PRACTICE OBSERVED

Thinking About the Unthinkable

Assault on a GP

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We received a paper from Dr Cembrowicz describing an attack on him in his surgery in an inner city area. He was unable to practise for two weeks because of injuries, and in the event had to apply to the Criminal Injuries Compensation Board for compensation. We asked someone from a medical defence society, someone from an insurance company, a general practitioner, and a lawyer to comment on Dr Cembrowicz's case.

The assault

I heard a commotion through my door. Outside I found my senior partner being furiously accosted by a young man wearing an anorak with the hood drawn up. He appeared wildly angry and was accusing my partner of sending him electricity bills.

Violence seemed imminent, and I tried to usher our patient away, laying a gentle hand on his arm. This triggered several blows to my face, and I found I was defending myself with a surprisingly professional straight left. Before I could congratulate myself on this new skill I received a vigorous karate style kick on the left testicle. After a short fierce struggle my three partners and I managed to restrain our patient by sitting on him and tying his shoe laces together.

At this stage he still appeared furiously agitated. We felt that he was either suffering from some acute paranoid psychosis or was intoxicated, perhaps with amphetamines. We agreed to sedate him and told him so; he seemed to assent, and my partner injected 50 mg of chlorpromazine intramuscularly.

By now I felt dizzy and weak and lay down on my examination couch, expecting to feel better after a few minutes. The police arrived and removed my assailant. The pain steadily increased over the next half hour, and the upshot was that I spent a few very uncomfortable days in bed with a scrotal haematoma.

After removal by the police, my assailant was seen by a consultant psychiatrist with a view to "sectioning" him under the Mental Health Act. Surprisingly, he was calm, lucid, and reasonable, saying that he felt that we were part of his wrangle with the electricity board. He realised that he was mistaken, accepted a voluntary admission to hospital, and was clearly not sectionable. He stayed in hospital without further symptoms or medication and wandered off at the end of the week. No diagnosis was made apart from that of a disintegrated and depersonalised youth who was perhaps intoxicated with drugs. I asked his mother, a faithful patient who was greatly distressed by all this, if he would like to meet me to try to make some sense of this attack, but he did not appear. I had wondered, perhaps unrealistically, whether our mutual experience of violence might be the start of a working relationship. After some consideration he was removed from our list.

I was now in a dilemma. On the one hand, I was reluctant to encourage legal action against an odd, damaged, or disintegrated patient whose family I had sympathy for (and who incidentally was a member of an ethnic minority group with poor relations with the police). But, on the other hand, I felt responsible to my family, profession, and neighbourhood and thought that the effects of such behaviour should not be ignored and that it was wrong for me to judge this matter myself.

I wondered why I had not been asked to give a police statement. When I telephoned the police station I was surprised to be told that a prosecution would not be made as (*i*) our patient was obviously mentally ill and would "only be sentenced to a treatment order"; (*ii*) any fine would be pointless as he would be unable to pay; and (*iii*) we had "counterassaulted" (sic) him by sedating him with

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chlorpromazine and any defence solicitor would make capital of this. They said that I could start a private prosecution or could seek compensation from the Criminal Injuries Compensation Board.

This information from the police left me vaguely unsatisfied. I contacted the BMA and my defence society, who expressed sympathy but advised me to consult my own solicitor. By now I realised that I would be unfit for work for a second week, which meant that my partner would have to cancel his week's leave. My despondency increased when I read my BMA recommended sickness policy to find that it did not include the first fortnight's illness.

I gradually felt fitter and returned to work. While doing night calls I saw my assailant once or twice outside clubs and pubs, still wearing his hood.

After a month I felt increasingly dissatisfied with the lack of police action and asked to see the superintendent at our local police station. To our surprise there was no record of this incident: the constables concerned had not recorded these events. I then gave a statement and my assailant was later convicted of grievous bodily harm and fined £100. The Criminal Injuries Compensation Board offered me £350 compensation, which was increased to £1000 at appeal (less my legal expenses).

My conclusions are, firstly, that the police may misunderstand violence between patient and doctor as "domestic" and be unwilling to act. Secondly, our professional bodies cannot represent us in these circumstances. Would it cost too much for the BMA to give legal advice to doctors who are victims of violence?

P G T Ford comments:

Doctors are always at risk of physical violence from patients who are mentally disturbed because of psychiatric illness or drug or alcohol abuse. Particularly vulnerable are general practitioners, psychiatrists, and those who work in accident and emergency departments. Relatives also may resort to violence to express dissatisfaction with the treatment provided to a loved one, and there is the possibility of being mugged when responding to a call, especially at night.

