Fear of aggression at work among general practitioners who have suffered a previous episode of aggression

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SUMMARY

Background. *Relatively few data exist on the scale of aggression from patients or patients' relatives suffered by doctors at work. Such aggression might be expected to pose considerable risks of continued morbidity among abused practitioners.*

Aim. *This study set out to survey the continued levels of intimidation experienced by general practitioners who had suffered a previous episode of aggression.*

Method. *A retrospective survey was carried out of all general practitioners in the West Midlands Health Authority region, using a piloted postal questionnaire. Of the 2694 surveyed 1093 (41%) responded. Among responding doctors, 687 (63%) had suffered some degree of aggression in the previous 12 months, and these respondents reported on the degree of intimidation experienced during specified clinical duties.*

Results. *Nearly three quarters of previously abused doctors did, at times, express ongoing fears for their safety at work. Indeed, 71% of doctors who qualified in India and Pakistan and 57% of doctors who qualified in the United Kingdom experienced some degree of intimidation within their surgery (90% and 73%, respectively, on night visits). Fear was most commonly reported during visits made out of hours with mild fear being occasionally experienced between 19.00 and 23.00 hours by 316 (56%) of the responding abused doctors and after 23.00 hours by 286 (51%). Eleven respondents (2%) were frequently severely fearful on evening visits and 15 (3%) were always fearful. On night visits frequent severe fear was reported by eight respondents (1%), while 31 were always fearful (6%). The differences between men and women doctors were relatively small within the surgery, but during out-of-hours calls women were significantly more likely to report intimidation than men practitioners and to report significantly higher levels of severity of fear.*

Conclusion. *These findings support further consideration of the contractual commitment for general practitioners to provide out-of-hours visiting, of investment in safer surgeries and of greater provision of in-service training in handling aggression and its attendant stress.*

Keywords: Violent patients; doctors' safety; doctors' attitude; out of hours; home visits; night visits.

Introduction

RECENT studies have provided some data on the scale of aggression from patients or patients' relatives directed at general practitioners at work.[1-3] Aggression which leads to actual physical injury is fortunately uncommon, although such injury did occur for nearly 4% of the 1093 general practitioners responding to a survey on aggresion in the West Midlands during a 12-month period.[4] However, the fear of attack may itself be a cause of considerable morbidity[5] and there is evidence that threat of violence is a common source of worry for practitioners.[3,5-7] Despite the scale of this problem, there are few published data on the degree, or frequency, of fear about aggression that is experienced by doctors during the course of their professional duties. General concerns about violence against general practitioners have, however, prompted the Secretary of State for Health to establish a working party to examine the problem (Department of Health, press release, 1993).

The aim of this study was to identify a cohort of general practitioners who had suffered previous intimidation from patients or patients' relatives and then to determine their continued levels of intimidation at work. This study was conducted as part of a major survey on aggression towards general practitioners in the West Midlands.

Method

A piloted structured questionnaire was posted to all 2694 unrestricted principals in the West Midlands Health Authority region in 1989. Full details of the method used have been described previously,[2] but briefly the questionnaire comprised several sections: the doctor's experiences of aggression at work, with further details on incidents during the previous 12 months; changes made to practice as a consequence of aggression; and continued levels of intimidation. The definition of an aggressive incident was any episode at work involving verbal or physical abuse or injury (five categories from verbal abuse to major injury[1]) which produced fear in the doctor. The final section of the questionnaire was directed only at the subgroup of doctors who had suffered aggression in the previous 12 months. Questions in this section[2] explored these abused doctors' degrees of intimidation over aggression, or the threat of it, in a variety of consulting situations (when consulting in the surgery; on call at home; during daytime home visits; evening visits, 19.00 to 23.00 hours; and night visits, 23.00 to 07.00 hours). Doctors were requested to provide a single response on a seven-point scale of intimidation, denoting whether they felt intimidated and if so at what level, during each of these clinical activities. The scale ranged from never fearful (scoring one) through very occasional/occasional mild fear, occasional severe fear, frequent mild fear, frequent severe fear, to always fearful (scoring seven).

Comparisons were made between practitioners with regard to their sex, age, country of qualification and size of partnership; it did not prove possible to separate the doctors into comparison groups according to the likely social deprivation of their patients. The results from the questionnaire were initially analysed using the *SPSS-PC* programme[8] and subsequent multivariate tests calculated on the *BMDP* package.[9] Methods of analysis used were multidimensional frequency tables using log linear models and analysis of variance and covariance of quantitative responses.

