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Violence in general practice

Demands individual and concerted action

General practitioners tend to take little interest in violence until they or their staff are assaulted.[1-6] But many have now experienced such assaults, and individual doctors and practices and local and national organisations need to think hard about how to respond to this growing problem. The implications for the quality of consultations, the appointment of committed principals and other staff (especially among women), and the use of deputising services in areas perceived as being high risk are worrying.

A study in Dundee in 1986 found that about four out of every 100 patients were potentially violent and estimated that threats of violence occurred in one in every 500 consultations.[6] A larger survey showed that 10% of general practitioners have suffered a physical assault and that 5% have been threatened with a weapon.[7] In London the percentage of general practitioners who had been assaulted rose from 0·3% in a survey conducted in 1980 to 11% in a 1987 survey (J Oldroyd, personal communication). The study from Birmingham published in this issue (p 97) showed that 11% of general practitioners have been assaulted and that 91% have been verbally abused. The effects on staff are demotivation, loss of self esteem,[8] and increasing fear[9]; about one in four doctors feels under threat in surgery hours (p 97). Little attention has been paid to assaults on receptionists or other patients, but 77 assaults on receptionists and 46 on other patients were reported in a survey in London in 1987 (J Oldroyd, personal communication).

Theories abound about the causes of violence in general,[10] but research is needed to elucidate the problem in general practice. We need to remember the biological basis of violence[11] and to understand how to handle it. Violence seems to be increasing generally: violent crime in London rose by a quarter between 1986 and 1987,[12] and new applications to the Criminal Injuries Compensation Board rose by 6·5% over the same period.[13] Changes in eligibility for social security may be increasing violence as may homelessness, insecurity among council tenants, delays and obstacles in health services, and the failures of the democratic system to express people's fears.[10,14] We also need to know more about the assailants. One study found that they were largely men and had a surprisingly high average age of 41, a high consultation rate, and a history of psychiatric illness.[6] The management of violent psychiatric patients is familiar,[13,15] but it is important to remember that only a minority of schizophrenics are potentially violent. Mental handicap is not itself a cause of violence.[16] A study of general practitioners treating patients who abused opiates showed that the threat of violence hampered the establishment of a constructive therapeutic relationship.[17] There are no good data measuring violence related to alcohol, but it seems to be an important problem (p 97).

One of the first responses of general practitioners to violence should be to report all incidents to the family practitioner committee[18]: most incidents go unreported[18,19]—perhaps because doctors think nothing can be done or because they believe themselves to be at fault.[20] Most worrying is a claim that 90% of attacks on Asian general practitioners are going unreported because of fear of racial attacks on their families.[21] General practitioners should also report assaults to the police and take legal advice from their medical defence society.[22] Calls have been made for the Department of Health to compensate general practitioners as well as other health service workers for injuries received at work.[2] General practitioners should also consider taking out one of the new specialist packages of insurance for unprovoked assault as most policies fully insure neither general practitioners nor their staff.[23]

Victims of assault suffer considerable shock.[11] The need for training in managing violence and in victim support services has been recognised,[7,18,24] but family practitioner committees have been slow to react despite demand from general practitioners.[20] Postgraduate advisers and the organisers of vocational training schemes and courses should place the prevention of violence high in their priorities, emphasising the patient's needs for space, respect, and dignity.[25] Understanding body language and mediation may be more useful than learning self defence.[24] Local medical committees should consider an interesting proposal for practices to pay a voluntary levy for a regional training fund,[26] while pressing the government to expand section 63 funding for such training.

General practitioners should develop with the primary health care team a practice policy for managing potentially violent patients. This should include the identification of "at risk patients," a strategy to minimise failed communication, a policy on removing patients from the list, and a consistent policy on issuing sick notes and addictive drug prescriptions and on managing addicts in general. The policy should aim at reducing waiting times, producing an incident recording book, providing homely non-threatening but secure premises, supporting and training staff, providing for partners' absence after assault, and sharing information among professionals. Guidelines for safe home visiting should

be included—telephoning the patient before visiting, not carrying an identifiable medical bag, taking personal alarms, informing people of your whereabouts, using car telephones, working with the police and deputising services, and ensuring availability of numbered council estate maps. Local authorities should provide adequate lighting, naming, and security on estates.

