

Managing violence in primary care: an evidence-based approach

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SUMMARY

An understanding of the risk factors for violence can help primary care staff to evaluate and manage risk in the primary care setting. They will be able to acknowledge that risk factors are not static but can vary according to time, place, situation, and support networks. General practitioners (GPs) should not ignore their clinical acumen, but should use their knowledge of the patient to form part of a risk assessment. Managing violence in primary care should focus on the individual; for example, in the training of primary care staff. It should also involve an examination of the wider structure of primary care; for example, the safe design of buildings, avoiding long waiting times, and having 'no intoxication' policies for practices. There is a pressing need for primary care-based research in this area.

We acknowledge that in our understanding of this topic there are two extremes that should be avoided. The first is that our perceived risk of violence often exceeds the real, absolute risk. Where our perceptions are overstated, patients run the risk of being excluded from primary care or of being inappropriately detained on psychiatric wards under the Mental Health Act. At the other extreme, where risk is understated, staff can play the 'hero' or the 'martyr' in an attempt to defuse a situation without support from other colleagues. Like many other situations in primary care, working in isolation carries real and important risks. Threats of violence are best managed in primary care by having a collaborative practice approach underpinned by a support ethos from primary care organisations.

Keywords: *violence; primary care staff; staff attitudes; risk management; evidence-based medicine.*

Introduction

ALTHOUGH violence or threats of violence are common in primary care, many general practitioners (GPs) pay little attention until they or their staff are assaulted.^{1,2} Indeed, reports in the United Kingdom (UK) identify the workplace as a setting for 1.2 million violent incidents a year,³ and primary care is no exception.^{4,5} This was recognised by the government's publication, *Zero Tolerance* in 2000.⁶ Seven violent incidents are reported every month for every thousand staff in the National Health Service (NHS).⁶ One in seven of these are physical assaults or injuries caused by patients or their relatives. Many attacks are directed towards nurses,⁷ emergency medicine staff, ambulance staff, and carers of psychiatric patients. Nevertheless, GPs and their staff are not exempt from such experiences,⁶ although less research has been conducted in this area.²

An aggressive act is any deliberate attempt to inflict physical or psychological harm, and it includes both verbal and physical abuse.⁸ 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.'⁹ As employers, GPs have a responsibility for the health and safety of their staff. Many people may be responsible for the daily running of the surgery. As the intermediaries between GPs and patients, receptionists are an intrinsic part of the doctor-receptionist-patient triad.¹⁰ However, the job can be difficult if reception staff find themselves involved with a tension of conflicts between the GP and a demanding patient.¹¹ In the NHS there have been recent developments and recommendations regarding primary care provision for patients who pose a risk of violence. In the year 2000 the NHS Executive launched its 'Zero Tolerance' campaign, followed by recommendations to primary care organisations regarding the setting up of specialised centres for violent patients.¹² A recent circular from the Chief Executive of the NHS showed that large numbers of Primary Care Trusts had still not made arrangements for the provision of such centres.¹³

This discussion examines the causes of violence in the primary care setting, draws on the evidence base from other disciplines, and offers practical advice and support to primary care staff regarding the assessment, estimation, and management of the risk of violence.

Prevalence of violence in primary care

A systematic review of the prevalence and management of violence in the primary care setting was conducted. The electronic databases MEDLINE, PREMEDLINE, EBM Reviews, the Cochrane Database of Systematic Reviews, CINAHL, EMBASE, PsycINFO, and HealthSTAR were searched from the earliest dates available up to 2002 to

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identify published literature on the topic. The detailed search strategy used for MEDLINE is shown in Box 1.

Relevant journal articles were selected and their appropriateness was independently verified by a second researcher. The reference lists of the selected papers were also searched for any other appropriate articles. The *British Medical Journal* and the *British Journal of General Practice* were hand searched for the years 2000 to 2002. Finally, appropriate websites were identified through the World Wide Web search engine Google using the keywords 'workplace' and 'violence.' The key themes emerging from the literature were identified, including any literature relating to secondary care and its relevance to primary care.

