Occupational violence in general practice

The risk of occupational violence is a cause for considerable concern in Australian general practice. Emerging evidence from Australian general practice is consistent with evidence from the United Kingdom that occupational violence is common and has important effects on practitioner welfare and delivery of care. This article provides an overview of the evidence of prevalence and impact of violence directed against GPs as a context for measures to increase the safety of GPs and their staff.

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The health care workforce is at high risk of violence in their every day working lives.[1,2] A broad range of violent and aggressive acts toward health care professionals have been documented, including verbal abuse, physical assault, theft of property, and sexual harassment.[3,4] Doctors and nurses rank highest in terms of health workers at risk of threats and assaults.[5] Furthermore, general practitioners have been identified as being more concerned about patient violence than doctors working in hospitals.[2] This may not be surprising given that the accessibility and intimate nature of the general practice consultation has been proposed as greatly increasing the vulnerability of GPs to aggressive behaviour.[6]

What is known about GPs and occupational violence?

Results from a survey of rural Australian GPs in 1998 found that 73% of the GPs had been verbally abused and 20% had experienced physical abuse during their careers.[3] In other Australian studies, 68% of GPs reported experiencing occupational violence during their careers[7] and 64% had experienced violence in the past 12 months.[4] These statistics are comparable with United Kingdom[6,8,9] and New Zealand[10] studies. Furthermore, studies show that UK GPs perceive an increase in the aggressive behaviour they experience,[8,9] with up to 87% of GPs reporting that they perceive an increase in violence in the work place.[8]

In Australian general practice it is apparent that the prevalence of violence varies between different divisions of general practice.[3,4] Despite findings that an apparently large proportion of GPs experience violence, it must also be appreciated that it is difficult to gauge the extent of violence against health professionals, particularly GPs. In many cases violent incidents are not reported,[2,6,8,11] and studies performed in general practice have been retrospective and subject to recall bias.

Impact of violence on GPs' health

Many doctors who have experienced violence report both psychological and physical effects,[1] including post-traumatic stress-like symptoms.[4,12] Harris[11] argues that GP victims of assault or abuse suffer shock, loss of motivation or self esteem and an increasing sense of fear. Other forms of violence such as property damage have also been suggested to increase feelings of vulnerability.[13] Fear of violence and stress related to out of hours service have been identified as among the greatest stressors for GPs and there is a close link between the stresses of out of hours work and fearfulness.[14]

After hours care and violence

An Irish study suggests that after hours call is inherently stressful for GPs and that an aspect of this stress, especially for women, is the potential for violence.[15] General practitioners in rural[16] and urban[17–19] Australia reported feelings of apprehension when dealing with patients after hours. Experiencing fear of aggression from patients can lead to a retreat from after hours work,[8,12,13,17–20] thus compromising patient care.[8]

Further sequelae

Forty-two percent of GPs studied in Northern Ireland reported that a violent incident they had experienced had affected their work,[1] and 45% of the GPs had consequently contemplated withholding treatment. Effects of occupational violence on the recruitment and retention of GPs have been linked to large cost implications[7] and this has important implications given difficulties with recruitment and retention of GPs experienced world wide.[21] Disillusionment with medicine has also been identified as a consequence of violence – practitioners have been found to contemplate giving up their practice, and are less committed to medicine.[6,12]

These sequelae should be considered in the light of GPs' risk assessment in relation to occupational violence (and their responses to perceived risk and threat) being largely ad hoc and based on anecdote rather than being systematic and evidence based.[22]

Risk factors for violence

While very little is known regarding the underlying causes of violence in general practice, a number of risk factors or associations of violence have been established.

Geographic

Risk of violence has been found in UK studies to be related to the geographical location of the general practice. General practitioners in urban areas are at increased risk compared to GPs practising in rural areas.[23] Inner city GPs are at increased risk of attempted injury, while the degree of risk for verbal abuse or actual injury was similar to that of suburban doctors.[9] It was noted in studies of rural[3] and urban[4] GPs in Australia that the prevalence of violence was different across different divisions.

