



Patient initiated aggression and violence in the Australian general practice setting

Prepared on behalf of The Australian Primary Health Care Research Institute

Associate Professor Rhian M Parker*

Dr Dagmar M Ceramidas

Dr Laura E Forrest

Dr Pushpani M Herath

Dr Ian McRae

Australian Primary Health Care Research Institute (APHCRI)
ANU College of Medicine and Health Sciences
Building 62A, Eggleston Road
The Australian National University. Canberra ACT 0200
T: +61 2 6125 0766
F: +61 2 6125 2254
E: aphcri@anu.edu.au
W: www.anu.edu.au/aphcri

* CORRESPONDING AUTHOR

Table of Contents

TABLE OF CONTENTS	3
LIST OF TABLES	7
LIST OF FIGURES	9
ABBREVIATIONS AND GLOSSARY OF TERMS	11
ACKNOWLEDGEMENTS	13
EXECUTIVE SUMMARY	15
METHODOLOGY (CHAPTER 2).....	15
LITERATURE REVIEW (CHAPTER 3).....	15
STAKEHOLDER CONSULTATIONS (CHAPTER 4).....	15
QUALITATIVE INTERVIEWS, FOCUS GROUPS AND AFFINITY GROUPS (CHAPTER 5)	16
NATIONAL ONLINE SURVEY (CHAPTER 6).....	16
<i>Verbal aggression</i>	16
<i>Physical aggression</i>	17
<i>Perceived times of risk</i>	17
<i>Perpetrators of aggression</i>	17
<i>Perceived change in aggression</i>	17
<i>Impact of aggression</i>	17
NATIONAL PAPER BASED SURVEY (CHAPTER 7).....	17
<i>Verbal aggression</i>	17
<i>Physical aggression</i>	18
<i>Perceived times of risk</i>	18
<i>Perpetrators of aggression</i>	19
<i>Perceived change in aggression</i>	19
<i>Impact of aggression</i>	19
<i>Practice safety</i>	19
OVERVIEW	19
CHAPTER 1 INTRODUCTION	21
BACKGROUND AND POLICY CONTEXT	21
RESEARCH AIMS AND STRATEGIES.....	21
<i>Primary aims</i>	21
<i>Secondary aims</i>	21
<i>Major strategies</i>	22
DEFINITION OF TERMS	22
PROJECT OVERVIEW.....	23
SUMMARY	24
CHAPTER 2 METHODOLOGY	25
INTRODUCTION	25
ETHICS APPROVAL	25
STATISTICAL CLEARING HOUSE CLEARANCE	26
STAGE 1: LITERATURE REVIEW.....	26
STAGE 2: STAKEHOLDER CONSULTATIONS.....	27
<i>The Stakeholder Group</i>	27
STAGE 3: QUALITATIVE INTERVIEWS, FOCUS GROUPS AND AFFINITY GROUPS.....	28
<i>Sampling strategy</i>	28
<i>Recruitment</i>	29
<i>Research techniques</i>	29
<i>Data analysis technique</i>	30
STAGE 4: NATIONAL SURVEY	30
<i>Development of the survey instruments</i>	30
<i>Dissemination of online survey</i>	32
<i>Completion of the online survey</i>	33
<i>Analysis of the online survey data</i>	33

<i>Development of the paper-based survey instrument</i>	33
<i>Dissemination of the paper-based survey instrument</i>	33
<i>Data analysis</i>	34
STUDY LIMITATIONS	34
SUMMARY	34
CHAPTER 3 LITERATURE REVIEW	35
GENERAL PRACTICE WORKFORCE IN AUSTRALIA.....	35
PATIENT INITIATED AGGRESSION AND VIOLENCE TOWARDS GENERAL PRACTICE STAFF	35
EXPLORATION OF PATIENT INITIATED AGGRESSION AND VIOLENCE IN GENERAL PRACTICE	36
<i>Australia and New Zealand</i>	36
<i>United Kingdom</i>	38
<i>North America</i>	40
<i>Europe and the Middle East</i>	40
OVERALL FINDINGS FROM EMPIRICAL RESEARCH	40
<i>Prevalence and incidence of violence in general practice</i>	40
<i>'Mad' verses 'bad' patients and tolerance towards low level violence</i>	41
VIOLENCE PERPETRATED TOWARDS OTHER HEALTH PROFESSIONALS	41
<i>Violence experienced by hospital staff</i>	41
<i>Violence in the emergency department</i>	42
<i>Violence experienced by paramedics and other emergency services personnel</i>	42
GREY LITERATURE	43
<i>Anecdotal evidence of health professionals experiences of violence</i>	43
<i>Available packages, policy documents & publications</i>	44
CONCLUSION	44
CHAPTER 4 STAKEHOLDER INTERVIEWS	47
INTRODUCTION	47
FINDINGS	47
<i>Stakeholder respondents' perceptions of violence</i>	47
<i>Organisational response</i>	50
ORGANISATIONS WITH DIRECT GENERAL PRACTICE INVOLVEMENT	51
<i>Policies and procedures</i>	51
<i>Publications</i>	52
<i>Education and training</i>	52
<i>Support and organisational involvement</i>	53
<i>Zero tolerance attitude of organisation</i>	53
ORGANISATIONS WITH INDIRECT GENERAL PRACTICE INVOLVEMENT	53
<i>Policies and procedures</i>	53
<i>Publications</i>	53
<i>Education and training</i>	54
<i>Support and organisational involvement</i>	54
<i>Divisions of General Practice (DGP) activity</i>	55
<i>General practice-level response to violence</i>	57
<i>Incidents of violence reported by stakeholder respondents</i>	60
CONCLUSIONS.....	61
CHAPTER 5 QUALITATIVE INTERVIEWS, FOCUS GROUPS AND AFFINITY GROUPS	63
INTRODUCTION	63
FOCUS GROUPS	63
IN-DEPTH INTERVIEWS WITH GPs	63
FINDINGS	65
<i>Incidence / prevalence</i>	66
<i>Targets of aggression</i>	68
<i>Triggers</i>	68
<i>Risk factors</i>	70
<i>Trends in violence</i>	73
<i>Consequences and outcomes of violence</i>	73
<i>Effective strategies to minimise the risk of harm from patient initiated aggression</i>	74
<i>Barriers to implementing strategies</i>	79
<i>Suggested strategies to further reduce violence</i>	81

CONCLUSIONS.....	82
CHAPTER 6 NATIONAL ONLINE SURVEY.....	83
INTRODUCTION	83
ONLINE GENERAL PRACTITIONER SURVEY RESULTS	83
<i>General practitioner demographics.....</i>	<i>83</i>
<i>Incidence of verbal aggression</i>	<i>84</i>
<i>Incidence of physical aggression.....</i>	<i>85</i>
<i>Trends.....</i>	<i>90</i>
<i>Impact and perceptions of patient aggression</i>	<i>91</i>
ONLINE PRACTICE MANAGER SURVEY RESULTS.....	96
<i>General practice demographics.....</i>	<i>96</i>
<i>Incidence of verbal aggression</i>	<i>97</i>
<i>Incidence of physical aggression.....</i>	<i>98</i>
<i>Patient initiated aggression by demographic.....</i>	<i>102</i>
<i>Trends and periods of particular risk.....</i>	<i>104</i>
<i>Impact of aggression</i>	<i>107</i>
SUMMARY OF ONLINE SURVEY FINDINGS.....	110
<i>Verbal abuse</i>	<i>110</i>
<i>Physical aggression.....</i>	<i>110</i>
CHAPTER 7 NATIONAL PAPER-BASED SURVEY	113
INTRODUCTION	113
PAPER-BASED GENERAL PRACTITIONER SURVEY RESULTS.....	113
<i>General practitioner demographics.....</i>	<i>113</i>
<i>Incidence of verbal aggression</i>	<i>114</i>
<i>Incidence of physical aggression.....</i>	<i>116</i>
<i>Trends.....</i>	<i>122</i>
<i>Impact and perceptions of patient aggression</i>	<i>124</i>
PAPER-BASED GENERAL PRACTICE SURVEY RESULTS	128
<i>General practice demographics.....</i>	<i>128</i>
<i>Incidence of verbal aggression</i>	<i>129</i>
<i>Incidence of physical aggression.....</i>	<i>130</i>
<i>Patient initiated aggression by demographic.....</i>	<i>135</i>
<i>Trends and periods of particular risk.....</i>	<i>137</i>
<i>Impact of aggression</i>	<i>141</i>
SUMMARY OF PAPER-BASED SURVEY FINDINGS	143
<i>Verbal aggression</i>	<i>143</i>
<i>Physical aggression.....</i>	<i>143</i>
<i>Trends in patient aggression</i>	<i>144</i>
CHAPTER 8 DISCUSSION AND CONCLUSIONS	145
STAKEHOLDER CONSULTATIONS.....	145
QUALITATIVE STUDY.....	146
NATIONAL SURVEYS.....	146
<i>Online Survey Results</i>	<i>146</i>
<i>Paper Based Survey Results</i>	<i>149</i>
<i>Comparison of online and paper based survey results.....</i>	<i>152</i>
CONCLUSIONS.....	155
REFERENCES	157
LIST OF APPENDICES.....	163
APPENDIX A: LIST OF DIVISIONS OF GENERAL PRACTICE TARGETED FOR PAPER-BASED SURVEY	164
APPENDIX B: DISTRIBUTION OF FOCUS GROUPS AND INTERVIEW SESSIONS ACROSS AUSTRALIA.....	165
APPENDIX C: CONSULTATION GUIDE	166
APPENDIX D: SURVEY INSTRUMENT – GENERAL PRACTITIONER	171
APPENDIX E: SURVEY INSTRUMENT – PRACTICE STAFF.....	177
APPENDIX F: SUMMARY OF MARKETING STRATEGY	193
APPENDIX G: LIST OF STAKEHOLDER ORGANISATIONS	197
APPENDIX H: STAKEHOLDER CONSULTATIONS – THEMATIC FRAMEWORK FOR INTERVIEW	198

