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# General practice as a fortress

## Occupational violence and general practice receptionists

### Background

Occupational violence is well documented among general practice receptionists, who are singularly vulnerable because they are placed in the general practice 'frontline'. One response to this threat has been to physically isolate reception staff from waiting room patients by having a perspex shield at the reception desk and a locked door between waiting room and staff areas.

### Method

A qualitative study employing semistructured interviews, an inductive approach and a thematic analysis. The study explored the experiences and perceptions of three receptionists who work in a practice with a perspex and lockdown system, and 16 who work in practices without these.

### Results

Receptionists were universally positive about the safety measures for reducing risk. But there was also a view that these safety measures potentially compromise the feeling of a practice being patient centred by alienating patients from staff and, paradoxically, increasing levels of patient violence and staff fearfulness.

### Discussion

These safety measures, while viewed positively by receptionists, may have adverse effects on patient-staff relationships and exacerbate violence and increase staff fearfulness.

**Keywords:** general practice; safety, occupational; occupational medicine, qualitative research; medical receptionists



General practitioners and their staff are at risk of experiencing violence while they perform their everyday work.<sup>1,2</sup> Over a 12 month period, 64% of GPs working in urban New South Wales experience violence at work – ranging from verbal abuse to physical assault.<sup>3</sup> Studies of general practice receptionists have demonstrated a career prevalence of violence of 62% in receptionists from the Republic of Ireland,<sup>4</sup> and a 68% 12 month prevalence in receptionists in England.<sup>5</sup> As it does with GPs, occupational violence has marked effects on receptionists' wellbeing.<sup>6</sup> While violence directed toward GPs is well recognised as a significant occupational health issue,<sup>7,8</sup> the issue of violence should be conceptualised as a whole-of-practice problem.

The experience of violence, though, may well be different for receptionists than it is for GPs<sup>9</sup> because receptionists are positioned in the 'frontline' of general practice. They are physically at the front desk and they are conceptually the 'gatekeepers' of general practice care.<sup>10-12</sup>

One response to violence that was detailed in previous research<sup>12</sup> was employing a security guard in an after hours general practice service waiting room. Some respondents in the study believed this arrangement to be confrontational and to have the capacity to increase patients' propensity for violence – a situation characterised by them as the 'bowling for Columbine' effect (named for the 2002 documentary film of the same name and its contention that a heightened perception of their own risk of violence creates fear and causes Americans to have a propensity to perpetrate violence).<sup>12</sup> Receptionists, given their frontline role with patients in the waiting

room, would be particularly vulnerable to violence precipitated by such an effect.

In this article findings on structural practice responses are reported from a broader study that aimed to explore occupational violence against general practice receptionists and practice management staff. The overall results of this study have been reported previously.<sup>9</sup> One of the practices involved in the study had structural responses to the threat of violence that could have potential to create a 'bowling for Columbine' effect – the receptionists were isolated from waiting room patients by a thick perspex shield, and access to the clinical areas from the waiting room was only possible after activation of a staff operated button unlocking a safety door between the two areas.

### Method

This project employed the European Commission definition of occupational violence: 'Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well being or health.'<sup>13</sup> The methodology of the study has been described previously in a paper reporting the overall results.<sup>9</sup> Briefly, this was a qualitative study employing audio recorded and transcribed semistructured interviews, concurrent data collection and analysis using an inductive approach and constant comparison, thematic saturation, and thematic analysis. A code book was compiled via this iterative process and the codes were applied to the transcripts. Coded materials were collated using the cut and paste functions of Microsoft Word and then organised into second order and third order codes. The codes 'lockdown' and 'perspex' were grouped in the second order code, 'structural' within the third order code 'strategies'.

