Violence in general practice: a survey of general practitioners' views

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Abstract

Objective—To survey the extent of abuse and violence directed towards general practitioners during the course of their professional duties and to categorise the characteristics of such aggression.

Design—Retrospective survey of the views of a large sample of general practitioners by using a piloted postal questionnaire.

Setting—All medical practices in the west midlands.

Subjects—A total of 1093 general practitioners (40.6% of the total sample) who responded to the questionnaire.

Main outcome measure—Number of incidents of aggression experienced by the general practitioners during a period of 12 months and the incidence of various precipitating factors.

Results—Although the response was low at 40.6%, this study is the largest published database on aggression towards family doctors. In all, 687 (62.9%) of the responders had experienced abuse or violence during the previous 12 months, and 191 (17.5%) had experienced some sort of abuse at least once a month and 11 (1%) had experienced verbal abuse every day. Even assuming that all of the non-responders did not experience any violence, then aggression in patients affects 25.5% of general practitioners in the west midlands. For those practitioners who had experienced aggression in patients the annual incidence of an event per general practitioner was 2.42. In all, 96 (14%) of these general practitioners thought that aggression was increasing. A total of 1520 (91.3%) of all incidents comprised verbal abuse or threats with no direct physical act. The surgery was the commonest location for aggression, with 942 (56.6%) incidents; however, 90 (62.5%) of the incidents involving assault or injury occurred during domiciliary visits and 22 (66%) of the injuries were received during night calls. Relatives were the aggressors in 668 (37.6%) cases, anxiety was a precipitant in 435 (25.7%) cases, and a long wait in 183 (10.8%).

Conclusions—Violence towards general practitioners is common and may be increasing. Some of the precipitants of aggression are potentially avoidable and practices should make strenuous attempts to identify such factors and 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. Doctors should avoid delays for patients by rearranging booking policies or surgery times and lengths. Victims of aggression must be followed up. A prospective study or centralised recording of incidents should be funded.

Introduction

Aggression directed at health service staff continues to attract substantial media interest. Despite this the

scale of the problem facing the general practitioner, who is the first point of contact for most patients, continues to be underresearched. Most published work on aggression has been based either on small surveys¹⁻³ or on anecdotal personal reports.⁴⁻⁸ Perhaps of even greater importance than the aggression itself are the consequences for the victim and the general level of intimidation among doctors. Evidence on these issues is even less well documented.⁹

Various factors may lead doctors to avoid discussing or reporting that they have suffered abuse¹⁰: it might be seen as an inevitable feature of the job²; suffering regular abuse may be seen as a consequence of poor doctoring skills¹¹; anonymity is sometimes sought because victims fear retribution¹²; there may be concern to avoid publicity in case this presents general practitioners as "legitimate" targets. The media's capacity to sensationalise important and delicate issues is a further inhibition; indeed, the publication of the pilot survey for this study² resulted in columns appearing in four national and six local newspapers (under predominantly lurid headlines) and invitations to speak about the problem on four radio programmes.

The lack of information on aggression towards general practitioners compared with other groups in close contact with the public, such as teachers,¹³ social workers,^{14 15} transport workers,^{16 17} and community nurses,¹⁸ prompted the present study. The principal aim was to survey the extent of abuse and violence directed towards a large sample of general practitioners during the course of their professional duties. Previous studies have identified some of the precipitants of violence,¹⁹ which include alcohol,² drug abuse, and mental illness,^{20 21} but little else of note. A second aim was, therefore, to categorise the severity, frequency, location, and precipitants of this reported aggression.

Subjects and methods

A questionnaire, piloted in an earlier small survey,² was posted to all unrestricted principals in contract with the family practitioner committees of the West Midlands Regional Health Authority—a total of 2694 doctors. The survey took place in March 1989. A short covering letter explaining the purpose of the study was included with an addressed, but not stamped, envelope for the reply. The questionnaire consisted of predominantly closed questions, with tables to record the recalled incidents of aggression with scale of violence on one axis and characteristics on the other. Open questions elicited the views of the doctors on violence in practice. The practitioners worked in a wide variety of practices, from those in inner city deprived locations to those in rural communities.