List of Tables

Table 1. Details of studies examining patient aggression and violence conducted in Australia and New Zealand.....	37
Table 2. Types of patient initiated aggression experienced by General Practitioners within a 12 month period in Australia and New Zealand.....	38
Table 3: Social and medical contributors to patient aggression.....	50
Table 4: Summary of the PHC RIS list of project-related training and education events conducted by Divisions in 2006-2007.	57
Table 5: Demographic summary of focus and affinity group attendees.	64
Table 6: Demographic summary of GP interviewees.....	65
Table 7: General Practitioner profile.....	84
Table 8: General practice profile.....	96
Table 9: General Practitioner profile.....	114
Table 10: GPs' experiences of verbal aggression.....	115
Table 11: GPs' experiences of property damage or theft.....	118
Table 12: GPs' experiences of stalking.....	119
Table 13: GPs' experiences of physical assault.....	120
Table 14: GPs' experiences of sexual harassment.....	121
Table 15: GPs' experiences of sexual assault.....	122
Table 16: GPs' perceptions of trends in patient aggression.....	125
Table 17: Impact of aggression in the previous 12 months on GPs.....	126
Table 18: General practice demographics.....	128
Table 19: Percentage of verbal aggression during last 12 months.....	130
Table 20: Percentage of property damage or theft during last 12 months.....	131
Table 21: Percentage of stalking during last 12 months.....	132
Table 22: Percentage of physical assault during last 12 months.....	133
Table 23: Percentage of sexual harassment during last 12 months.....	134
Table 24: Times of perceived risk.....	138
Table 25: Other times of perceived risk.....	139
Table 26: Changes in types of aggression.....	141
Table 27: Impact of verbal aggression on staff.....	142
Table 28: Comparison of online and paper based survey results for GPs.....	153
Table 29: Comparison of online and paper based survey results for general practice staff over 12 months or ever.....	154

List of Figures

Figure 1: Schematic diagram of study design.....	27
Figure 2: Schematic diagram of first survey distribution technique.....	32
Figure 3: illustrating the number of stakeholder organisations that responded to violence in the general practice setting, and their areas of response.....	51
Figure 4: illustrating the number of times stakeholder organization representatives discussed their organisation’s interventions related to violence in the general practice setting.	51
Figure 5: The differences between organisations specifically with regard to policies and procedures and guidelines available for their members.....	55
Figure 6: Experience of verbal aggression	85
Figure 7: Summary of physical aggression incidence	86
Figure 8: Experience of damage or theft of property	86
Figure 9: Experience of stalking.....	87
Figure 10: Experience of physical assault	88
Figure 11: Experience of sexual harassment.....	88
Figure 12: Experience of sexual assault.....	89
Figure 13: Risky times of day	90
Figure 14: Other times of risk.....	91
Figure 15: Perceptions of aggression	92
Figure 16: Impact of aggression	93
Figure 17: Practice environment	94
Figure 18: Verbal abuse.....	97
Figure 19: Property theft or damage.....	98
Figure 20: Stalking	99
Figure 21: Physical assault.....	100
Figure 22: Sexual harassment	101
Figure 23: Sexual assault.....	102
Figure 24: Male vs. female patient aggression	103
Figure 25: Patient vs. Person accompanying Patient Perpetrated Aggression	104
Figure 26: Times of particular risk	105
Figure 27: Other times of particular risk.....	106
Figure 28: Change in the incidence of aggression	107
Figure 29: Impact of verbal aggression	108
Figure 30: Impact of physical aggression	109
Figure 31: Experience of verbal aggression	115
Figure 32: Summary of physical aggression incidence	116
Figure 33: Experience of damage or theft of property	117
Figure 34: Experience of stalking.....	118
Figure 35: Experience of physical assault	119
Figure 36: Experience of sexual harassment.....	120
Figure 37: Experience of sexual assault.....	121
Figure 38: Risky times of day	123
Figure 39: Other times of risk.....	124
Figure 40: Perceptions of aggression	125
Figure 41: Impact of aggression	126
Figure 42: Practice environment.....	127
Figure 43: Verbal abuse.....	129
Figure 44: Property damage or theft.....	131
Figure 45: Stalking	132
Figure 46: Physical assault.....	133
Figure 47: Sexual harassment	134
Figure 48: Sexual assault.....	135
Figure 49: Male vs. female patient aggression	136

Figure 50: Patient vs. Person accompanying Patient Perpetrated Aggression	137
Figure 51: Times of particular risk	138
Figure 52: Other times of particular risk	139
Figure 53: Change in the incidence of aggression	140
Figure 54: Impact of verbal aggression	142
Figure 55: Impact of physical aggression	143

Abbreviations and glossary of terms

ACMHN	Australian College of Mental Health Nurses
ACRRM	Australian College of Rural and Remote Medicine
ADGP	Australian Divisions of General Practice
AAPM	Australian Association of Practice Managers
AGPN	the Australian General Practice Network
AMA	Australian Medical Association
AMPCo	Australian Medical Publishing Company
AMS	Aboriginal Medical Services
ANF	Australian Nursing Federation
ANU	The Australian National University
APHCRI	The Australian Primary Health Care research Institute
APNA	Australian Practice Nurses Association
CEO	Chief Executive Officer
CR & C	Campbell Research and Consulting Pty Ltd (Melbourne)
CRANA	Council of Remote Area Nursing
DGP	Division of General Practice
DoHA	The Department of Health and Ageing
Full time	staff who work up to 30 hours or more per week
GP	General practitioner
GPRA	General Practice Registrars Australia
Large practice	A practice employing four or more GPs (derived from consideration of spread of online survey data)
NAMDS	National Association for Medical Deputising Services
OH & S	Occupational Health and Safety
Older GP	A GP aged 51 or older (derived from consideration of spread of the survey data)
Part time	staff who work 29 hours or less per week
PHC RIS	The Primary Health Care Research Institute Service
Physical abuse	A patient or their friend/s or family member/s physically attack you. It includes behaviours such as punching, slapping, kicking, or use of a weapon or other object with the intent of intimidating you or causing bodily harm (Tolhurst et al., 2003).
Property damage or theft	Damage or theft to property belonging to you, your family or your workplace. It includes damage to or theft of a vehicle, personal effects (i.e. personal property at workplace), home contents, medical or office equipment, and supplies, or office furnishings. Attempted theft of the above items is also included (Tolhurst et al., 2003).
RACGP	Royal Australian College of General Practice
RCNA	Royal College of Nursing, Australia
RDAA	Rural Doctors Association of Australia
RRMA	Remote, Rural, Metropolitan Area (classification)
SBO	State-based Organisation
Sexual abuse	Any forced sexual act, rape or indecent assault perpetrated by patients or their friend/s or family member/s. It includes brushing, touching, or grabbing the genitals or breasts (Tolhurst et al., 2003).
Sexual harassment	Any form of sexual propositions or unwelcome sexual attention from patients or their friend/s or family member/s. It includes behaviours such as humiliating or offensive jokes and remarks with sexual overtones; suggestive looks or physical gestures, inappropriate gifts or requests for inappropriate physical examinations, pressure for dates, and brushing, touching, or grabbing excluding the genital or breast area (Tolhurst et al., 2003)
Smaller practice	A practice employing three or fewer GPs
Stalking	A patient/s purposely stalks or follows you to or from your home or your place of work (i.e. surgery, home visit, or hospital) (Tolhurst et al., 2003).