The police should be informed without delay about any assault other than the most trivial, and the action then taken will depend on the facts of the assault. If the police decide to take no action the doctor's initial reaction may be to want to initiate a private prosecution or a civil claim for damages. Rarely, if ever, would either course be appropriate or productive, particularly if the assailant is mentally disturbed. The possibility of compensation is better pursued through an application to the Criminal Injuries Compensation Board, for which early notification of the assault to the police is essential. It is to be regretted that through no fault of his own Dr Cembrowicz was left to pursue his claim to the Criminal Injuries Compensation Board through his own solicitor since advice and help with such practical matters is normally available through the doctor's protection society.

Dr Cembrowicz has drawn attention to a very real problem and his unpleasant experience may have been similar to that which Dr Frank Wells described in the *BMJ*.[1] Although the medical victim may suffer nothing more than shortlived worry or anger, it is not uncommon for depressive and phobic states to be triggered off by a violent incident. Brown *et al* emphasise that the extent of shock to the victim should not be underestimated.[2] A full appreciation of the sequelae is essential so that the victim may be offered appropriate professional support and help. The protection societies can provide all the necessary help to cope with legal issues and may be able to offer other support, although it might be more appropriate if this was provided locally. I would welcome discussion with the BMA and other bodies with responsibilities to general practitioners about how the best comprehensive support for victims of assault might be coordinated and achieved.

1 Wells F. Assault. *Br Med J* 1983;286:113-4.
2 Brown R, Bute S, Ford P. *Social workers at risk—the prevention and management of violence*. London: Macmillan Education, 1986.

J C Winn comments:

Regrettably, the incidence of assault is increasing throughout the United Kingdom. This means that any member of the public is more likely to be subjected to some form of physical violence and this includes doctors. Indeed, doctors tend to be more at risk because they come into contact with many people, often work late at night, and have to visit the "deprived" inner city areas where much of the violence occurs.

The insurance market has over recent years developed policies to provide cover in two main areas:

Legal expenses insurance—This type of policy is designed to provide cover against the legal costs incurred by an individual protecting his rights. Most costs in this type of action are covered—solicitors' and barristers' fees, court costs, witnesses' expenses, etc. All good legal expenses policies will cover the pursuit of a claim for injury suffered by the person insured.

Loss of income—There is a wide range of policies that provide payments, either lump sum or regular weekly or monthly amounts, in the event of a doctor being unable to work because of illness or injury.

In the case of general practitioners many of the modern surgery policies include specific cover for assault for the doctors and their staff. There are also many personal sickness and injury policies designed to reimburse lost income both over short periods and in the event of long term disability. These policies, however, usually provide for cover to start after a waiting period that may be anywhere between seven days for the short term policies and six to 12 months for the long term permanent contracts. These waiting periods are designed to fit the circumstances of the doctor. Hospital doctors, for example, are paid full salary by their employers for six months and many general practices have agreements that cover the sickness or injury of one of the partners.

There are of course exceptions to these examples, and if a doctor requires cover to start from the first day of absence from work then this can usually be arranged. The cost in such cases is much higher, and this has to be weighed against the benefit.

As with most types of insurance, once a need for cover is established there is usually a range of excellent policies available to the doctors for their protection.

Dr Mervyn Goodman comments:

Violence against the person is an increasing hazard of every day life, reflecting the trend of modern society. Such events may occur anywhere, not only in underprivileged areas. Doctors are more vulnerable than many other groups because they may be accosted by psychopathic, intoxicated, or drug dependent patients.

It is important that we make every effort to minimise the risk to ourselves. In the surgery or the casualty department panic buttons or personal alarms should be readily available to summon help. On home visits only the minimum amount of equipment should be carried; pocket diagnostic equipment now makes this possible. If further equipment or drugs are necessary a member of the patient's family should be asked to accompany you to and from the car. In particularly violent areas a police escort may be requested.

When a physical assault is made on a doctor the police must be asked to prefer charges. The fact that the assailant may be mentally ill is no reason not to do so. If, as in the case of Dr Cembrowicz, it is subsequently found that the police have no record of the incident representations should be made to the Police Complaints Board. My own opinion is that a private prosecution is not only unnecessary but it is also expensive. I think that the suggestion of "counterassault" was totally unrealistic if sedation was administered to protect the public from harm.

Most sickness policies do not cover the first two weeks of illness and most partnerships will not qualify for locum payments from the family practitioner committee for this period (*Statement of Fees and Allowances* 48.7). Although Dr Cembrowicz ultimately received £1000 less expenses from the Criminal Injuries Compensation Board, I believe that the Department of Health and Social Security should compensate all Health Service workers for the sequelae of any injury sustained in carrying out their duties.