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The variables of levels of intimidation (scores of one to seven) in the different consulting situations were considered. The association between these variables and age, place of qualification and sex of the general practitioner and size of the practice were tested.

Results

Of the 2694 general practitioners surveyed 1093 returned full questionnaires (40.6%). The denominator population comprised the 687 doctors identified from the 1093 practitioners as having suffered abuse in the previous 12 months (62.9%). Of these 687 practitioners, 611 (88.9%) completed at least some of the questions on their levels of intimidation at work.

Levels of intimidation

When consulting in the surgery 357 doctors (58.4%) experienced fear at times, although for 304 of them, this was only occasional mild fear (Table 1). The activities associated with most intimidation were evening and night calls: fear at times was reported by 409 (72.4%) and 419 (74.2%) respondents, respectively. Least intimidation was reported when on call at home and on visits during the day: fear at times was reported by 217 (42.8%) and 232 (45.3%) doctors, respectively.

The majority of intimidation was reported as very occasional/occasional mild fear (Table 1). However, some degree of frequent or permanent fear was experienced by 17 doctors (2.8%) when consulting in the surgery, by 13 (2.6%) when on call at home, six (1.2%) on day visits, 43 (7.6%) on evening visits and 62 (11.0%) on night calls. Feelings of severe intimidation were experienced on at least some occasions by 76 (13.5%) doctors on evening calls and 110 (19.5%) on night visits.

Consulting in surgery

Two way frequency tables showed associations between doctors reporting fear when consulting in the surgery and place of qualification ($P<0.001$), size of practice ($P<0.001$) and age ($P<0.001$) — there was also an association between place of qualification and size of practice ($P<0.05$). After allowing for these inter-correlations, an association persisted between doctors recording intimidation in the surgery and place of qualification ($P<0.05$) and size of practice ($P<0.05$) but not with age (Table 2). These findings were confirmed by analyses of variance which showed that those whose place of qualification was India or Pakistan reported a higher mean level of intimidation ($P<0.05$) when consulting in surgery than those qualified in the United Kingdom and that those in single handed practice reported a higher level of intimidation than those in larger practices (Table 3). After log transforming the data, analysis of variance showed that women doctors had a mean score approximately 0.2 units higher than men ($P<0.05$); the same comparison was not quite significant on the untransformed data.

On call at home

Two way frequency tables showed an association between doc-

Table 1. Reported levels of intimidation in different consulting situations.

	% of respondents				
Level of intimidation	Consulting in surgery (n = 611)	On call at home (n = 507)	Visits during day (n = 512)	Visits 19.00 to 23.00 hours (n = 565)	Visits 23.00 to 07.00 hours (n = 565)
Never fearful	41.6	57.2	54.7	27.6	25.8
Very occasional/occasional mild fear	49.8	35.9	41.4	55.9	50.6
Occasional severe fear	5.9	4.3	2.7	8.8	12.6
Frequent mild fear	1.5	1.2	0.4	3.0	4.1
Frequent severe fear	0.7	0.6	0.4	1.9	1.4
Always fearful	0.7	0.8	0.4	2.7	5.5

n = total number of respondents.

Table 2. Reported levels of intimidation when consulting in the surgery, by doctor and practice characteristics.

	% of GPs reporting level of intimidation					
Characteristic	Never fearful	Very occasional/ occasional mild fear	Occasional severe fear	Frequent mild fear	Frequent severe fear	Always fearful
GPs' place of qualification						
UK (n = 530)	42.8	51.3	4.3	0.9	0.2	0.4
USA, rest of Europe (n = 14)	42.9	42.9	0	0	7.1	7.1
India/Pakistan (n = 49)	28.6	40.8	22.4	4.1	2.0	2.0
GPs' age (years)						
≤35 (n = 163)	37.4	56.4	5.5	0.6	0	0
36–45 (n = 220)	35.0	56.8	5.0	1.4	0.5	1.4
46+ (n = 224)	50.9	38.4	6.7	2.2	1.3	0.4
No. of principals in practice						
1 (n = 64)	29.7	48.4	10.9	6.3	3.1	1.6
2–4 (n = 312)	42.6	48.7	6.4	1.3	0.6	0.3
5–12 (n = 231)	43.7	51.9	3.5	0.4	0	0.4

n = total number of respondents in group.

