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Violence in the General Practice/Family Medicine Workplace

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Introduction:
Violence in the workplace is defined as, 'any incident in which an employee is threatened or assaulted by a member of the public in circumstances arising out of the course of his/her employment[3]. In general practice/family medicine this applies both to doctors and to practice staff.
It is difficult to estimate the true incidence of violence in general practice/family medicine. Available incidence data suggest widespread variation in rates between doctors working in different areas and among different groups of patients[1]. The results of a survey conducted by the UK National Health Service in 1998 revealed 65 000 acts of violence against NHS staff each year. In UK, the Zero Tolerance Campaign started in October 1999, requiring all health service staff to be vigilant to the reality of violence[2].
The survey conducted in Leeds identified that 54% of GPs suffered verbal abuse and that 6% were victims of physical action[3]. One of the surveys done in an Australian urban area had the following results: the majority (63.7%) of GPs surveyed had been subjected to some form of violence within the previous 12 months. The most common forms of violence were verbal abuse (42.1%), property damage or theft (28.6%), threats (23.1%), and slander (17.1%). 12.9% experienced high level violence, while 49.8% experienced only low level violence[4]. A telephone survey by the BMA News Review in 1995 found that 61% of GPs had been threatened with, or suffered violence during the course of their work[3].
42% of GPs/family doctors in Denmark have been subjected to verbal or written threats, 4% to physical assault and 1.4% to serious physical violence resulting in injury.

Causes of Violence in General Practice/Family Medicine:
Structural factors:

- As violence increases in a community, violence also increases in primary care.
- The most disadvantaged and alienated citizens have ready access to general practice/family medicine.
- Problems with health insurance or access to various social benefits and with a gap between expectation and provision may turn aggression towards GPs/family doctors even though they are not responsible.
- Increasing heterogeneity of culture and ethnicity within European societies with potential for violence between different communities and with heightened perceptions of racism both founded and unfounded.
- Prolonged waiting times in general practice/family medicine may precipitate aggressive behaviours.
- The public demonisation of doctors for political or journalistic purposes will tend to exacerbate exposure to violence.

Patient factors:

- Patient anxiety is one of the most important triggers of verbal abuse
- Surveys of violence against GPs/ family doctors show that the perpetrators of violence are more likely to be young and male. Drugs and alcohol are frequently cited causes of violence. Mental illness and intoxication are major factors[3].
- Inappropriate demands by patients for different medications, particularly those associated with addiction or dependency, can precipitate aggressive behaviours.
- Companions or relatives were more often involved in violent incidents than patients themselves.

Doctor factors:

- Inner-city GPs/ family doctors are likely to have suffered more abuse[3].
- GPs/ family doctors face aggressive behaviours or have fears for their personal security more often during evening hours and on home visits, particularly if the patient is not known to the doctor.
- GPs/ family doctors may lack skills in dealing with aggressive behaviours and potentially violent situations

Effects of Violence:
The health implications of violent events can be considerable and include post traumatic stress disorder[1].The main reported effects of violence are illness and demotivation[3]. Even though it is hard to quantify the emotional distress caused by verbal violence, varied symptoms including stress, insomnia, agoraphobia and depression have been reported following such incidents at work[1].

How to Manage Violence in General Practice/Family Medicine:
The essential foundation is in ensuring universal and equitable access to high quality health care as a human right.

Violence in primary care can be minimised by addressing both the structural risk factors for violence (such as poor building design, lack of policies and/or training) and the interaction at the individual level between clinician and patient[3].Some of the precipitants of aggression are potentially avoidable and practices should make strenuous attempts to identify such factors and

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remedy them. Staff training in interpersonal skills and recognising anxious or intoxicated patients is essential and should be supplemented by consideration of surgery layout and repair[5]. Doctors should attempt to minimise delays for patients by rearranging booking policies or surgery times and lengths[5]. Patient should be kept informed of likely waits and provided with explanations for delays[1].

GPs/family doctors and practice staff should be taught how to avoid and manage potentially aggressive situations. Training should include awareness of warning signals, such as the body language that can precede an aggressive outburst. Communication skills training can help doctors to control their emotions and manipulate the situation.
The security of general practice/family medicine workplaces should be discussed in the community. Improvements could include panic alarms, dedicated security staff, and closed video systems in public areas.

Special attention needs to be paid to minimising exposure to potential violence when and where doctors are working alone or without support.

Lay and citizen representatives have a role in promoting the more widespread recognition of responsibilities as well as rights for those receiving health care and in establishing zero tolerance of violence within public services. Societies should recognise that doctors and their staff are put at risk when doctors are expected to act as agents of distributive social justice.

Action for UEMO

National medical associations are urged to develop policy in this area and to share those policies through UEMO.

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