Verbal abuse A patient, their friend/s or family member/s swears, threatens or uses obscene gestures with the intent of offending you. It can include threats or abuse over the phone (Tolhurst et al., 2003)

Younger GP A GP aged 50 or younger

Acknowledgements

Mr Hitendra Gilhotra and Ms Jennifer Terweil, both from the Department of Health and Ageing, Canberra, provided ongoing support for the project. Other contributors to the project included the Reference Group:

1. Mr Hitendra Gilhotra, Department of Health and Ageing
2. A/Professor Kelsey Hegarty, Department of General Practice, University of Melbourne
3. Dr Parker Magin, Department of General Practice, the University of Newcastle
4. Dr Rod Pearce, AMA
5. Julie Porritt, the Australian General Practice Network
6. Ms Stefanie Colella, RACGP
7. Ms Libby Davies, Rural Doctor's Association Australia, meeting 1
8. Dr Jenny May, Rural Doctor's Association Australia, meetings 2 & 3
9. Ms Evelyln Brophy, CR&C (Observer)
10. Mr David Spicer, CR&C (Observer), meetings 1 & 2
11. Ms Natasha Ludowyk, CR&C (Observer), meeting 3
12. Mr Stephen Campbell, CR&C (Observer), meeting 3
13. A/Professor Rhian Parker, APHCRI (Chair, project leader)
14. Dr Dagmar Ceramidas, (Minutes), APHCRI (Observer)
15. Dr Laura Forrest, APHCRI (Observer)
16. Mr Will Wright, APHCRI (Observer), meeting 2

Thanks are extended to all Australian State-Based Organisation and Divisions of General Practice staff for their assistance in disseminating project information and online survey links. In addition, the project team acknowledges those Divisions of General Practice who participated in the additional paper-based survey.

Most importantly, the greatest contribution to the project came from the GPs and practice staff who responded to the surveys. Appreciation and thanks are extended to all survey respondents in acknowledgement for the time they invested into this research.

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing. The information and opinions contained in this paper do not necessarily reflect the views or policies of the Australian Government Department of Health and Ageing.

Executive summary

This is the first national study to be conducted in Australia examining the incidence and prevalence of violence against general practitioners and general practice staff.

The study was conducted between April 2009 and March 2010.

The broad aims of the study were;

1. To develop a national evidence base for the prevalence and incidence of violence against GPs and general practice staff in Australia; and
2. To assess the impact of violence on GPs and general practice staffs' ability to provide quality primary care services.

The study comprised of:

- a comprehensive international literature review,
- consultation with stakeholder organisations,
- qualitative research including focus groups and affinity with GP staff across eastern Australia, and interviews with GPs from across Australia, and
- national online and paper based surveys to assess the incidence and prevalence of patient initiated violence against GPs and GP staff.

The study was advised by a Reference Group made up of representatives of general practice organisations, health practitioners, academics and representatives from the Department of Health and Ageing.

Methodology (Chapter 2)

- Data were collected in five phases and included a literature review, stakeholder consultation, qualitative interviews, focus groups and affinity groups, a national online survey and a paper based survey targeted at particular areas across Australia.

Literature Review (Chapter 3)

- Literature suggests that patient initiated aggression and violence is not unique to general practice staff but affects most health care professionals and other employees working in healthcare services internationally.
- Evidence from the literature suggests that verbal abuse is the most commonly perpetrated form of aggression directed towards healthcare workers, and younger staff are more likely to experience patient initiated aggression and violence.
- Although studies on violence in general practice have been conducted in Australia these have not gathered national data and there are significant limitations with their findings due to the differences in definitions used to enquire about types of patient aggression and violence.
- There are limited empirical data about the experience of general practice staff other than GPs.

Stakeholder consultations (Chapter 4)

- Respondents generally reported that their professional organisations were neither proactive in advocating harm minimisation strategies, nor were they responsive in terms of post-incident support. In some instances, it was beyond the current charter of the organisation to provide

support, and rural and remote organisations were logistically hindered in the support they were able to provide.

- Respondents reported a general sense that professional organisations were not keeping abreast of changes in society and of member needs in the area of patient-initiated aggression in the Australian general practice setting. Respondents acknowledged the need for GP education and training but related limited knowledge of Division of General Practice education in the area of patient aggression.
- Industry accreditation requirements reportedly overlook this issue.

Qualitative interviews, focus groups and affinity groups (Chapter 5)

- A series of focus groups and in-depth interviews were conducted to explore the staff experiences of patient-initiated aggression while working in Australian general practices. The qualitative research did not seek precise identification of the incidence or prevalence of patient-initiated aggression.
- The focus groups and interviews found that some practice staff, including GPs, had not experienced aggressive patient behaviour so believed that precautionary measures were unnecessary.
- Others had experienced patient aggression and/or violence, and believed that all aggression, including verbal aggression, was unacceptable. These practice staff reported a variety of harm minimisation measures that were in various stages of implementation across practices. Staff also reported a range of barriers that hampered optimum measures but generally they believed that some action had been taken to maximise their safety in the workplace.
- All participants agreed that frontline staff were the principal recipients of patient aggression. In addition, participants agreed that drug-affected and drug-seeking patients were the most common perpetrators of aggressive incidents.
- Triggers to patient-initiated aggression included procedural issues such as long waiting times to see a doctor, unavailability of the doctor of choice, and refusal of specific patient-requested medication or treatment. Other triggers of aggression included issues of payment and refusal of bulk-billing.
- Some practices had made effort to protect staff and to minimise the risk of harm through patient-initiated aggression, other practices reported barriers preventing them from taking action in this area. Barriers included the enormous cost of renovating old practice buildings, the cost of purchasing alarms or security devices, and 'head-in-the-sand' attitudes of practice owners.
- Overall, participants agreed that patient-initiated aggression was a problem in general practice, and many staff welcomed education, training, and other measures to maximise their safety, to maintain maximum possible service delivery and to ensure safety for other patients attending their practice.

National online survey (Chapter 6)

Verbal aggression

- Almost all GPs and practice staff had experienced verbal aggression at some stage in their career and 72% of GPs had experienced verbal aggression in the past 12 months. Frontline practice staff experienced verbal aggression more frequently than GPs.

Physical aggression

- GPs more than other practice staff experienced physical aggression with damage to property being most frequently mentioned (29%) over the past 12 months.
- One in five practices had ever experienced property theft or damage and one in ten practices had experienced this over the past 12 months.
- Male GPs were more likely to experience physical assault than female GPs, and full time GPs were more likely to experience physical assault than part time GPs.
- Between 40% and 50% of practice staff had ever experienced physical assault and between 2% and 4% reported having experienced physical assault over the past 6 to 12 months.
- About 10% of practice staff had ever experienced sexual assault.
- Receptionists working at larger practices were more likely to experience verbal aggression and physical assault.

Perceived times of risk

- GPs identified that they were at most risk of aggression when the practice was closing for the day (40%) and when staff were at the practice after hours (31%).
- Practice managers reported that the riskiest times were when the practice had a limited staff on duty (36%) and the times immediately after opening and closing (28% and 27% respectively).

Perpetrators of aggression

- Males were reported as the most likely perpetrators of aggression.

Perceived change in aggression

- Only 25% of GPs reported that patient aggression had become worse in the past 12 months.
- 40% of practice managers reported that verbal aggression had increased in the past 12 months.

Impact of aggression

- GPs most commonly reported that aggression had a negative effect on their emotional wellbeing (38%), and had an impact on service provision (23%) and physical wellbeing (14%).
- Practice managers reported that aggression had caused staff distress (63%) and that there was a need to change practice policy and procedures (58%).

National paper based survey (Chapter 7)

Verbal aggression

- Almost all GPs (88%) had experienced verbal aggression from patient and 58% had experienced such aggression in the past year.
- Practice staff experience verbal abuse most commonly and receptionists experience more of this form of abuse than other staff working in general practice. Twenty one per cent of receptionists experience verbal abuse weekly or more often compared with 9% of practice managers, 4% of practice nurses and 1% of allied health professionals.

-
- Practice staff working in practices with more than one GP reported higher percentages of verbal abuse than those working in solo GP practices.
 - Receptionists, practice managers and practice nurses working in non metropolitan areas experienced more verbal abuse than their counterparts in metropolitan areas.
 - Practice managers were generally unaware of the experiences of allied health professionals across all questions asked in the survey. As such these results should be interpreted with caution.