Surveys in general practice

There appears to be a paucity of research into violence in the primary care workplace. Most surveys in primary care relate to incidents involving GPs; however, little work focuses on violence and threats of violence towards general practice receptionists. Receptionists are arguably more at risk of verbal abuse and threats of violence than GPs. Hobbs' survey of violence against GPs found that 63% of GPs in Birmingham had suffered abuse or violence in the previous year. While 3% of them suffered minor injuries, 0.5% suffered a serious injury.¹⁴ Risk varied according to where the doctor worked.¹⁵ Inner-city GPs and staff were more vulnerable, with 54% of them being involved in a major episode of violence in the previous few years. 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.¹⁶ The latest and most recent survey was conducted in Leeds, which identified that 54% of GPs suffered verbal abuse and that 6% were victims of physical action.¹⁷ This result indicated just one doctor (0.3%) suffering physical injury, which was much lower than Hobbs' annual rate of physical injury of 3.8%. Once again, doctors working in practices in areas of high deprivation (assessed by Jarman indices) were subject to more abuse.¹⁷ Although threats of violence are common, it is reassuring that acts of violence against health staff are rare. However, we should not underplay the effects that persistent threats can have on morale and job satisfaction.

Violence in nursing

The risk of workplace violence varies considerably according to occupation. Nurses are among the highest risk categories, with 7.9% of them experiencing assaults annually; four times the national average, coming second only to police officers.¹⁸ Most of these figures are for hospital nursing staff. A survey of nurses in a London hospital found that 59% had suffered verbal abuse in the past year and that a worrying 20% had experienced physical violence in the same period. However, the prevalence of violence and aggression against nursing staff within primary care is under-researched and unknown. This raises important questions for primary care; for example, is the incidence of violence towards primary care nursing staff lower than that for hospital staff, or is it that violence in primary care is under-reported? If the incidence is lower, is this because the structure of primary care is such that nursing staff and patients

1. Violence
2. Aggression
3. Dangerous behaviour
4. Impulsive behaviour
5. Anger
6. Physical abuse
7. Verbal abuse
8. Abuse
9. Assault
10. Physical assault
11. Verbal assault
12. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11
13. Family practice
14. General practice
15. Family medicine
16. Primary health care
17. 13 or 14 or 15 or 16
18. 12 and 17
19. Physicians, family
20. Physicians
21. Physician-patient relations
22. Physicians role
23. Medical staff
24. Medical receptionists
25. Medical secretaries
26. 19 or 20 or 21 or 22 or 23 or 24 or 25
27. 18 and 26

Box 1. MEDLINE search strategy.

can build therapeutic relationships over time? If the incidence of violent acts is lower in primary care, is the incidence of threats of violence or intimidating behaviour also lower? Despite this, however, many staff may feel that as expectations of patients and governments increase, violence and abuse may escalate as patients see them as legitimate targets for their aggression.

Causes of violence in primary care

All studies involving violence against GPs identify that perpetrators of violence are more likely to be male, with a mean age of 36 years, and a frequent consultation rate.¹⁹ The incidents are often linked to disinhibition caused by taking alcohol or drugs, long waiting times, or mental illness.^{14,17,19-21} Most incidents occurred in the surgery, although GPs had a greater fear during night visits.^{15,20,22} Given that most incidents were surgery based, it is important to identify how other practice staff are affected. Inner-city GPs were likely to have suffered more abuse,²⁰ and this may also apply to other primary care staff. Under-reporting of incidents was well documented,^{2,19,23,24} therefore results vary. Individual members of staff may respond differently to abuse, and although, as professionals, most staff would not respond by inciting further aggression, the perpetrator may react to a member of staff, escalating the situation.

Secondary care — what can we learn?