GP characteristics

In overseas and Australian studies, women GPs have been found to be at higher risk of violence and have been shown to experience more fear and implement more changes to the way they practise due to violence, to be more likely to call police to the surgery, and to have less confidence in their work as a result of violence.[4,6,19,24]

Patient characteristics

Many common characteristics of offenders in episodes of violence have been identified. Men have been identified as the most common instigators of aggression both overseas[6] and in Australia.[3] Mental illness, alcohol and anxiety have been identified as precipitants of both the most common forms of violence and more serious incidents in overseas studies.[6,8,23] Rural Australian GPs also reported that precipitating factors for aggression were psychiatric disorders, and drug and alcohol use.[3]

GPs' reporting of violence

Myerson[8] found that UK GPs infrequently reported incidents of violence. A large percentage of GPs have been found to make no disclosures of their fears.[6]

Strategies as a response to violence

While a broad range of strategies in response to violence has been documented qualitatively,[17] Hobbs[24] found that only 28% of abused GPs had made changes to their practices due to fears of abuse. Furthermore, some of the changes implemented by GPs may have adverse effects, eg. prescribing on demand[8] or restriction of services to patients.[17,19] In rural Australia, the most common change GPs reported making to after hours practice involved referral of patients to hospitals or other public facilities.[16] In urban Australia the risk of aggression and violence had caused 4.7% of GPs not to provide any after hours home visits during the previous 12 months and, of those who do provide after hours home visits, 27% have restricted or modified their practice because of risk of violence.[19]

Both planning and training are identified as avenues for protecting against and addressing violence. Training programs to prevent and manage violence toward GPs have been recommended.[6,9,11] However, to date (despite much recent activity in Australia in designing and implementing such programs) evaluations of efficacy are still awaited.

Safety versus duty of care

Difficulty in implementing strategies has also stemmed from the conflict between the GP's responsibility to treat patients, the need for protection, and cost effectiveness. Restriction of practice is a prominent response to fears of violence,[17,19] yet GPs are urged not to limit their accessibility to patients, not least as this is likely to increase delays and anxiety for patients – two major contributors to violence against GPs.[25] Selective restriction of practice also increases the risk of contributing to a growing underclass, a population that lacks access to primary health care.[17] Also, this practice may simply shift the problem to other GPs or other health services.[2] Qualitative research suggests that GPs (reluctantly) withhold care from patients who they consider to be potentially violent – which they perceive to be compromising equality of access to care.[17,18] The potential for stigmatisation of groups identified as being an 'increased risk' on demographic grounds must also be considered. For example, 'most people who are violent are not mentally ill, and most people who are mentally ill are not violent'[26] and a general characterisation of the mentally ill as dangerous can lead to stigmatisation and discrimination.

Table 1. Recommended precautions to improve GP and staff safety cover the following areas[28]

- Consider undertaking a safety audit
- Measures to improve physical security
- Practice processes and systems
- GP and staff training in the recognition and management of 'difficult' patients
- Security when GPs and staff are moving around
- Effective complaints management
- Effective relationships with local services
- Patient information sheet
- Patient behaviour contracts

The medical model or zero tolerance?

The GP's construct of duty of care to their patient is not consistent with inflexible punitive policies regarding violent patients. The UK National Health Service promotes a zero tolerance campaign which enforces the principle that violence will not be tolerated.[2] However, some English GPs have stated that they believe zero tolerance is not possible to implement in general practice, is ineffective, and is purely a political tool.[23] In Australia, a zero tolerance policy has been instituted in the New South Wales state public system.[27] It can be argued that such a 'one size fits all' approach that fails to appreciate the culture of general practice (especially the complexity and diversity of this culture) would be inherently flawed in the general practice context. Conversely, dealing with violent patients has sometimes been depicted as inevitable GP 'dirty' work, and as a 'background' risk of the job.[23] This normalisation of violence has the potential to impede policies and actions aimed at minimising incidents of work related violence.[7]

RACGP position statement

In Australia, The Royal Australian College of General Practitioners (RACGP) has attempted to

incorporate considerations of general practice culture and GPs' anxieties, feelings, levels of work stress and 'instincts about people' in their policy statement on general practice occupational violence (available at www.racgp.org.au/gpissues/safety). The broad areas of recommendations are outlined in *Table 1*. The statement also recognises, as well as the GP's 'right to feel, and be, safe', the real willingness of GPs to care for people who may have a propensity for violence (rather than an adoption of a blanket 'zero tolerance policy').[28]

Conclusion

There are no simple or easy solutions to this complex problem. The RACGP's position statement is welcome in that it recognises the complexity of the situation while offering practical advice on measures to lessen risks that are congruent with our current (limited) understanding of the demographics and characteristics of general practice occupational violence. We do not have evidence, however, of efficacy of risk management or response strategies in general practice. Given the urgency of the situation, we must act on the incomplete evidence that is available.

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