Physical aggression

- The incidence of physical aggression reported by GPs was highest for damage to or theft of property. 37% of GPs had ever experienced theft or damage to property with 16% experiencing it in the past year. Male GPs, those working full time and metropolitan GPs experienced more frequent property theft or damage compared with their counterparts.
- Few staff experienced property damage or theft with practice managers reporting that 71% of receptionists, 66% of practice managers, 57% of practice nurses had never experienced property theft or damage.
- Most GPs had never been stalked (83%) by a patient, 8% had ever been stalked and 2% had been stalked in the past 12 months.
- Very few practice staff ever experienced stalking.
- 16% of GPs had ever experienced physical assault with 6% experiencing it in the past year, however 81% of GPs had never experienced physical assault by a patient.
- The majority of practice staff had never experienced physical assault, none experienced it weekly or more often and 5% or fewer staff had ever experienced physical assault.
- 19% of GPs had ever been sexually harassed with 7% experiencing this in the past year and over three quarters of GPs had never experienced sexual harassment. More female GPs and younger GPs reported experiencing sexual harassment compared with their counterparts in the previous 12 months and at some time in their career.
- Very few reports of sexual harassment with 80% of receptionists, 70% practice managers, 56% of practice nurses and 47% of allied health professionals never having experienced this form of abuse from patients.
- Sexual assault was the least common form of aggression reported by GPs with almost all (94%) reporting that they had never experienced sexual assault perpetrated by a patient.

Perceived times of risk

- The most commonly reported time when GPs felt at greatest risk of patient aggression was when the practice was closing for the day (25%) and after hours (19%). But almost 60% of GPs indicated that there were no times of particular risk for practice staff.
- Metropolitan GPs (30%) were more likely to identify closing time as a risky period compared with non metropolitan GPs (20%). Similarly to the risks identified at closing time, metropolitan GPs (30%) were more likely to identify the period after closing as staff walked to their cars as risky compared with regional and rural based GPs (20%).

-
- Practice managers identified the times immediately after the practice opened and when the practice was closing as periods of particular risk of patient aggression. However half of the practice managers reported that there were no particular times of elevated risk.

Perpetrators of aggression

- For all forms of aggression male patients were perceived to be the aggressors.

Perceived change in aggression

- 65% of GPs did not think that patient aggression had become worse over the past 12 months and 11% of GPs felt that it had.
- When asked about the changing incidence of patient initiated aggression over the past 12 months 24% of practice managers reported an increase in verbal aggression, 57% saw no change and 9% reported a decrease.

Impact of aggression

- 27% of GPs felt that their emotional wellbeing had been affected by patient aggression and 11% felt it had affected their capacity to provide services. 7% said it had impacted on their physical wellbeing.
- The most common form of negative impact of verbal aggression was staff distress with 57% reporting that verbal aggression caused distress, 37% reported that it had resulted in a change of practice procedures.

Practice safety

- 67% of GPs felt that their practice took the safety of staff seriously although 8% disagreed with this statement. Also 44% agreed that the physical layout of the practice helped minimise the risk of harm from aggression. 43% of GPs thought that the practice had adequate security to minimise harm from patient aggression.
- Almost 60% of GPs disagreed that their practice could not afford to provide adequate security.

Overview

- This first national survey of patient initiated aggression in Australian general practice has clearly identified that verbal aggression is the most commonly occurring form of aggressive patient behaviour and that front line general practice staff are by far the most likely to experience this form of aggression.
- GP organisations in the main do very little to address this issue.
- GPs and practice managers who perceived there were times of increased risk of patient aggression identified practice closing time as the most risky time.
- The majority of GPs did not feel their emotional wellbeing had been affected by patient aggression, whereas the majority of practice managers thought that patient aggression caused staff distress.
- Male patients were perceived to be the main perpetrators of all types of aggression towards general practice staff and GPs.

-
- Triggers of patient aggression include when the practice is short staffed and when GPs are running late.
 - Financial and time constraints were not identified as barriers to improving staff safety.
 - GPs and practice managers who responded to the online surveys reported more frequent patient aggression for all types of aggression compared to those who responded to the paper based survey.

Chapter 1 Introduction

The Australian Government Department of Health and Ageing (DoHA) engaged the Australian Primary Health Care Research Institute (APHCRI) to undertake an evidence-based national study on the prevalence and incidence of patient initiated violence against general practitioners (GPs) and general practice staff in Australia. DoHA identified the need for a better understanding of the impact of such violence on GPs and general practice staff and on their ability to deliver clinical services.

This document reports the findings and outcomes of the study.

Background and policy context

Over the last two decades, occupational violence in general practice perpetrated by patients, patients' family members or friends has been increasingly recognised as an issue for general practice staff internationally.¹ The spectrum of violence is broad and encompasses verbal abuse, intimidation, stalking, physical assault and sexual harassment and abuse.² The potential for patient violence to affect general practice staffs' health and wellbeing is well documented in the most extreme cases. These are commonly featured in the media and have most recently included the murder of a female GP in 2006 who was working in Victoria. While this case brought the issue of patient initiated violence into focus, there is little understanding of the frequency or effect of other types of violence with less obvious outcomes on general practice staff.

A number of regional studies have been conducted in Australia over the last decade which have attempted to document the incidence, prevalence and impact of patient violence on general practice staff. These studies are evaluated in greater detail in the literature review presented in chapter 2. Nevertheless, there has been no national study conducted to date which has determined the national prevalence and incidence of patient initiated violence toward general practice staff. The provision of a national estimate of the frequency that general practice staff encounter threats to their health and wellbeing from violent patients would provide evidence of whether some types of violence are perpetrated more commonly than others. This evidence could be used as a basis to develop policies and procedures to ensure the highest possible standards of safety for all staff, patients and visitors to general practices nationally.

Research aims and strategies

Primary aims

This study aimed to develop a comprehensive understanding of patient initiated violence in Australian general practice. The primary aims were:

1. To develop a national evidence base of the prevalence and incidence of violence against GPs and general practice staff in Australia, and
2. To assess the impact of violence on GPs and general practice staffs' ability to provide quality primary care services.

Secondary aims

The secondary aims were to assess:

1. Trends in the severity of violence against GPs and general practice staff;
2. Trends in frequency of violence against GPs and general practice staff;
3. Type of violence perpetrated against GPs and general practice staff, and

-
4. The effect of violence against GPs and general practice staff.

Major strategies

The major strategies used to meet the research aims were:

1. The compilation of a comprehensive and extensive literature review of relevant national and international literature;
2. Stakeholder consultations with relevant primary care organisations;
3. A national qualitative exploration of general practice staffs' experience of patient initiated violence, and
4. A national online and paper based survey completed by general practice staff to determine the prevalence, incidence and impact of patient initiated violence.

Data collected reflected the experiences of GPs and general practice staff over the previous 12-month period.

Definition of terms

The definition of patient initiated violence employed by this study is based upon a definition developed by the Royal Australian College of General Practitioners.³ Our definition states:

Patient initiated violence includes any incidents where GPs or their staff are abused, threatened, harassed or assaulted by patients, patients' relatives or their friends in circumstances related to their work or where property is damaged or stolen, which involves an explicit or implicit challenge to the safety, well-being and health of the people working in general practice.

For the purposes of this study the terms 'incidence' and 'prevalence' have been used to determine the frequency that patient initiated violence is perpetrated towards general practice staff. More specifically, incidence refers to the rate that patient initiated violent events occur. For example, the number of violent events general practice staff have experienced over a 12 month period divided by the total number of general practice staff of that population. Whereas, prevalence refers to how commonly patient initiated violence occurs towards general practice staff. This is calculated by the number of general practice staff who have ever experienced a violent event divided by the total number of general practice staff of that population.

General practice staff were not considered as a whole entity. Instead, each profession employed within general practices were asked to report their experiences of patient initiated violence. Furthermore, violence was also subdivided into different types. Tolhurst et al. (2003) produced definitions of violence based on an extensive literature review.² These include:

Verbal abuse

A patient, their friend/s or family member/s swears, threatens or uses obscene gestures with the intent of offending you. It can include threats or abuse over the phone.

Property damage or theft

Damage or theft to property belonging to you, your family or your workplace. It includes damage to or theft of a vehicle, personal effects (i.e. personal property at workplace), home contents, medical or office equipment, and supplies, or office furnishings. Attempted theft of the above items is also included.

Stalking

A patient/s purposely stalks or follows you to or from your home or your place of work (i.e. surgery, home visit, or hospital).

Physical abuse

A patient or their friend/s or family member/s physically attacks you. It includes behaviours such as punching, slapping, kicking, or use of a weapon or other object with the intent of intimidating you or causing bodily harm.

Sexual harassment

Any form of sexual propositions or unwelcome sexual attention from patients or their friend/s or family member/s. It includes behaviours such as humiliating or offensive jokes and remarks with sexual overtones; suggestive looks or physical gestures, inappropriate gifts or requests for inappropriate physical examinations, pressure for dates, and brushing, touching, or grabbing excluding the genital or breast area.

Sexual abuse

Any forced sexual act, rape or indecent assault perpetrated by patients or their friend/s or family member/s. It includes brushing, touching, or grabbing the genitals or breasts.

Project overview

The research design for this study was based on the findings from the literature review and the stakeholder interviews. A reference group was also established to oversee the design and conduct of this study.