Social security staff, local government workers, social workers, nurses, and health visitors have all had guidelines from their unions or professional bodies.[18] A few local medical committees such as Glasgow have taken initiatives, but the BMA and the Royal College of General Practitioners have done little, fearing that highlighting the problem will lead to copycat crimes. The General Medical Services Committee is to conduct a nationwide survey of the extent of the problem in general practice, but it is so urgent that the GMSC should immediately facilitate the development of national guidelines for local medical committees and general practices. Soon controversial contractual arrangements may well be introduced between family practitioner committees and doctors, and it would be better for the profession to make a voluntary system of controlling violence work rather than wait for the government to impose one. The GMSC must press the government to recognise that measures against violence require extra resources.[18]

Central to the problem in inner cities is the urgent need for improving premises. The reinstatement of the enhanced improvement grant and differential relaxation of cost rent limits to match building costs are vital, especially in London. The Department of Health should set up a proper national reporting system for violence in general practice and collect data from family practitioner committees, medical defence societies, deputising services, and the Criminal Injuries Compensation Board. Family practitioner committees with a high incidence of violence will need to press the department for more generous cash limiting of their ancillary staff budget—to encourage appointment of security staff, psychiatric social workers for staff counselling, and psychologists and extra nurses for assistance with drug and alcohol related problems. Family practitioner committees should consider appointing a facilitator in each area to oversee a policy for preventing violence, bringing together local authorities, the police, and general practitioners.

Practices take for granted preventing the spread of infection, but now we must spend time and money preventing the greater risk of violence.

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Chancroid

Epidemics in some developing countries but still rare in Britain

Chancroid is a sexually transmitted disease causing painful destructive genital ulcers and enlarged inguinal lymph nodes that in time may suppurate. It is caused by *Haemophilus ducreyi*, a fastidious bacterium not easily cultured except in experienced hands. The disease is possibly the leading cause of genital ulceration in developing countries.[1-4] In the developed world the main cause is herpes simplex,[5] and chancroid is rarely seen or diagnosed.

Recently, however, outbreaks of chancroid have been seen in Greenland,[6] Rotterdam,[7] and various parts of the United States.[8-11] The epidemiology is similar in all these outbreaks: the cases mostly occur among poor, heterosexual people and often result from contact with prostitutes. In the United States many of the men were migrant workers. The association with prostitution has also been described in Nairobi, where three fifths of men with chancroid acquired it from prostitutes.[12]

Prostitutes are probably a source of infection more for economic than physical reasons. When facilities for diagnosing and treating genital complaints are cheap and freely available patients with genital ulceration will seek help and treatment. When the population is poor and facilities are limited or expensive patients may delay in seeking medical advice. This may apply particularly to poor prostitutes who rely on sexual activity for their subsistence.

In Britain chancroid is exceptionally rare: in 1965 only 74 cases in men and five in women were reported from clinics for sexually transmitted diseases. This represented 0·001% of all cases attending clinics, and the number seen each year since then has remained virtually static. There have always been many more cases among men than women, but in recent years the gap has narrowed: from 1965 to 1969 only 14 of the 362 (4%) patients were women compared with 114 of the 425 (27%) seen between 1981 and 1985. This may reflect an increased number of prostitutes.

In the early 1980s workers in Sheffield developed a modified culture medium said to be superior to the media used previously for culturing *H ducreyi*.[13-15] Using this medium they cultured an organism said to be *H ducreyi* from over a quarter of patients with genital ulcers as well as from several people without symptoms presenting to the local clinic for sexually transmitted diseases.[14,16] These studies are contrary to those from other Western cities, including Liverpool,[17] Manchester,[18] Winnipeg,[19] and Antwerp,[20] where

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