Confidential details were obtained on the age and sex of the doctor, medical school of qualification, number of partners, and practice location. A scale was devised which categorised aggression into five degrees of increasing severity: (I) verbal abuse; (II) verbal abuse

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with specific threats (for example, shaking a fist) or with physical action against inanimate objects (for example, banging a table, throwing an object, forcing a door); (III) physical action against the doctor without injury (for example, pushing or obstructing); (IV) physical violence with minor injury (for example, cuts, bruises); and (V) physical violence with severe injury (for example, the doctor was knocked out, needed hospital care). Except for the addition of category II in this study the scale was similar to that used in the largest published survey on violence in the health service.²² This earlier study investigated the recollections of 3000 people working in a great variety of grades in the hospital and community services.

Practitioners were requested to recall the frequency of aggressive episodes in the previous 12 months, providing details on the level of aggression, the location of the incident, the age and state of health of the aggressor, and the main precipitating factor. They were also questioned on their level of concern over aggression during various periods of the working day and at night. A list of any changes made to the practice because of aggression were recorded. Finally, details were requested on the frequency of aggression towards receptionists and other staff.

TABLE 1—Characteristics of general practitioners in study sample compared with national estimates. (Figures are number (percentage) of practitioners)

Characteristic	Sample (n=1093)	National figures*
Age:		
<35	215 (19.8)	208 (19.1)
35-44	398 (36.7)	335 (30.7)
45-54	270 (24.9)	270 (24.8)
55-64	177 (16.3)	227 (20.8)
≥65	24 (2.2)	50 (4.6)
Not known	9 (0.1)	
Where general practitioner was qualified:		
United Kingdom	921 (84.3)	18 394 (73.8)
India or Pakistan	109 (10.0)	
Other	29 (2.7)	6 528 (26.2)
Not known	34 (3.1)	
Sex:		
Male	900 (82.3)	900 (82.6)
Female	190 (17.4)	190 (17.4)
Not known	3 (0.3)	
Number of partners:		
Single	121 (11.1)	3 007 (11.3)
2-3	369 (33.8)	9 309 (35.1)
4-5	403 (36.9)	8 950 (33.8)
≥6	200 (18.3)	5 243 (19.8)

*National percentages for age and sex derived from the Department of Health and Social Security (n=1090),²³ for where doctors were qualified from the Department of Health (n=24 922),²⁴ and for partnership size from the Office of Health Economics (n=26 509).²⁵

TABLE 2—Frequency of aggressive incidents experienced by general practitioners (n=1093) who had experienced aggression in the previous 12 months. Figures are number (percentage) of practitioners

Frequency of aggressive incidents	Type of aggression*				
	I	II	III	IV	V
Constantly (every day)	9 (0.8)	2 (0.2)			
Frequently (>1/month)	148 (13.5)	29 (2.7)	3 (0.3)		
Infrequently (<1/month)	485 (44.4)	222 (20.3)	75 (6.9)	36 (3.3)	5 (0.5)

*I Verbal abuse, II verbal abuse with threats, III physical action, IV physical action with minor injury, V physical action with major injury.

TABLE 3—Location of aggressive incidents reported by general practitioners (n=687). Figures are number (percentage for type of aggression) [percentage of total] of incidents

Location	Type of aggression*					All types
	I	II	III	IV	V	
Consulting room	476 (42.0) [28.6]	158 (40.9) [9.5]	24 (23.3) [1.4]	9 (25.0) [0.5]	2 (40.0) [0.1]	669 (40.2)
Waiting room	182 (16.0) [10.9]	72 (18.7) [4.3]	19 (18.4) [1.1]			273 (16.4)
Day visit	249 (22.0) [15.0]	72 (18.7) [4.3]	24 (23.3) [1.4]	8 (22.2) [0.5]		353 (21.2)
Night visit	227 (20.0) [13.6]	84 (21.7) [5.0]	36 (35.0) [2.2]	19 (52.8) [1.1]	3 (60.0) [0.1]	369 (22.2)
Total	1134 [68.1]	386 [23.2]	103 [6.2]	36 [2.2]	5 [0.3]	1664 [100]

*I Verbal abuse, II verbal abuse with threats, III physical action, IV physical action with minor injury, V physical action with major injury.

Results

Of the 2694 unrestricted principals, 1093 (40.6%) returned their questionnaires. Although this was a low percentage response, the characteristics of the responders compared with those of the non-responders were similar with respect to age and sex of the doctor and size of practice (table 1). The only highly significant difference was an underrepresentation of general practitioners who had qualified outside the United Kingdom, and there was a slightly significant lack of doctors aged 65 and over.