As outlined in the major strategies (section 1.2.3) this study involved four stages of research. The first stage, the literature review, involved the collection and evaluation of any publications relevant to patient initiated violence in the healthcare workplace. Therefore, this included both peer-reviewed publications and grey literature produced by governmental organisations and departments, international organisations and research institutes.

The second stage, interviews with key stakeholders, occurred concurrently with the literature review. Stakeholder organisations were selected with input from DoHA to represent the range of professions employed in general practice and give voice to those with an interest in primary care.

The findings from the literature review and the key stakeholder interviews were used as a basis to develop the framework for the third stage, the qualitative interviews, focus groups and affinity groups with general practice staff. Consequently, the findings from the qualitative stage were subsequently used to inform and develop the survey conducted in the fourth stage.

In order to ensure the completion of the project within the required time frame, APHCRI subcontracted Campbell Research and Consulting (CR & C) to conduct the interviews, focus groups and affinity groups for the third stage and host the survey.

Interviews, focus groups and affinity groups with GPs and other practice staff provided rich and detailed information about the perceived frequency of different types of violence and the impact on general practice staffs' health and wellbeing. This qualitative stage gathered data from a range of practice staff working in a variety of general practice settings across the country.

The qualitative data indicated that one survey enquiring about all general practice staffs' experience of patient violence would be challenging to complete by a general practice representative. Therefore, the survey was redesigned resulting in two surveys: a very brief survey for GPs and a second longer survey for the practice manager to complete on behalf of the other staff (medical receptionists, practice nurses and allied health staff). In addition, the qualitative data suggested that general practice staff would be more receptive to an electronic survey based online. The surveys were designed to determine the prevalence and incidence of patient initiated violence towards GPs and general practice staff and the impact patient violence may have had on general practice services.

The online format of the surveys subsequently presented unforeseen difficulties which resulted in very poor response rates from GPs and practice managers. The surveys were therefore reformatted into a paper based form, identical in content to the online versions. The paper based surveys were then distributed to a purposive sample of GPs and practice managers nationally.

Summary

DoHA commissioned APHCRI to conduct research into the incidence and prevalence of patient initiated violence in the Australian general practice setting. The four stage project design involved a literature review, key stakeholder interviews, and gathered quantitative and qualitative data about the experiences of general practice staff of patient initiated aggression over the previous 12-month period. Part of the data collection was sub-contracted in order to maintain the timeframe allocated to the project. A thorough national and international literature review informed the qualitative and quantitative aspects of the study, and has enabled comparison of study findings with previous published and unpublished literature. The study will provide the first national evidence base for patient initiated violence in the Australian general practice setting.

Chapter 2 Methodology

Introduction

In 2008, DoHA commissioned APHCRI to undertake an evidence-based national study on the prevalence and incidence of patient initiated violence in general practice. In the interests of maintaining a short timeframe, it was proposed that some sections of data collection be subcontracted to a social marketing research company. Preliminary research design of the project was developed by staff at APHCRI and included a literature review, stakeholder interviews, a qualitative exploration of general practice staffs' experiences and a national survey to determine the prevalence and incidence of patient initiated violence in general practice. A tender was advertised for social marketing companies to complete the qualitative and survey components of the project. CR & C were successful in obtaining the tender and were subcontracted to begin work on the project in January 2009.

The Chief Investigator commenced work on this project in early 2009, with project staff beginning in March 2009. The APHCRI project staff began compiling the literature review and conducting the stakeholder interviews. The findings from the literature review and stakeholder interviews would inform the development of the framework and interview schedule for the qualitative stage. Subsequently, the content of the online survey would be informed by the findings of the qualitative stage. See Figure 1 (pg 27) for an overview of the project design.

A reference group was established to oversee the methodology and to provide critical advice throughout the term of the project. The reference group of nine members comprised experts in the field, representatives from medical and nursing organisations integral to the Australian general practice setting, key personnel from DoHA, from CR & C, and from APHCRI. Three teleconference meetings were scheduled throughout the duration of the study (see Figure 1) with out-of-session business being conducted by email and by telephone as necessary.

Ethics approval

Ethics approval was sought from the Human Research Ethics Committee (HREC) of The Australian National University (ANU) to conduct the qualitative interviews, focus groups and affinity groups and the national online survey. The first application was completed and submitted on the 8th May 2009. The HREC responded with concerns about general practice staff participating in the qualitative stage who may have been traumatised by previous violent events. The committee required that further measures were implemented to support participants should they become distressed during an interview, focus group or affinity group. In addition, as the online national survey was in draft form awaiting finalisation from the qualitative findings, the HREC required submission of the final version of the survey prior to release.

Amendments to the original application were submitted on the 25th May 2009 containing assurances of the implementation of increased support for the participants of the qualitative stage and agreement that the finalised survey would be submitted as a variation to the protocol prior to release. The ANU HREC approved the study on 1st June 2009, protocol number 2009/213.

The first variation was submitted on the 21st September 2009 with the final version of the survey as required by the HREC. This variation request included that two differing surveys be administered: one for general practitioners and one for other general practice staff. Additionally, the qualitative findings had indicated that general practice staff preferred the term 'aggression' to violence so the title of the project and all accompanying documents now referred to patient initiated aggression. This variation was approved on the 22nd September 2009.

After a poor response rate to the online survey, a second variation was submitted to the HREC on the 9th November 2009 to re-run the surveys in a paper based format. This variation was given approval from the HREC on the 10th November 2009.

Statistical Clearing House clearance

As this research was funded by the Australian Government, the survey required clearance from the Statistical Clearing House (SCH) of the Australian Bureau of Statistics (ABS). The initial SCH scoping template was completed and submitted and APHCRI was subsequently advised that the full SCH information template was required. After submission of this template, the SCH advised that the survey did not need to go through the SCH approval process. The SCH considered that the survey was being conducted through non-direct contact as survey respondents were being approached by a generic email which did not specifically target any individual respondent or practice. Although the survey did not require their approval, the SCH provided suggestions for the development of the survey tool.

Stage 1: Literature review

An extensive search of the literature was undertaken to identify relevant peer-reviewed publications, grey literature and any reports, training manuals, or publications produced by organisations addressing violence in the general practice workplace. In addition, to place information about violence towards general practice staff within a broader context, literature was also collected to offer an insight into occupational violence experienced by other health care professions such as nurses, hospital-based doctors, paramedics and other emergency services personnel.

Publications were collated by searching Web of Science (ISI), Medline, PubMed, CINAHL PLUS (EBSCO) and SCOPUS using the terms: primary health care, general practice, family practice, violence, patient initiated violence, occupational violence, and aggression. Publications and reports addressing violence in general practice were collected from organisations such as the Royal Australian College of General Practitioners, the Australian General Practice Network, the State Based General Practice Organisations, and the local Divisions of General Practice (DGP). In addition, the Primary Health Care Research and Information System (PHCRIS) online database, the Roadmap of Australian Primary Health Care Research, was searched to identify any other projects which were investigating patient initiated violence in Australian general practice .

The literature reviewed encompassed both grey literature and peer reviewed publications. The grey literature was sourced directly and indirectly from all Australian DGP, through State-Based Organisations (SBOs) of general practice, and through the Australian General Practice Network (AGPN). Stakeholders also provided information leading to sources of grey literature.

