tools' booklet
- Write an article for the local newspaper on a topic relating to this education module.

This activity must involve at least 2 hours time commitment and details must be submitted with your evaluation.

Part 5. Reinforcing activity

Write answers to the following questions:

1. How would you define patient initiated violence?

2. Do you consider the risk of patient initiated violence to be 'part of the job'?

3. What would you do if a patient became aggressive during a consultation?

4. How would you manage the situation of a patient requesting benzodiazepines or other drugs of addiction?

5. Under what circumstances would you undertake a home visit for a new patient, or a patient requesting specific analgesia, or a patient previously known to behave aggressively?

6. Would you refuse to treat a patient who became aggressive?

7. If so, how would you go about terminating the therapeutic relationship?

8. What features of consulting room and practice design may improve the physical safety of staff?

9. Please refer to the learning objectives you developed in the predisposing activity. Were your objectives met? Are there any learning areas you need to follow up?

Additional resources

Cognitive Institute. Mastering difficult patient interactions. Course available from www.cognitiveinstitute.org

Mayhew C. Preventing client-initiated violence – a practice handbook. Australian Institute of Criminology 2000. Research and Public Policy Series no. 30

Sim M, Khong E, Rispoli P, Wain T, Hendricks, Rudd C. Managing behaviours safely in general practice. Edith Cowan University, 2008. Available at <http://snmpm.ecu.edu.au/research/aggression/>

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General practice management toolkit. Steer N, editor. South Melbourne: The Royal Australian College of General Practitioners, 2007. Available to purchase from [/www.racgp.org.au/publications/orders](http://www.racgp.org.au/publications/orders).

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Appendix 1. Acceptable behaviour agreement

An acceptable behaviour agreement indicates that although a patient has acted unacceptably, the practice team is willing to continue a therapeutic relationship with the patient, provided the patient complies with the conditions outlined in the agreement.

In the medical profession there is a body of support for the use of acceptable behaviour agreements as a useful tool to modify behaviour.²⁹ However, practitioners should note that acceptable behaviour agreements are not suitable for universal application. The context in which they have been found to be effective is in clinics that have the following characteristics:

- a proportion of patients suffer from drug/alcohol abuse related conditions, drug seeking behaviours, or mental instability
- the practitioners who use such agreements are highly experienced in dealing with patients having drug/alcohol addiction and related conditions or mental instability, and
- the circumstances are such that the patient can be persuaded that there is a trade off, beneficial to the patient, in agreeing to modify behaviour as a condition of continuing treatment.

While the utility of acceptable behaviour agreements has strong support, agreements are not appropriate and are more likely to trigger aggression where:

- the practitioner is inexperienced in dealing with patients having drug/alcohol addiction and related conditions or mental instability
- where recourse to an acceptable behaviour agreement is an over reaction to a trivial incident, and
- in an emergency situation.

It is recommended that where acceptable behaviour agreements are used, they are introduced as follow up to a letter indicating that the provision of care by the practice will be ceased if the unacceptable behaviour continues. Even then, caution needs to be exercised and medical staff need to give careful consideration to the likely risks.

- Where possible the agreement should be tailored to the actual behaviour observed in the individual
- Where possible use written agreements
- Establish clear boundaries
- Patients need to be informed of the consequences of stepping outside the boundaries set out in the acceptable behaviour agreement, eg. termination of the doctor-patient relationship except in an emergency
- Establish a review process.¹⁴

The consequences need to be one which the practice can and will carry out. In this context, it is important for the practice team to be in agreement with the policy.

Legal advice provided to the RACGP about legal issues associated with 'acceptable behaviour agreements' can be found at www.racgp.org.au/gpandpracticeteamsafety/medicolegal.

Appendix 1. Acceptable behaviour agreement

Acceptable Behaviour Agreement

I, _____(individual) agree to enter into an agreement with

_____ (practice) ('the Practice') based on the following conditions.

As a condition of the Practice agreeing to continue my treatment, I promise that I WILL NOT whilst I am in the clinic:

- Swear at staff or in the presence of other patients
- Shout or make offensive remarks
- Make verbal or physical threats
- Attend when intoxicated with alcohol and/or drugs
- Damage or steal property
- Act in a manner which is likely to cause harassment, alarm, or distress to others in the general practice

_____ (other)

If I breach this agreement I understand that:

- I may be asked to leave the practice
- Police attendance may be requested by practice staff, and
- My future attendance at this practice may be discontinued and I may have to seek health care elsewhere.

DECLARATION

I confirm that I understand and agree to the conditions of this undertaking.

I also acknowledge that the consequences of breaching the conditions of the acceptable behaviour agreement have been explained to me.

SIGNED _____ DATE _____

WITNESS _____ DATE _____
(GP, nurse or senior staff member)



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