Of the 1093 responders, 687 (62.9%) had suffered some form of aggression in the previous year, with 100 (14.6%) of these stating that aggression was increasing and 31 (4.5%) that it was decreasing. Table 2 shows that 157 (14.4%) of the responding practitioners suffered regular verbal abuse (at least once a month), with 31 (2.8%) experiencing regular threatening behaviour and three (0.3%) regular minor assault or obstruction. In the group of doctors who had actually experienced an aggressive incident during the 12 months these percentages rose to 22.9%, 4.5%, and 0.4% respectively. One per cent of the sample had to tolerate verbal abuse every day. Thirty six general practitioners (3.3%) had received minor injuries from an assault in the previous year and five (0.5%) doctors a severe injury.

Most (942; 56.6%) of the 1664 incidents in table 3 occurred in the surgery, with 669 (40.2%) of all events taking place in the consulting room. Some 1520 (91.3%) of the incidents exclusively comprised some level of verbal abuse, but 41 (2.5%) involved actual injury. Serious violence happened more on domiciliary visits, particularly at night, with 24 (23%) assaults and eight (22%) injuries occurring on day visits and 36 (35%) assaults and 22 (54%) injuries on night visits.

As in previous surveys the usual instigators of aggression were men, who accounted for 1166 (65.7%) of the 1776 cases in table 4. Of these, 664 (37.4%) were male patients and a surprisingly high figure of 441 (24.8%) were male relatives. Indeed, a total of 668 (37.6%) of the 1776 aggressors were relatives of patients. In all, 110 (76%) of obstructions, assaults, and injuries were attributed to men. Aggression was almost exclusively associated with direct patient contact as only 97 (5.5%) incidents involved the general public, 86 (90%) entailing verbal abuse only. The aggressor was under 40 in 1008 (75.6%) of 1334 cases. There was no difference between the 15 to 29 and 30 to 39 age bands. This three to one preponderance of under 40s was consistent, whatever the type of aggression. This rather surprising finding that it is not predominantly the young who engage in aggression towards general practitioners agrees with that in another smaller study, in which the average age of the aggressor was 40.¹

Table 5 shows that the most frequent factors precipitating aggression were the influence of drugs or alcohol (464, 27.4% cases) and anxiety (435, 25.7% cases). Interestingly, the most commonly quoted cause of verbal abuse (337, 28.6% of incidents) was an anxious patient, a factor not noted in any previous

TABLE IV—Characteristics of aggressors according to type of aggression towards general practitioners (n=687). Figures are number (percentage for type of aggression)/[percentage of total] of cases

Characteristic	Type of aggression*					
	I	II	III	IV	V	All types
Type of aggressor (n=1776):						
Male patient	424 (33.7) [23.9]	167 (44.7) [9.4]	51 (48.6) [2.9]	20 (57.1) [1.1]	2 (40) [0.1]	664 (37.4)
Female patient	266 (21.2) [15.0]	57 (15.2) [3.2]	17 (16.2) [1.0]	5 (14.3) [0.3]	2 (40) [0.1]	347 (19.5)
Male relative	314 (25.0) [17.7]	99 (26.5) [5.6]	21 (20.0) [1.2]	6 (17.1) [0.3]	1 (20) [0.1]	441 (24.8)
Female relative	186 (14.8) [10.5]	32 (8.6) [1.8]	8 (7.6) [0.5]	1 (2.9) [0.1]		227 (12.8)
Male general public	39 (3.1) [2.2]	13 (3.5) [0.7]	6 (5.7) [0.3]	3 (8.6) [0.2]		61 (3.4)
Female general public	28 (2.2) [1.6]	6 (1.6) [0.3]	2 (1.9) [0.1]			36 (2.0)
Age of aggressor (n=1334):						
15-29	336 (37.0) [25.2]	129 (43.9) [9.7]	37 (42.0) [2.8]	15 (38.5) [1.2]	2 (40) [0.1]	519 (38.9)
30-39	334 (36.8) [25.0]	112 (38.1) [8.4]	26 (29.5) [1.9]	15 (38.5) [1.2]	2 (40) [0.1]	489 (36.7)
40-49	159 (17.5) [11.9]	37 (12.6) [2.8]	15 (17.0) [1.1]	5 (12.8) [0.4]	1 (20) [0.1]	217 (16.3)
≥50	79 (8.7) [5.9]	16 (5.4) [1.2]	10 (11.4) [0.7]	4 (10.2) [0.3]		109 (8.2)

*I Verbal abuse, II verbal abuse with threats, III physical action, IV physical action with minor injury, V physical action with major injury.