Table 3. Mean scores for intimidation, by doctor and practice characteristics.

Characteristic	Mean score[a] (standard deviation) [no. of respondents]				
	Consulting in surgery	On call at home	Visits during day	Visits 19.00 to 23.00 hours	Visits 23.00 to to 07.00 hours
GPs' place of qualification					
UK	1.8 (0.9) [530]	1.6 (0.1) [449]	1.6 (0.8) [456]	2.2 (1.2) [491]	2.4 (1.4) [490]
USA, rest of Europe	2.6 (1.5) [14]	1.2 (0.4) [9]	1.4 (0.5) [10]	2.7 (2.9) [15]	2.0 (1.7) [11]
India/Pakistan	2.3 (1.9) [49]	2.6 (1.8) [35]	2.3 (1.4) [34]	3.4 (2.0) [43]	3.9 (2.2) [48]
GPs' age (years)					
≤35	1.8 (0.8) [163]	1.7 (1.0) [144]	1.6 (0.7) [149]	2.2 (1.1) [159]	2.4 (1.2) [157]
36–45	1.9 (1.1) [220]	1.8 (1.1) [185]	1.6 (0.9) [182]	2.4 (1.4) [210]	2.7 (1.6) [211]
46–64	1.9 (1.2) [215]	1.6 (1.1) [167]	1.6 (1.0) [172]	2.3 (1.5) [186]	2.6 (1.8) [188]
65+	1.3 (0.5) [9]	1.6 (1.1) [7]	1.2 (0.4) [5]	1.5 (0.5) [6]	1.6 (0.5) [5]
No. of principals in practice					
1	2.4 (1.5) [64]	2.1 (1.5) [39]	2.0 (1.4) [39]	3.2 (2.0) [49]	3.8 (2.3) [48]
2–4	1.8 (1.0) [312]	1.6 (0.9) [266]	1.6 (0.8) [270]	2.3 (1.4) [297]	2.5 (1.6) [295]
5–12	1.7 (0.8) [231]	1.7 (1.0) [199]	1.6 (0.7) [201]	2.1 (1.1) [215]	2.3 (1.2) [218]
GPs' sex					
Male	1.8 (1.1) [505]	1.7 (1.0) [418]	1.6 (0.8) [417]	2.2 (1.3) [466]	2.4 (1.5) [472]
Female	2.0 (1.0) [104]	1.9 (1.1) [88]	1.8 (1.0) [93]	2.7 (1.5) [99]	3.3 (1.9) [92]
All respondents	1.9 (1.0) [609]	1.7 (1.1) [506]	1.6 (0.9) [510]	2.3 (1.4) [568]	2.5 (1.6) [564]

[a]1 = never fearful, 2 = very occasional mild fear, 3 = occasional mild fear, 4 = occasional severe fear, 5 = frequent mild fear, 6 = frequent severe fear, 7 = always fearful.

tors reporting fear when on call at home and place of qualification ($P<0.05$) only. This was confirmed by analysis of variance with those qualified in India or Pakistan having a higher mean score than those who qualified in the UK ($P<0.001$) (Table 3). Analysis of variance after log transforming the data resulted in the sex of the general practitioner becoming a significant factor ($P<0.05$) with women having a mean score approximately 0.2 higher than men.

Daytime visits

Two way frequency tables showed an association between doctors reporting fear when making daytime visits and age ($P<0.05$) only. Analysis of variance, which makes use of the additional information of the numerical values of the categories of fears on daytime visits, suggested that place of qualification was the more relevant variable. There was a very strong association between age and place of qualification ($P<0.001$). Again it was the group who qualified in India or Pakistan who showed the higher level of intimidation on visits ($P<0.05$) (Table 3).

Evening visits

Two way frequency tables showed associations between doctors reporting fear when making evening visits and place of qualification ($P<0.001$), size of practice ($P<0.001$), age ($P<0.001$) and sex ($P<0.001$). Allowing for the inter-correlations between these variables, a strong association remained with sex ($P<0.001$) and less strong with size of practice ($P<0.01$) and place of qualification ($P<0.05$) (Table 4). The analysis of variance confirmed that women doctors had a significantly higher mean score for intimidation on evening visits than men (difference approximately 0.6 units) ($P<0.001$) (Table 3). The level of fear reduced with the number of partners. Those who qualified in India or Pakistan showed the highest level of intimidation (mean score approximately 0.9 units more than that of those qualifying in the UK), but those qualifying in the United States of America and the rest of Europe also showed a higher level (mean score approximately 0.5 units more than those qualifying in the UK).