Many disciplines outside of primary care have studied aspects of violent behaviour. In particular, the fields of forensic psychiatry, criminology, and social work provide a wealth of research into the causes and management of patients with a propensity for violence. Such research is relevant to the primary care setting, especially the concept risk. Prins²⁵ endorses and expands upon the definitions described by

the Royal Society,²⁶ and defines risk as 'the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge'. Understanding the notion of hazards and risk is crucial when assessing, estimating, and evaluating risk in particular primary care situations. Monahan and Steadman (1994) have developed a similar discussion, and argue that in assessing risk, the degree of harm and the probability of that harm occurring need to be considered. They suggest that an assessment of risk should be separated into three distinct parts: initially identifying the 'risk factors' used to predict violence, identifying the type of violence and likely harm anticipated, and then thirdly assessing the probability that the violent act will actually occur.²⁷

The literature is conflicting regarding causes of violence. This is partly because some studies rely on self-reporting or use cross-sectional methodologies. While associations are described, longitudinal studies are required to demonstrate causality. A number of associations have been identified as indicators of violence.²⁸⁻³¹ Age and sex are important factors, as young males are more likely to commit violent acts. Situations in which harmful behaviour has occurred also increase the risk of future similar events. The type of social interaction likely between offender and potential victim is also important when assessing the indicators of violence. Indeed, a previous history of abuse of healthcare workers may increase the risk of similar behaviour when in similar circumstances. For example, a patient who is verbally abusive when waiting a long time to see a doctor may only pose an increased risk under the same conditions. The presence or absence of internal inhibitors and of pro- or anti-social values, such as those described in people who have a 'personality disorder', can also impact on the likelihood of violence. A history of mental illness, the availability of and preparedness to use a weapon, and the use of illicit drugs or alcohol leading to disinhibition (although not drug use or alcohol use *per se*) have also been associated with violent situations.

Such work is exceptionally relevant to staff working in primary care, and will help in assessing risk in a given situation. In particular, past behaviour, and the circumstances in which it occurred, is a helpful predictor of future behaviour. The risk of violence in the same individual can be variable and dependent upon other factors. This is helpful when seeking to manage situations that could escalate into violence. If triggers are identified and removed, then it is unlikely that violence will occur.³²

Historically, forensic psychiatry has devised tools that would have a high degree of sensitivity and specificity in predicting the risk of violence in populations, although typically such tools have poor predictive value for an individual patient.³³ Nevertheless, clinicians do have a greater probability of correctly predicting future violence than chance alone.^{27,34} Monahan explores this topic and highlights the lack of reliability in confidently predicting risk in an individual by identifying that out of every three mentally disordered persons predicted to be violent by psychiatrists or psychologists, only one will be found to commit a violent act. In addition, it is stated that the best predictors of violence among mentally disordered people are the same demo-

graphic factors that are the best predictors of violence among non-disordered offenders. These include age, sex, social class, and a history of prior violence. On the other hand, the poorest predictors of violence among the mentally disordered are psychological factors such as diagnosis, severity of disorder, or personality traits.³⁵ Monahan and Steadman argue that risk factors for violence are not discrete variables but are points on a continuum.²⁷ Rather than an assessment giving a concrete answer to these factors, they acknowledge that harm and the extent of probability can vary over time and also be dependent upon a number of factors. They argue that, owing to the large number of variables involved in assessing risk, the assessment should not be reliant solely upon actual knowledge of the patient. It should also take account of 'clinical cues' associated with violent behaviour. In other words, we should use our current knowledge regarding risk of violence to inform our clinical acumen in the consulting room, rather than ignoring our clinical knowledge and understanding of our patients.

Effects of violence

The effects of violence in clinical staff have been reported,¹⁸ and include illness and demotivation. Alongside this, long-term sick leave is also probable in staff who have suffered verbal or physical abuse, especially if they feel demoralised and are to be faced with the same environment when returning to work.³⁶ In some cases, therefore, it is not surprising that the experience of abuse, especially if severe or repeated, can lead to staff resignations. This will lead to ongoing recruitment and retention problems within the practice or organisation.

Managing violence in primary care

Violence in the primary care setting is managed 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. Strategies aimed at improving the structure of primary care so that it can manage threats of violence in an effective manner have also been suggested.