Clare Dyer comments:

The police are not obliged to prosecute every time a crime is committed; if they did the courts would be hopelessly clogged. Reasons for not prosecuting include insufficient or poor quality evidence, the fact that the offence is trivial or technical, or humanitarian considerations—for instance, the fact that the offender is old, ill, or mentally disordered. In assault cases the seriousness of the injuries is obviously an important factor. The Metropolitan Police (not, of course, the force concerned here) say that they treat assaults on doctors in the same way as assaults on any

other member of the public. Normally in cases of grievous bodily harm if the evidence appears sufficient to secure a conviction and if the doctor presses for prosecution the assailant would be prosecuted, though each case is considered individually on its merits.

On the "counterassault" point, in private prosecutions for assault the accused often makes counterallegations of assault against the prosecutor; these cases are rarely worth proceeding with because magistrates have difficulty in deciding who is at fault and will usually just bind over both parties to keep the peace. This case, however, is quite different. The partners believed that the assailant consented to the injection, and even if he had not he suffered no injury from it and it was arguably no more than the use of reasonable force in self defence. Even if it were not, it would not in any way be a defence to the charge of grievous bodily harm.

Dr Cembrowicz's main concern, understandably, was compensation for financial loss because of time off work. He has gained nothing personally from the prosecution, except for the deterrent effect it may have on this patient or other potential assailants who may be aware of it (though its value as a deterrent must be doubtful, given that most patients who assault their doctors are presumably not acting rationally). The court can order someone who is convicted of a crime to pay compensation to the victim, but this depends on the perpetrator's ability to pay. Compensation by the Criminal Injuries Compensation Board does not depend on a prosecution; all that is required is that the crime must be a crime of violence reported without delay to the police, and the injuries must now be worth at least £550.

If the assailant is not arrested no record would be made on the incident sheet, say Bristol police. There would, however, be a record in the officer's notebook. (The Criminal Injuries Compensation Board writes to the police for confirmation that the incident was reported.) If the police refuse to act a victim can bring a private prosecution, but this is not advisable because he will probably have to pay the defendant's costs if he is acquitted and even if he is convicted the victim is unlikely to uncover all his legal costs.

The obvious bodies to provide legal advice and help for doctors assaulted in the course of their work seem to be the defence societies, who (in appropriate cases) will defend doctors facing criminal charges and therefore have some expertise in criminal law and procedure on tap. At the very least they should pay the costs of a Criminal Injuries Compensation Board appeal, which will otherwise leave the doctor out of pocket.

Practice Research

Determinants of mood in general practitioners

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Abstract

A pilot study was conducted in which 44 general practitioners completed cognitive behavioural self monitoring diaries. Hourly changes in emotional state were recorded together with associated circumstances. Lowering of mood was associated mainly with "hassle" at work, pressure of time, and domestic dissatisfaction. Improvement in mood was associated with domestic happiness and satisfaction at working efficiently and to time. Mood was significantly lower when the doctor was on call. Women doctors were more prone to mood changes associated with domestic matters. Responses to a questionnaire suggested that the doctors preferred traditional clinical medicine to problems of a social or psychological origin.

Managerial skills would help alleviate several of the problems identified in this study and should be more prominent in the training that all doctors receive.

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Introduction

Most general practitioners find their work interesting but suffer at times from anxiety, boredom, and frustration. Cartwright found that the more pleasurable aspects of general practice stemmed from personal contact with patients, the variety of work, freedom of action, and satisfaction in helping people.[1] The less pleasurable aspects were associated with the unacceptable behaviour of patients, trivial consultations, lack of time, and late or inopportune requests for visits. The repeat of this survey by Cartwright and Anderson generally showed only minor changes, but lack of leisure time was no longer a major cause of dissatisfaction.[2] Balint and his followers have studied in depth the frustrations of general practitioners in their relationship with patients,[3] but little consideration has been given to the contribution of home life and outside interests to the mood of family doctors. Porter *et al* undertook a pilot study to develop methods of measuring stress factors experienced by general practitioners who were asked to keep half hourly diaries to record self perceived pressures.[4] As far as we are aware, however, no study has been completed in which the thoughts and actions of family doctors, both at home and at work, have been related to their mood over a specific period.

Thoughts, mood, and behaviour are intimately related, and there has recently been considerable interest in the theory and practice of cognitive psychology, which relates emotional disturbance to faulty thinking. Misperception, misinterpretation, and unrealistic evaluations are characteristic of the type of thinking that leads to poor mood states. Cognitive therapy uses various methods to help modify a person's thinking and belief systems: reason and logic, practical