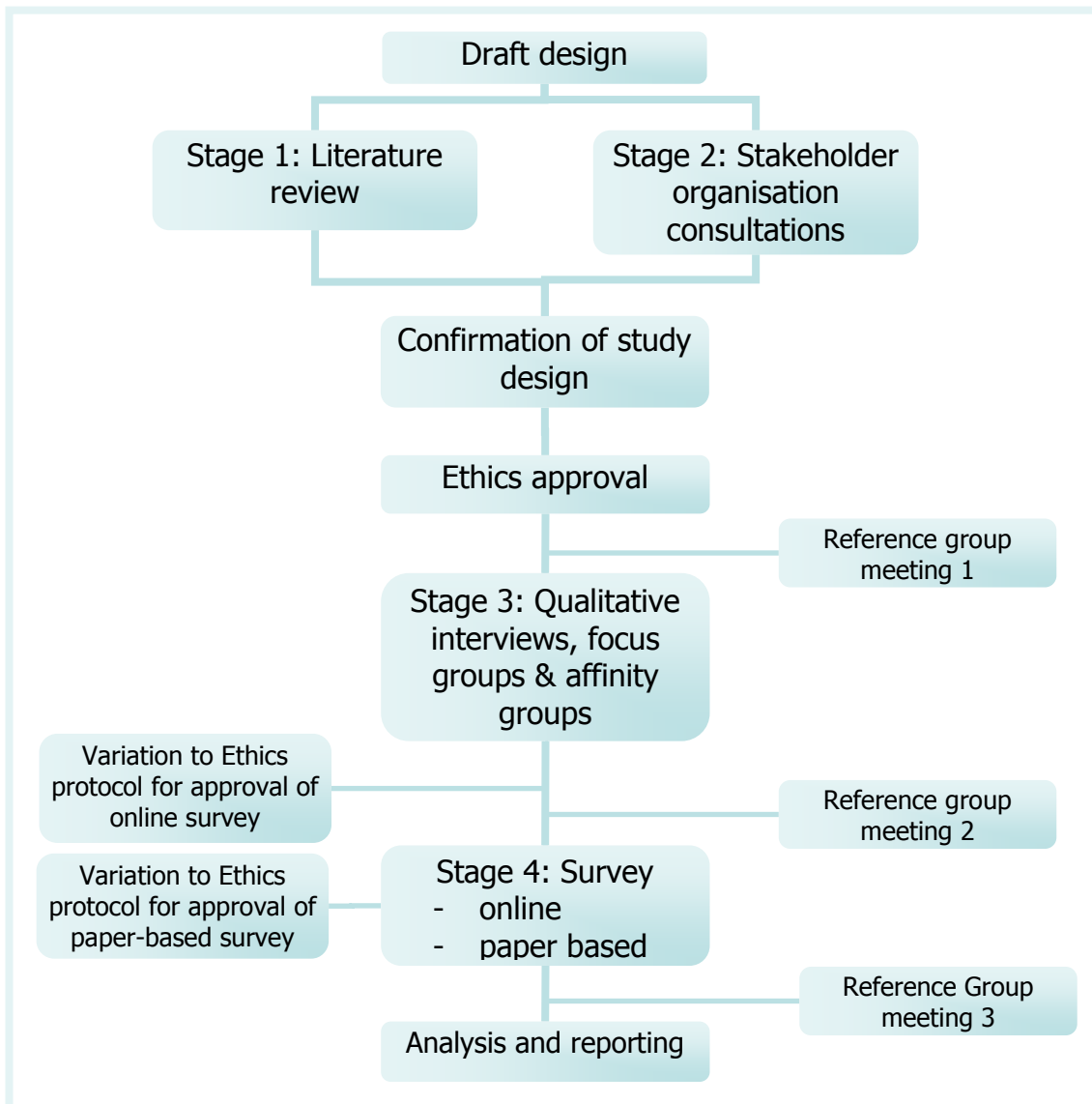


Figure 1: Schematic diagram of study design

Stage 2: Stakeholder consultations

The Stakeholder Group

APHCRI and DoHA jointly agreed the composition of the Stakeholder Group (Appendix G). The Australian Salaried Medical Officers Federation excluded themselves from the study as their membership comprises only salaried medical officers and not GPs. The Royal Flying Doctor Service did not perceive patient initiated violence to be an issue for their service and were therefore also excluded from participation in the stakeholder interviews.

The interview process

Each stakeholder organisation nominated a representative to be interviewed. The semi-structured interview (Appendix H) sought organisational views on patient, family, or relative-initiated violence in the general practice setting and to identify any relevant grey literature. In addition, the interview sought each organisation's support for dissemination of project information with a view to improved participation in the survey forming the fourth stage of the study.

All interview questions were open-ended, allowing the respondent to diverge from the interview themes as necessary to thoroughly convey organisational perspectives relating to the study. The interview themes covered each organisation's perception of patient, family or relative-initiated violence in the general practice setting, and the organisation's response to this violence. The interview

explored the extent, types, and patterns of violence and sought information on the organisations' views on the causes of workplace violence and on their response in terms of member support.

Data analysis

Interviews were digitally recorded and sent for transcription by a professional transcription agency. Transcribed interviews were imported into the NVivo 8 software for qualitative analysis. The following themes were identified from the data:

1. Stakeholder interviewee's perceptions of violence;
2. Organisational response;
3. DGP activity;
4. General practice-level response to violence, and
5. Incidents of violence reported by stakeholder respondents.

Some data searches were exported into Microsoft Excel for further analysis and to allow the development of charts and graphs.

Stage 3: Qualitative interviews, focus groups and affinity groups

The purposes of the qualitative research component of this project were to:

1. provide in-depth qualitative perspective of the issues from the general practice level, and
2. develop and refine the framework of key issues relating to patient initiated aggression in general practice to inform the development of the online survey.

The key related issues that were explored through this qualitative research, included:

- participants' experience of patient initiated violence in general practice (causes or triggers, contexts, and short-term management);
- the effects of the aggression, personally and on service delivery;
- the processes involved in the identification and reporting of aggression; risk assessment and associated problems; the interface with Occupational Health and Safety (OH & S) systems and requirements; and the role of the practice manager, OH & S and GPs in these processes;
- strategies developed and implemented to prevent, minimise and manage patient initiated aggression, and the effectiveness of those strategies, and
- the barriers and facilitators to adopting those strategies.

Sampling strategy

Staff working in general practices were recruited to participate in interviews, focus groups and affinity groups. Potential participants were recruited from purposively sampled DGP in four states. Seven DGP were selected from Victoria (n=2), New South Wales (NSW) (n=2), Queensland (n=2), and the Northern Territory (NT) (n=1). Purposive sampling of the seven DGP ensured representation of participants who reside and work in both urban and rural locations, and provide care for patients of varying socio-demographic status.

CR & C endeavoured to conduct a total of eight focus groups: one in each DGP with the exception of General Practice Network NT (GPNNT) where two focus groups would be conducted. The focus groups were planned to have a total of eight to ten participants per group. In addition, one affinity group per state was planned which would involve four to five participants recruited from the same general practice. Finally, Cr & C planned to conduct 20 interviews with GPs, either in person or via telephone. Additional telephone interviews were conducted with GPs located in South Australia (SA), Tasmania

and Western Australia (WA) to ensure representation from other states. See Appendix I for the distribution of interviews, focus groups and affinity groups.

Recruitment

CR & C sub-contracted Market Metrics, an accredited fieldwork supplier to conduct recruitment of participants. CR & C also used a number of avenues to select research participants independently, including cold calling and using the DGP websites.

Research techniques

Focus groups with practice staff

Focus groups were conducted in the evenings using specialised market research focus group venues, DGP meeting rooms, local motels, conference centres and other similar venues. Each focus group was scheduled to take up to 90 minutes. Light refreshments were provided, and attendees received a financial incentive of \$100 each to compensate for their time.

The composition of focus groups was structured to represent a broad cross-section of general practice staff, and of practice contexts and catchment areas within a DGP. Ideally, each focus group included practice nurses, allied health professionals, practice managers and practice receptionists; staff from hours services, co-located practices, deputising services, solo practices, group practices, and corporate practices; and represented varied socio-economic status of patient catchment area and client mix.

Affinity groups with practice staff

In some geographical areas, smaller staff numbers determined that it was not possible to form standard-sized focus groups of eight to ten participants. In these instances, affinity groups were established as the tool through which to capture the data. Affinity groups may have been drawn from one general practice. Each affinity group was designed to last 90 minutes, with about four attendees. As with the focus groups, light refreshments were offered, and attendees received a financial incentive of \$100 each to compensate for their time.

In-depth interviews with GPs

Where possible, general practitioners were interviewed in person. Telephone interviews were conducted with general practitioners where geographical isolation or time constraints prevented a personal approach. Individual interviews lasted between 30 and 60 minutes, and a financial incentive of \$200 compensated for the loss of income incurred through the general practitioners involvement in the interview.

General practitioner interviews aimed to capture information from a broad cross-section of practitioner demographics, including: a range of roles (practice principle, associates, GP employee); gender, age group, years of experience as a general practitioner, and overseas qualified practitioners.

The research tool

All focus groups, affinity groups and individual interviews were conducted by senior staff of CR & C. The broad areas covered within each consultation were designed to draw the information required for the study. The key issues explored through this qualitative research included:

- participants' experience of violence in the general practice (causes or triggers, contexts and consequences and short-term management);
- the impact on those who have directly and indirectly experienced the violence and the impact on the ways in which affected practice staff provide care and service;
- the processes involved in the identification and reporting of violence; risk assessment and associated problems; the interface with OH & S systems and requirements; and the role of the practice manager, OH & S officer and GPs in these processes;

- strategies developed and implemented to prevent, minimise and manage such violence and the effectiveness of those strategies, and
- the barriers and facilitators to adopting those strategies.