Specialised primary care centres for patients with a history of violence

The introduction of 'zero tolerance'⁶ set standards, but practical measures have also been suggested by other parties. In the past, such approaches included removing patients from the registration list. While there may be some benefit in making it clear to patients that such behaviour is unacceptable, it does not address the problem completely. More recent ideas include seeing violent patients at certain times in a specified place by GPs recruited by the health authority.³⁷ Such services are paid for directly as a retainer fee and a capitation fee per patient, and have been included in the enhanced services of the new Contract.³⁸ General practitioners are protected by a security guard at all times and have a maximum number of violent patients. Emergency or out-of-hours care is only undertaken in the presence of security guards.³⁷ Despite this being a success in some areas of the UK, new reports show that only seven out of 41 health

authorities have set up such safe havens,³⁹ which would reduce the exposure of GPs and other primary care staff to violence by removing people who are likely to be abusive based on past history. Taking such patients away from the general practice setting does seem to have the desired effect in pilot schemes. The new Contract has established that GPs providing such 'enhanced' services could benefit by receiving additional payments. However, pricing such a Contract has not as yet been completed,³⁸ and it remains to be seen whether such centres will be cost-effective. Certainly, if a centre is reserved for those patients who have been removed from primary care surgeries because they have carried a weapon, the numbers will not be large.

It will be interesting to see if removing such patients from mainstream primary care and seeing them in 'specialised' centres will be backed by primary care and health services managers. For example, there have been ethical arguments regarding 'specialised' primary care centres for homeless people.⁴⁰ Critics argue that such centres risk 'ghettoising' the provision of health care to an already socially excluded group. However, without such centres the individuals who use them would be denied access to primary health care. Such specialised centres are useful, as the patient often presents in crisis or with a multitude of unresolved health and social needs. However, once their situation has stabilised, the patient should be encouraged to use mainstream primary care. This could also work with abusive or violent patients. The evidence suggests that individuals with a propensity for violent acts are not violent all the time and in all situations. Therefore, the patient could be seen in a specialised primary care violence centre at times of high risk and then encouraged to register with a mainstream general practice once their risk had reduced. However, it is not possible to be prescriptive about how long a patient would be seen in a specialised centre, as it would have to depend on each individual scenario. Such a model would balance the health needs of the patient with the need to manage any risk to primary care staff.

Structure of buildings

The design structure of primary care buildings plays an important part in minimising the occurrence and adverse effects of violent activity. Recently, the need for modernisation of primary care buildings has been the subject of political focus.⁴¹ The design of primary care buildings is a specialised area within the architectural profession.⁴² Francis has described core characteristics of primary care building design that maximise a safe working environment.⁴³ Such features will acknowledge and address the sometimes conflicting requirements of ease of access, confidentiality, and safety. They include: ensuring that all of the waiting area can be observed from reception; avoiding the use of barriers, grilles and glass screens in reception by having a high desk that patients would not be able to jump over, yet not so wide that staff could not easily hear patients; and a means of escape from the reception desk that would not entail the receptionists going through the waiting area or into the area of conflict. Where this is not possible, other features include having reception shutters with a shatter-proof glass screen so that the waiting area can be observed when the shutters

are closed, having a curved reception desk that links an entrance lobby to the waiting room, and keeping patient areas on the ground floor. The threat to personal safety in the consulting room can be minimised by inserting panic alarms and ensuring that the patient is not seated between the clinician and the means of exit.

Management and training in primary care

Despite the primary care receptionist acting as the intermediary between the conflicting demands of the patient and the GP, anecdotally they receive little training in dealing with abusive patients or resolving conflict. Patient impatience and annoyance may often be directed at primary care receptionist staff, rather than at a GP, and this can lead to receptionists feeling unappreciated, both by the GP and the public.^{44,45} While they may be regarded as 'dragons behind the desk',¹⁰ this does not justify abuse, whether physical or verbal.