TABLE V—Factors contributing to act of aggression towards general practitioners (n=687). Figures are number (percentage for type of aggression)/[percentage of total] of incidents (n=1692)

Factor	Type of aggression*					
	I	II	III	IV	V	All types
Drugs or alcohol	289 (24.5) [17.1]	121 (33.0) [7.2]	36 (35.0) [2.1]	15 (38.5) [0.9]	3 (60.0) [0.2]	464 (27.4)
Anxious patient	337 (28.6) [19.9]	82 (22.3) [4.8]	11 (10.7) [0.7]	4 (10.3) [0.2]	1 (20.0) [0.1]	435 (25.7)
Mental illness	180 (15.3) [10.6]	78 (21.3) [4.6]	37 (35.9) [2.2]	18 (46.2) [1.1]	1 (20.0) [0.1]	314 (18.6)
Long wait	146 (12.4) [8.6]	32 (8.7) [1.9]	3 (2.9) [0.2]	2 (5.1) [0.1]		183 (10.8)
Recent bereavement	72 (6.1) [4.3]	11 (3.0) [0.7]	3 (2.9) [0.2]			86 (5.1)
Other	154 (13.1) [9.1]	43 (11.7) [2.5]	13 (12.6) [0.8]			210 (12.4)
Total	1178 [69.6]	367 [21.7]	103 [6.1]	39 [2.3]	5 [0.3]	1692 [100]

*I Verbal abuse, II verbal abuse with threats, III physical action, IV physical action with minor injury, V physical action with major injury.

study. Anxiety was the second most common cause (82, 22.3% of incidents) of threatening verbal abuse and was even implicated in 11 (10.7%) of the assaults that did not cause injury. Two additional factors that could be associated with anxiety, a long wait for patients and a recent bereavement, were reported for 183 (10.8%) and 86 (5.1%) incidents respectively. Virtually all of these incidents (261 out of 269) were confined to some type of verbal abuse.

Mental illness was implicated in only 258 (15.2%) incidents of verbal abuse. However, this factor became the most important one for serious incidents involving assault or injury. It was recorded for 56 out of 147 (38.1%) incidents, closely followed by alcohol or drugs for 54 (36.7%) incidents.

Discussion

It is unfortunate that this postal survey received only a 40.6% response rate. This was likely to have been influenced by the failure to attract funding for the study, which in turn precluded stamped return envelopes and a second mailing to non-responders, both features in the pilot study of 83 Birmingham practitioners which achieved a response rate of 80%. The low response has certainly reduced the study's ability to provide an objective survey of violence towards family doctors. Inevitably, relying on recollections of incidents (as have all previous studies) rather than prospective recording further erodes objectivity. The study does, however, accurately represent the perceptions of responding practitioners to their personal level of violence, and represents the experience of nearly 4% of all general practitioners in England and Wales.

The low response rate poses the concern that general practitioners suffering aggression were more motivated to reply and are therefore overrepresented in the sample. However, the 119 responders (10.9% of the sample) who experienced assault or injury in the previous year produced a similar rate to previous surveys, which have reported rates of 11%,⁹ 10%,¹ and 11%.² Furthermore, 405 doctors (37.1%) had not suffered any sort of abuse in the previous year. This

compares with only 9% who had not suffered abuse in a previous (urban) survey of general practitioners.² Another reassuring finding was the similarity of the responders with non-responders with respect to expected rates for age, sex, and practice size and location.

This survey confirms that aggression during the working day is a regular feature for many general practitioners; some 687 (62.9%) of those replying had suffered aggression during the previous 12 months; 191 (17.5%) had experienced some type of abuse at least once a month, with 11 (1.0%) being verbally abused every day. Even if all the non-responders were assumed to have avoided any abuse then at least 25.5% of general practitioners had experienced violence at work. By extrapolating the 1664 incidents over the year to the total of 2694 doctors surveyed would produce a minimum incidence of aggression in general practice of 0.62 incidents per doctor year (1.52 incidents per responding general practitioner year or 2.42 events per general practitioner victim year). It is worrying to note that of those doctors who experienced aggression, over 14% felt it was increasing. Although aggression is common, it seems confined to certain groups of doctors as nearly 40% of responders in the sample had never suffered any abuse from patients.

Most of the incidents consisted of verbal abuse alone, but the effects of this are difficult to predict accurately. Where this abuse is persistent (in 1% of the sample it occurred every day) it is likely to have a detrimental effect on doctors,⁹ their staff,²² and, indeed, other patients who are waiting to see the doctor. It would also be interesting to note how many of the incidents of assault or injury had escalated from simple verbal abuse.