The consultation guide (Appendix C) was developed jointly by CR & C and APHCRI. The process of each research activity was:

1. Introduction
 - Project background
 - Definitions of violence being used by the study
 - Format of the session
 - Reporting (de-identification of the data and confidentiality)
 - Distress protocol
 - Signing of consent forms
 - Group rules/protocol
2. Participant introductions
3. Experiences of violence: causes, context, consequences, management, perceived trends
4. Impact of the violence upon staff and on others in the vicinity
5. Processes: identification and reporting of violent behaviour
6. Strategies: violence recognition, minimisation, management, education and training
7. Successes: outcomes of the general practice strategies or actions
8. Conclusion

Following participant agreement, each session was audio recorded. The CR & C Privacy Policy was observed, and participant confidentiality was maintained as per ethical requirements. Data were analysed after de-identification. CR & C provided raw data and data analysis to APHCRI in keeping with ethics requirements and with the DoHA contractual agreement.

Data analysis technique

All interviews and focus group recordings were transcribed for analysis. The qualitative data were analysed manually by one of the CR & C researchers who also conducted the interviews and the focus groups. The researcher selected the key study themes – type, frequency and impact of violence – and sought data from the transcripts that reflected these themes. The researcher also captured data reflecting types of language, and matched all study themes across the various staff types. Identified data were then listed in groups and the groups of data informed the study findings and the subsequent development of the survey instrument.

Stage 4: National survey

The development of the national survey was informed by the results from stage 3: the qualitative stage. The findings from the qualitative stage suggested three changes to the national survey. The first was that general practice staff would be more receptive to an online survey rather than a paper based survey and it was perceived that this approach would result in a positive response rate. Secondly, producing a separate, shorter survey instrument for GPs would maximise GP response rates. Thirdly, general practice staff preferred the use of the term 'aggression' which was perceived as being more relevant than 'violence'.

Development of the survey instruments

A range of information was gathered to inform the development of the survey instruments. Findings from the literature review included information about surveys examining patient initiated violence in general practice that were previously conducted in Australia. The authors of these studies were contacted and provided their survey instruments as examples. Other results from the literature review together with findings from the stakeholder interviews provided further information for the survey

development. In addition and in collaboration with CR & C, the findings from the qualitative data were incorporated in the development process.

The draft survey instruments were released to the reference group members for comment. The members provided feedback on the content of the surveys, some of which was incorporated into the surveys.

Cognitive testing of the instrument

CR & C undertook cognitive testing of the survey instruments to ensure the content of the survey was understandable and the questions were readily answerable. A small sample of general practice staff located in Melbourne were selected to participate in the cognitive testing.

Three GPs and three practice staff participated in the 'cognitive testing'. Four of these interviews were conducted face-to-face, two were conducted via telephone.

Overall, participants reported that the survey instruments were effective and meaningful to GPs and practice staff. Using this approach, CR & C were able to identify a small number of issues that informed further refining of the survey instruments:

- The survey instruments were thought to be too long and repetitive and likely to impose unnecessary burden on both GPs and practice staff. As a result, unnecessary items were culled from the draft instrument.
- The scale used to assess the incidence of aggression was thought to be problematic. Several revisions were developed to ensure that the scale could be answered easily by participants.
- The explanations provided for each type of aggression were confusing for some participants. These were edited for clarity and conciseness.

The cognitive testing confirmed another of the qualitative findings in relation to the use of the word 'violence'. The word was off-putting for some, and some GPs and practice staff did not immediately relate to their experiences to the term 'violence'. The term 'aggression' was thought to better fit these experiences and subsequently was used throughout the survey.

Cognitive testing respondents raised issues regarding the most effective means of administering the practice survey. Two options were considered: Sending a single survey to the practice manager (or equivalent) who would respond on behalf of other practice staff; or sending a survey to the practice manager to distribute among practice staff for response on an individual basis. Some practice managers indicated that they would be willing and able to respond to the survey on behalf of the practice without the need to consult or refer to an incident register. While this option could reduce the potential input of other practice staff, more importantly it could increase the overall survey response rate. This option emerged as the preferred option.

Following the above survey adjustments by CR & C, APHCRI submitted the final draft survey to the HREC as an amendment to the overall project (Figure 1). The approved survey instruments are at Appendices D and E.

Online pilot testing of the instruments

CR&C released survey links to one DGP for online pilot testing of the draft survey. The pilot test received only one response while it was live in the field indicating the need for a wide marketing strategy to encourage a better response rate for the survey.

Marketing strategy

The APHCRI marketing and communications consultant assisted with the development of a marketing and publicity strategy. This strategy included press and other media releases and radio interviews

through national, regional and local networks across Australia. APHCRI placed project information into RACGP Faculty newsletters where their release dates were favourable with project timelines. A summary of the marketing strategy is at Appendix F.

Dissemination of online survey

The first approach executed to distribute the links to the online survey to general practice staff was via the Australian General Practice Network (AGPN) to the State Based Organisations (SBOs) and onto the DGP (see Figure 2).

APHCRI provided project information via verbal report to the CEOs of each State-based Organisation (SBO) attending an AGPN meeting and also via emails sent in June and September 2009. SBO CEOs attending the AGPN meeting agreed to disseminate project information for publication in SBO newsletters and in emails to DGP. They also agreed to disseminate the survey links when these became available in October 2009. This structure of survey distribution is depicted in Figure 2 **Error! Reference source not found.** Two weeks following the issue of project information to SBOs, APHCRI staff telephoned at random one rural and one metropolitan DGP in each state and territory of Australia (16 DGP). No DGP had received any information from their respective SBO but this may reflect organisational issues rather than SBO non-compliance.

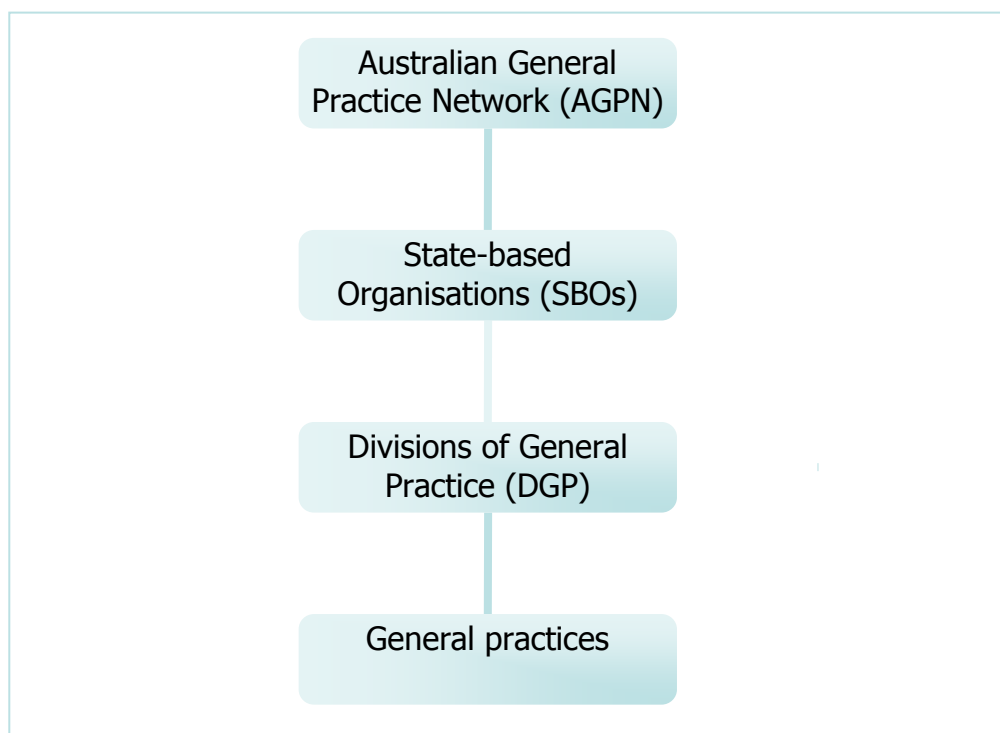


Figure 2: Schematic diagram of first survey distribution technique

The results of the project information dissemination by SBOs led APHCRI to develop an alternate recruitment strategy. With the assistance of PHCRIS, APHCRI were provided with the national list of DGP containing contact details of all chief executive officers. APHCRI staff then contacted all DGP by telephone to discuss the impending release of the national online survey. All DGP were asked to assist with recruitment by publishing information about the project in newsletters, faxes and emails to their members.

All DGP agreed to disseminate project information and subsequent survey links to the practices within their DGP, and many DGP provided the contact details of the most appropriate staff member within the DGP to receive information about the survey. Only one DGP, located in NSW, requested payment to disseminate project information.

DGP distributed the link in a number of ways, including:

-
- via e-mail;
 - via hard-copy newsletter (faxed and postal) which would require the GP or practice staff to manually type the URL of the survey website into an internet browser, and
 - by placing the link on their website.

As it was not possible to determine either the means by which links were distributed or the number of links distributed, it was not possible to determine a response rate to the surveys.

Completion of the online survey

The online survey was live for five weeks during which time practice staff and GPs could access the survey website using a web browser to complete the survey. CR & C provided online survey support to respondents who registered difficulty in accessing the survey, typically due to incomplete survey links.