In this study, reception and practice management staff represented a homogenous

'receptionist' group. Managers had progressed through the 'ranks', having started their work careers as receptionists and were often summoned by junior reception staff in the event of violence or potential violence.<sup>9</sup>

The study setting was in a New South Wales Network of Research General Practices (NRGP). The NRGPs encompass 14 urban and rural practices and a wide range of practice demographics – small and large group practices, urban and rural localities, and a range of socioeconomic status (SES) settings. All NRGPs reception and practice management staff were invited to participate, and consenting staff were purposively sampled from urban and rural practices and from practices of varying sizes, SES settings and billing practices. All potential participants were female, this reflected the demographics of the workforce.<sup>4</sup>

The aim of study was to explore the experiences and effects of workplace violence on general practice receptionists. The theme of waiting room 'quarantine and lockdown' and its relationship to other aspects of respondents' experience of violence emerged in early interviews with receptionists at a practice that employs these measures, therefore the attitudes of respondents from other practices concerning these measures were elicited in subsequent interviews.

## Results

After 19 interviews with receptionists from eight separate practices, thematic saturation was reached with regard to both the study's wider aims and to the theme of waiting room 'quarantine and lockdown' (though it should be noted that this saturation was from respondents who did not work in practices that employed 'quarantine and lockdown').

Respondents' perception of the level of violence in their own practice ranged from 'high prevalence' to 'low prevalence'. Respondents had a broad range of experience in their occupational setting (1–23 years) and worked in a range of general practice contexts – urban and rural (but not remote) practices and practices in areas of varying SES.

### Experiences behind the perspex

Staff at the practice in which a perspex and lockdown system was employed (three out of the 19 respondents) reported high levels of satisfaction with both the perspex and the lockdown. These receptionists explained that the measures increased

their safety and made them more confident in going about their daily work.

'Well, we are safe, we've got lots of protection here. We've got a front desk that's closed in with perspex. We've got safety doors that close, patients can't go back in... We try and monitor the doors, that they're always closed because it's for everyone else's protection and only people that we want to get in, come in so we're not as at risk.' (Interview 5)

Staff at this surgery highly valued the sense of protection and security engendered by this system. They were unreservedly pleased by its implementation and did not perceive any negative aspects to the system.

'I think it makes people feel more secure. Much, much more secure. [We] had people leaning over the desk shouting and spitting, you know, it was gross. [Perspex and lockdown] is where every general practice is going, it's where every accident and emergency practice has already gone.' (Interview 3)

'I like it. The other day, a lady came in and she became a bit agitated... She mumbled under her breath something about you know, "If we can't get seen I'm going to come back and knock your block off." I just thought, "thank goodness for the glass".' (Interview 4)

The receptionists felt that the safety system provided safety more from physical assault than from the more common experience of verbal abuse.

'They can't spit at you as much. Yeah they could still yell at you and all that kind of stuff, but they can't throw a chair.' (Interview 5)

### Perceptions from practices without perspex barriers

Receptionists from other surgeries similarly reported the perspex/lockdown measures to be an appropriate practice response to the threat posed by patient aggression and violence. Respondents working in practices in which they perceived the threat of violence to be high felt that the measures would be a welcome approach to safety in their own practice. However, some respondents who worked in 'low prevalence' practices, while feeling that the measures would be desirable in a higher risk situation, considered the levels of violence at their own surgeries not to warrant the institution of such a system.

'I think in the future it's going to be inevitable, it is going to become that way. I think it's pretty sad to think that you've got to put barriers up between you

and the public but I really do think that it's going to come to that, for the safety of staff.' (Interview 6)

### Potential negatives for patients

There was also a strong feeling among receptionists that these safety measures, while increasing staff safety, would come at a cost to the patient friendly ambience of a practice and perhaps to patient care.

'For me it's a bit of a contact thing too, you know. An elderly patient – you might go over and have a sit down with them or they might touch your hand or something when they're signing their form or paying their bill. Same as babies... if you're not actually having that physical contact – it's not as personal is it? It would be really more of a production line wouldn't it?' (Interview 18)

The receptionists also explained how the safety measures could set a different agenda regarding violence in the practice – one that had the potential to prejudice patient attitudes to safety in the practice.