Night visits

Two way frequency tables showed associations between doctors reporting fear when making night visits and place of qualification ($P<0.001$), age ($P<0.001$) and sex ($P<0.001$) and to a lesser extent the size of the practice ($P<0.01$). Allowing for inter-correlations left sex still strongly associated with fear on night visits ($P<0.001$) and to a lesser degree place of qualification ($P<0.01$) and age ($P<0.05$); size of practice was no longer associated (Table 5). The mean score for women general practitioners from the analysis of variance was approximately 1.4 units higher than that for men doctors. Those qualifying in India or Pakistan had a mean score approximately 1.1 units higher than those qualifying in the UK and those aged 36 years and over had mean scores approximately 1.0 units higher than those aged 35 years or less (Table 3). However, there was also an interesting interaction effect of sex and size of practice with women in practices with just one partner showing a mean score approximately 2.7 units higher than women from practices with two or more partners (5.8 units versus 3.1).

Discussion

Although the total 1093 respondents represented only 41% of those approached, the age, sex, number of partners and practice locations of the respondents did not differ from those expected in the total sample.[2] There was, however, a significant under-reporting from doctors qualifying outside the UK.[2] The low overall response rate to the total questionnaire could have undermined the representativeness of the sample of abused doctors who responded to the additional question on continued fears. However, the data presented here on levels of intimidation among abused doctors are not likely to be particularly confounded since this group of doctors would always represent a select sample. It is conceivable, though, that the aggrieved doctors who responded did so because they were more traumatized by the experience than non-responding abused doctors. Producing a scale and order to the numerical scores attached to the descrip-

Table 4. Reported levels of intimidation when making evening visits (19.00 to 23.00 hours), by doctor and practice characteristics.

Characteristic	% of GPs reporting level of intimidation					
	Never fearful	Very occasional/ occasional mild fear	Occasional severe fear	Frequent mild fear	Frequent severe fear	Always fearful
GPs' place of qualification						
UK (n = 491)	29.1	56.6	9.0	2.6	1.2	1.4
USA, rest of Europe (n = 15)	33.3	40.0	6.7	0	6.7	13.3
India/Pakistan (n = 43)	11.6	51.2	11.6	2.3	9.3	14.0
GPs' age (years)						
⩽35 (n = 159)	21.4	66.7	6.9	3.1	0.6	1.3
36–45 (n = 210)	21.9	60.0	10.0	1.4	2.9	3.8
46+ (n = 192)	38.5	42.7	9.4	4.7	2.1	2.6
No. of principals in practice						
1 (n = 49)	22.4	42.9	10.2	6.1	6.1	12.2
2–4 (n = 297)	27.9	56.2	8.4	2.7	2.0	2.7
5–12 (n = 215)	28.4	58.6	9.3	2.8	0.9	0
GPs' sex						
Male (n = 466)	31.8	53.0	8.4	3.0	1.7	2.1
Female (n = 99)	8.1	69.7	11.1	3.0	3.0	5.1

n = total number of respondents in group.

Table 5. Reported levels of intimidation when making night visits (23.00 to 07.00 hours), by doctor and practice characteristics.

Characteristic	% of GPs reporting level of intimidation					
	Never fearful	Very occasional/ occasional mild fear	Occasional severe fear	Frequent mild fear	Frequent severe fear	Always fearful
GPs' place of qualification						
UK (n = 490)	27.3	51.2	13.7	3.5	0.8	3.5
USA, rest of Europe (n = 11)	45.5	45.5	0	0	0	9.1
India/Pakistan (n = 48)	10.4	43.7	6.2	8.3	6.2	25.0
GPs' age (years)						
⩽35 (n = 157)	22.3	58.0	14.6	3.8	0	1.3
36–45 (n = 211)	20.4	55.5	12.8	3.3	1.4	6.6
46+ (n = 193)	34.7	38.9	10.9	5.2	2.6	7.8
No. of principals in practice						
1 (n = 48)	20.8	31.2	10.4	6.2	6.3	25.0
2–4 (n = 295)	27.5	49.8	11.9	4.4	1.0	5.4
5–12 (n = 218)	25.2	55.5	14.2	3.2	0.9	0.9
GPs' sex						
Male (n = 472)	29.2	49.8	11.9	4.0	1.5	3.6
Female (n = 92)	8.7	54.3	16.3	4.3	1.1	15.2

n = total number of respondents in group.