Wright has described the consultation skills needed to minimise the risk of verbal abuse precipitating into an act of physical violence in primary care.³² Such an approach focuses on 'de-escalation', whereby competition and confrontation is avoided; instead, a stepwise approach is taken, as identified in Box 2. If the above procedure is unsuccessful and the patient is still threatening, the panic button may be pressed. There should be a clear practice policy regarding team action in the event of a panic alarm sounding, so that every team member is aware of how to behave to ensure the safety of the team member under threat. It is important to avoid confronting the patient in a public place, and in some situations it may be necessary to call the police. It is important to take control of the situation rather than the person, as there is no place for restraining a patient in primary care unless done safely and appropriately by the police. After the event, the member of staff who was subject to aggression should debrief with another team member. If they remain emotionally or psychologically distressed by the incident, however, they could be offered access to a professionally-trained counsellor to vent their immediate feelings. While this could be considered good occupational health practice, the evidence on the benefit of counsellors for preventing long-term psychiatric illness in this setting has not been evaluated, and further research is needed. A Cochrane review of psychological debriefing for post traumatic stress disorder (PTSD) highlighted conflicting findings of previous studies and had limited generalisability to the situation of violence in the primary care workplace.⁴⁶ For a doctor anticipating conflict in advance of the consultation, it may be necessary to consult with another team member present for extra support. Each critical incident should be recorded in a log book, and there should be a review of practice organisation to assess whether the structure of the practice needs to change. These recommendations for managing violence in the primary care practice setting have been summarised in Box 3.

It is also important to consult with other organisations working with the same patient on a 'need-to-know' basis, such that episodes of threatening behaviour can be shared, and staff and the public protected. Alongside this, however, it must be remembered that risk factors for violence can be dynamic as well as static and that they can change over

- Patient vents feelings.
- Professional acknowledges the problem.
- Professional empathises with the situation to help defuse tension.
- Clinician explains why a particular demand cannot be met.
- Clinician negotiates to reach a compromise.

Box 2. Stages involved in de-escalation.

Do

- Provide panic alarms in all rooms where there could be patient contact.
- Use a critical incident book/database to record all threats or episodes of violence.
- Provide de-escalation training to all staff.
- Ensure that all of the waiting area can be seen from the reception desk.
- Provide a means of escape that does not involve crossing the path of the patient.
- Consult with another team member if conflict is anticipated.
- Call the police if an abusive situation seems likely to become violent.
- Reflect on one's own behaviour after each critical incident.
- Remove a patient from the list only as a last resort.
- Encourage all team members to 'own' the potential problem of violence.

Do not

- Use grilles, barriers, or glass screens inappropriately.
- Leave it to someone else to attend to the problem.
- Use physical force to restrain.
- Always see yourself as 'right' and the other party as 'wrong'.

Box 3. Recommendations for managing violence in the primary care practice setting.

time. A patient who has been banned from the surgery in the past could be re-registered if a repeat assessment shows either a change in the risk factors or a clear modification in their behaviour.³² This approach is an overview of the core concepts needed to resolve a threat of violence in the primary care setting. Other resources are available on the Internet.^{47,48}

Further research

There is a clear need for further research into the occurrence of violence in the primary care setting. Initially, we suggest that all general practices should have panic alarms and that they should record all threats or actual episodes of violence in a critical incident book. In this way, robust descriptive data should be available to Primary Care Trusts, and they would highlight the prevalence of violence in primary care. An additional priority area includes assessing the attitudes, beliefs, and expectations of the perpetrators of violence in a primary care setting. This will lead to a better understanding of the triggers of violence in primary care and how they can be ameliorated. This will necessitate consulting with the patient in a 'safe haven'. Such research would naturally lend itself to qualitative research techniques. Ascertaining the level of violence experienced by other primary care staff, particularly receptionists, who are often the first point of contact in a violent situation, is an essential area in which further research should be conducted. Finally, an evaluation of the health economics of the new 'safe havens' would provide valuable information regarding clinical cost-effectiveness.

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