'Well I don't think it would be very good coming in as a patient. I think you'd immediately sort of feel, "this can't be a very safe place to be, otherwise people wouldn't be behind those big perspex walls"... I think it would be offputting for them.' (Interview 17)

It was also suggested that there was potential for the security measures to increase patients' stress levels and alienate them from the practice staff, possibly increasing the potential for patient violence (despite protecting staff from that violence).

'I think it would make it much more sort of "us" and "them". I think it would add to people's stress levels. They'd wonder why we had to be sort of locked away and I mean, I think we are quite friendly with the patients and I wouldn't want to be that isolated from them.' (Interview 15)

### Negatives for practice and staff

Some receptionists at low violence prevalence practices described a practice ambience that discouraged violence by patients as a complex construct. It encompasses high level clinical competence of staff, patient oriented attitudes and processes of staff, and respectful patients (determined in part by practice demographics). The ambience consisted of a two-way relationship between staff and patients. The perspex and lockdown scenario was described as having the potential to disrupt this relationship – it was

suggested that such a set up could increase the perception of danger and risk among staff and therefore produce a sense of fear.

'I think if you've got that sort of scenario you immediately think there must be a reason why there's all this sort of security, and I think... it doesn't have to actually be a dangerous situation, if it's perceived to be dangerous you [the receptionist] can actually then be fearful.' (Interview 15)

## Discussion

### Principal findings

There were no caveats to the endorsement of the perspex and lockdown safety measures by those working with them. Staff from other high prevalence practices reported they would appreciate similar structural approaches to safety instituted in their own practices. Respondents from low prevalence practices did not see the need for them in their practices, but reported they would appreciate them being in place if they were working in a high prevalence practice.

But there were opinions expressed by respondents from other practices that the greater security and safety provided by a perspex and lockdown system could come at the cost of what staff at the low prevalence practices felt was the practice 'ambience', and at the cost of what could be classified as a 'patient centred' general practice. A potential decrease in a practice being patient centered could be seen as inherent in these measures because the separation of staff from potential perpetrators of violence was also seen to entail the alienation of staff from the patients they seek to care for.

### Implications for general practice

For policymakers and for GPs (especially general practice principals) in high prevalence practices, these findings raise difficult issues. There is a clear and overriding occupational health and safety legal responsibility to protect staff from potential violence. However, there is also a duty of care to patients and, though perhaps less clear than occupational health and safety responsibilities,<sup>14</sup> there is a suggestion from this study that duty of care may be compromised by higher level security measures. Alienating receptionist staff from patients and from the care aspect of their work could have adverse effects on job satisfaction

(notwithstanding the possible net positive effects of a greater sense of security).

### Study strengths and weaknesses

As far as the authors are aware, this study is the first qualitative study of general practice receptionist experiences of violence, and their attitudes toward occupational violence. It is also the first study to examine general practice experiences of, and attitudes to, these structural measures to reduce the risk of violence.

However, the study has sampled staff from only one practice employing such measures and the experience of these staff may not be generalisable to other general practices and other health settings.

### Questions for future research

There is an acknowledged imperative to act on occupational violence in general practice.<sup>8</sup> Yet responses to violence (even when effective) may have unforeseen effects: 'understanding the factors that place persons at risk for violence is critical to development of effective interventions'.<sup>15</sup> Current organisational responses to occupational violence in general practice, while reasonable and prudent,<sup>16,17</sup> are based on relatively sparse evidence<sup>17</sup> and may not be entirely generalisable to the Australian general practice context.<sup>16</sup> Participants' subjective experiences and perceptions of occupational risk and safety in this qualitative study suggest complex implications of responses to general practice violence. Prospective quantitative studies to establish the factors involved in risk, and subsequent trials of interventions based on that understanding are urgently required.

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