Some 942 (56.6%) incidents took place in the surgery, but more serious incidents of violence (58.3% of assaults and 75% of assaults that caused injuries) were more likely to occur on visits, especially at night. This study confirmed that being male (65.6% of cases), alcohol or drugs (27.4%), and mental illness (18.6%) were frequent precipitants of abuse, and particularly of the more serious forms. New findings were the

frequent involvement of relatives in aggression with 668 (37.6%) cases and the major precipitants of anxiety or a long wait by the aggressor in 435 (25.7%) and 183 (10.8%) incidents respectively. Such contributory factors are worth monitoring by doctors and their staff as early recognition and careful intervention may prevent subsequent actions of aggression.

Researching cause and effect of aggression towards health service staff remains important. The risks to non-medical staff such as social workers or housing office staff have generated sufficient concern among employers to fund experiments in safer ways of providing services. Examples of change in their practice include the provision of two way radios to social workers and enabling joint visiting in many circumstances. Local housing departments have researched better office environments where the public directly contact the service (by using open plan rooms, carpets, better fabrics, plants, and soft lighting) and providing specific training in interpersonal skills.²⁶ Such initiatives require investment in the service providers. The returns on such investment are improved confidence and effectiveness of staff,²⁶ reduced staff turnover,²⁷ and reduced levels of aggression from members of the public.²⁶

The self employed status of general practitioners militates against such major initiatives, but on a practical note practitioners should heed some of the lessons learnt by others. Furthermore, we have responsibilities as employers to provide acceptable and safe working environments for our staff, who may also suffer aggression from patients.

General practitioners who suffer abuse must talk about it within their practice and with colleagues. Aggression is more likely to occur when working with certain patient groups: those who are drunk or under the influence of drugs, the disturbed and agitated, anxious patients, and those who have had to wait a long time. The practice should have set protocols for dealing with such groups. Ideally these should have been agreed at staff meetings at which everyone has the opportunity for personal input. Staff should receive training in interpersonal skills to be effective in their numerous roles. Such skills become absolutely essential when handling abusive patients.

The doctor should accept responsibility for handling aggression where and as soon as it occurs, interrupting consulting if necessary. This will not only support staff but also allow the patient's concerns to be dealt with promptly and may possibly avoid escalation. Responding quickly is likely to be a positive sign to the 41.6% of patients who become aggressive owing to anxiety or because they have been kept waiting. (These two causes of aggression in general practice were previously unreported.)

As with dealing with any health issue, attention to the prevention of aggression must be the main priority for the practice. Close attention should be paid to the surgery environment. Open plan deep reception counters would seem the ideal, perhaps with a slightly raised platform on the receptionist's side.²⁶ Waiting room seating should be soft and there should be sufficient space to avoid crowding.²⁶ Soft toys (avoiding noisy ones) and reading material should be provided. Lighting should be adequate but soft, avoiding fluorescent strips.²⁶ Colours should be muted.²⁶ Consulting rooms should be similarly attractively appointed and sound proofed.

The risk of aggression is a further major impetus to doctors (and medical students) to develop good communication skills. Particular emphasis in teaching such skills should be directed to the handling of patients who are disinhibited, whether through mental illness or chemical abuse. Scenarios involving increasing levels of abuse in differing consultations

would be excellent material for role play sessions at medical schools.

Attention to improving surgery decor and layout has major implications for the uptake of cost rent schemes and improvement grants. Family health services authorities should give substantial support to practices that experience regular aggression and should consider maximising grants for improvements directed towards safer surgeries, an issue that may be much more difficult now that such schemes are cash limited. Small development budgets allocated to the family health services authorities (£300 000 in 1990-1 to cover all staff and premises developments in Birmingham with its 650 general practitioners and population of over 1 million) will not support such changes.

Aggression in society is increasing,²⁸ and its effects will inevitably permeate general practice. Two of the linchpins of general practice, its accessibility and the intimacy of the consultation, will inevitably increase the vulnerability of general practitioners to abuse. It seems likely that the experience of aggression, or even the fear of it, will undermine the confidence of doctors. How much this serves to erode the quality of the doctor-patient relationship, the availability of services, and the dedication of staff is an important question that will be explored in an ongoing analysis of the findings from this survey.

This study indicates that doctors should be cautious in reducing their accessibility to patients because of fears over abuse. For over a third of general practitioners, aggression is not a feature of their working lives. Furthermore, reduced access to the doctor would be likely to increase the stress and lengthen the delays for patients, two of the principal factors that precipitate violence.

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