tions of severity of intimidation was a necessary step to inform prediction of those variables with significant association. Inevitably, in purely qualitative terms, it is more difficult to judge the relative personal impact of these different levels of fear on each practitioner's well being.

Fear of aggression was a major concern for these general practitioners who had previously suffered aggression. Some level of continued intimidation was experienced, at times, by over three quarters of them, although the incidence of aggression was only 2.4 events per practitioner per year, and 91.3% of these incidents involved verbal abuse or threats with no physical act.[2] For 20% of the doctors this fear was, at least sometimes, severe and for 11% was frequently or always experienced during certain practice activities. There are likely to be detrimental consequences for the health of the 7% of general practitioners frequently or always fearful on night visits. This extreme level of intimidation was also suffered by 5% of doctors when on evening visits and 1% in surgery consultations.

Doctors aged 46 years and over were more likely than younger doctors to state that they never felt fearful, and this was especially true when consulting in the surgery. Indeed, of the nine doctors aged 65 years and over, none reported any feelings beyond occasional mild intimidation. This might indicate that older general practitioners develop better coping mechanisms or feel more able to avoid aggression in the first place. Women doctors had only a marginally significant difference from men in rate of fear during surgery consultations but for evening and night calls, women practitioners expressed both a greater frequency and higher degree of intimidation than men. Only 8% of women general practitioners stated they never felt fearful on evening visits

compared with 32% of men (corresponding figures for night visits were 9% and 29%), and 15% admitted being always fearful on night visits (compared with 4% of men).

The doctors who expressed most fears were those who had qualified outside the UK. In every consulting situation, they were significantly more likely to feel intimidated than doctors who had qualified in the UK. Indeed, 71% of doctors qualifying in India or Pakistan expressed some degree of fear even when consulting within the surgery. There is anecdotal evidence to suggest that some Asian practitioners fear racially motivated abuse[10] and this may be the prevailing factor influencing these findings.

Out-of-hours visits may represent only 4% of consultations in general practice,[11] but 74% of doctors in this sample who had suffered abuse expressed fears over aggression on night calls. This intimidation is likely to be one of the major factors prompting general practitioners to argue against their continued provision of 24-hour cover to their patients.[12,13] The issue was raised in a General Medical Services Committee discussion document,[14] and resulted in an overwhelming vote, at the 1992 Conference of Local Medical Committee Representatives, in favour of negotiating to remove the 24-hour cover requirement on general practitioners. Alternative strategies might, for example, involve a night visit service organized by the family health services authority with escorts for doctors, with out-of-hours medical services becoming a responsibility of the family health services authority rather than the doctor. In the light of these findings, it seems unreasonable to disadvantage doctors financially for using deputizing services. Such out-of-hours arrangements are inherently safer for the visiting doctor since deputies will usually be accompanied by a driver or route finder and the driver is in open radio communication with a central telephone exchange.

The high prevalence of intimidation during routine surgery consultations, however, also indicates that greater attention to surgery design is needed. Evidence exists that it is possible to reduce aggression in public premises through careful design,[15] and it is therefore incumbent on commissioning agencies to attempt to reduce intimidation of doctors at work by adequately resourcing building improvements designed to reduce the risk of abusive incidents. Methods could include enhanced or even 100% improvement grants for suitable safety features in surgeries. Another major priority for all authorities is the adequate provision of training programmes in the early recognition and subsequent handling of aggression, and sufficient post-event counselling services for victims. Such training has long been available to other groups in the public service, such as social workers[16] and teachers.[17]

In summary, this study has demonstrated frequent and high levels of intimidation reported by previously abused general practitioners, especially during out-of-hours calls. The degree of consequential morbidity is likely to be considerable and represents a major occupational hazard. The introduction of the new general practitioner contract has been associated with increased stress levels among general practitioners[18] and it is worth noting that this survey took place before the introduction of this contract.

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