CR & C provided regular updates of response rates according to DGP. APHCRI re-contacted DGP that registered no or low response rates according to daily CR & C reports.

Analysis of the online survey data

The online survey closed on 24th November 2009. CR & C were responsible for the data analysis and preparation of a report containing the survey results. At the close of the online survey, a very poor response had been received from general practice staff and GPs.

Data gathered through the online survey proved insufficient to inform this study. As there are an estimated 22,965 GPs practicing in Australia,⁴ receiving 178 online GP survey responses is a very poor response. Likewise, there are an estimated 7261 general practices nationally;⁴ therefore receiving 150 online practice manager surveys is also a poor response. Although not incorporated in the initial study design and methodology, a targeted paper-based survey was planned to gather additional GP and practice staff data nationally.

Development of the paper-based survey instrument

A second variation to the ethics protocol was submitted and approved by the ANU HREC. As the CR & C contract had expired, APHCRI took responsibility for conducting the paper-based survey. The paper-based survey instruments replicated the online surveys in content. This provided consistency in the data and reporting. A separate cover letter was prepared for each of the GP and the Practice Manager surveys which stated that GPs and practice managers were not to complete this survey if they had already participated in the online version of the survey.

Dissemination of the paper-based survey instrument

Nineteen DGP were purposively selected nationally. Three DGP were each selected from Victoria, NSW, Queensland, SA and WA. DGP in these states were selected to represent urban, rural and remote areas using the Rural, Remote and Metropolitan Areas (RRMA) classification system. States and territories such as ACT, NT and Tasmania only have one or two DGP, therefore these DGP were all included in the dissemination strategy. Every state and territory was represented in this dissemination strategy (Appendix A).

The paper-based surveys were mailed to all GPs and practice managers working in general practices that were located within the 19 DGP catchment areas. A mailing list of all the GPs and practice managers' postal addresses in the 19 DGP was purchased from the Australian Medical Publishing Company (AMPCo). The ANU print room printed and posted the paper-based surveys and reply paid envelopes were included to maximise the response rate. The survey was in the field for over two weeks, during which time a reminder post-card was mailed to all GPs and practice managers that had

been sent surveys.

Data analysis

Data were manually entered into an electronic database and analysed using SPSS. The SPSS database for the paper-based survey was constructed to be identical to the online survey database provided by CR & C. This enabled ease of comparison of data between the online and paper-based survey.

Study limitations

The primary limitation of this study was the poor response rate received for the online survey. There were two factors in this response: 1) the lack of uniformity in the use of computers and internet technology in general practices nationally, and 2) problematic electronic links to the online survey. This second factor arose due to CR & C failing to pilot the survey online as was planned in the methodology. As a result of this, APHCRI staff received nine telephone calls and a number of emails from potential participants reporting difficulty either accessing or completing the online survey. It is unknown how many potential participants were unsuccessful in completing the survey and did not report their difficulties to CR & C or APHCRI. Nevertheless, APHCRI endeavoured to address this shortcoming by re-conducting the survey with GPs and practice managers.

Response bias from GPs or practice managers whose practice staff had experienced extreme patient initiated aggression had the potential to skew the results. Conversely, those who have experienced none or very little patient initiated aggression may not have returned the survey. Additionally, the stakeholder interviews revealed that personal respondent definitions of what constitutes aggression or violence also influenced the individual perception of whether or not aggressive or violent behaviour had occurred. Several respondents regarded patient initiated aggression as inherent in the nature of general practice work. For these respondents, patient initiated aggression was considered as part of their role and not a remarkable issue. Respondents adopting this approach may report minimal if any incidents of aggression.

Summary

An initial project design was planned to include four stages of data collection: 1) literature review, 2) stakeholder interviews, 3) qualitative interviews, focus groups and affinity groups, and 4) a national survey. A reference group was established to guide the further development of the project design and methodology, and ethics approval was gained from the ANU HREC to conduct the qualitative stage and the national survey.

As the online surveys received a poor response rate, the methodology was amended to re-conduct the surveys in paper-based form.

Chapter 3 Literature review

General practice workforce in Australia

The general practice workforce most frequently comprises general practitioners (GP), practice nurses, practice managers and medical receptionists. However, professionals that staff general practices in Australia vary according to regional needs and staff availability, and may also include allied health professionals and visiting medical specialists. In 2007 – 2008, according to DoHA and the Primary Health Care Research & Information Service (PHC RIS), there were an estimated 22,965 to 24,903 general practitioners working in Australia.^{4, 5} The total number of general practices in Australia in 2007 – 2008 was 7261.4. Moreover, in 2007 the Australian General Practice Network estimated on the basis of a national survey, that there were 7728 nurses working nationally in general practices.⁶ There are no national data available regarding the number of medical receptionists, practice managers and allied health professionals who work in Australian general practices.

Patient initiated aggression and violence towards general practice staff

Over the last two decades, occupational violence in general practice perpetrated by patients, patients' family members or friends has been increasingly recognised as an issue for general practice staff internationally.¹ In reality, it is not only general practice staff who are at risk from patient aggression and violence, but it is recognised that all health care workers may experience patient aggression and violence directed towards them during their career.⁷⁻⁹ For this reason, there have been many international and domestic declarations and recommendations made about workplace safety for individuals working in the healthcare sector.^{7, 10-13}

The Royal Australian College of General Practitioners (RACGP) has adopted the definition of workplace violence as defined by a joint international programme involving the International Labour Office, the International Council of Nurses, the World Health Organization, and Public Services International as adapted from the European Commission:

"Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health"^{2, 7}

This definition encompasses various forms of aggression and violence towards general practice staff including verbal abuse, threats, intimidation, stalking, physical abuse, and sexual harassment and abuse perpetrated by patients, patients' family members or friends. Additionally, most extreme and highly publicised are the four GPs who have died over the last 12 years in Australia as a result of patient perpetrated violence.¹⁴ However, there are no national Australian data of the prevalence and incidence of violence experienced by general practice staff. Nevertheless, studies have been undertaken which have investigated GPs, medical receptionists, and other health professionals' experiences of violence in Australia, the United Kingdom (UK) and the United States of America (USA). In addition, there are many commentaries illustrating and discussing violent incidents experienced by GPs and other health professionals. The following literature review examines the available information about violence in general practice in Australasia, Europe, the UK and the USA.

Exploration of patient initiated aggression and violence in general practice

Australia and New Zealand

There have been four of empirical studies conducted in Australia and one in New Zealand which have collected data on the prevalence and incidence of violence in general practice (see Table 1 on pg 37).^{2, 15-18} These studies have predominantly included GPs collecting both qualitative data through interviews and focus groups and quantitative data through surveys.^{2, 15, 16, 18, 19} However, Magin et al. (2009) more recently conducted interviews with medical receptionists working in general practices about their experiences of patient aggression and violence.¹⁷ Nevertheless, there have not been any Australian or New Zealand studies conducted which involved other general practice staff such as practice nurses, practice managers, or any allied health staff or medical specialists who also provide services within general practices. The studies have all involved retrospective methodologies where participants are asked to recall violent incidents from the 12 months prior to participation and some additionally enquired about violent incidents experienced during their careers.

Methods of data collection and definitions of violence

Tolhurst et al. (2003) undertook the first Australian study investigating violence perpetrated by patients, patients' family members or friends towards GPs. Tolhurst and colleagues designed a two stage mixed methods approach involving focus groups and a questionnaire.^{2, 20} The focus groups and a literature review were used to define six types of violence: 1) verbal abuse, 2) property damage or theft, 3) stalking, 4) physical abuse, 5) sexual harassment, and 6) sexual abuse.² This same methodology and definitions of violence were also used by subsequent Australian studies conducted in New South Wales by Magin and colleagues and in Victoria by Koritsas and colleagues. The latter, however, did not use qualitative focus groups.^{16, 18} In addition to the definitions used by Tolhurst et al. (2003), Magin et al. (2005) also included threats and slander¹⁸, and Koritsas et al. (2007) included intimidation.¹⁶ Alexander et al. (2004) conducted a multidisciplinary survey including GPs and also used similar definitions but excluded property damage or theft, and instead included obscene behaviour, threatening behaviour and threats made over the telephone.¹⁵ In contrast to these studies, Gale et al. (2006) conducted a national questionnaire in New Zealand.²¹ This study used some similar definitions but also added threats to the GPs' family, sexualised touching, assault and vexatious complaint.²¹ For an overview of the definitions used in the studies, please see Table 2 on pg 38.

Geographic attributes

The Australian GPs who participated in these studies were recruited from differing locations, with one study focussed on rural, another on urban GPs and the third study recruited GPs from both rural and urban areas (see Table 1). Despite the differences in geographic location of participants, a comparable number of GPs, 73 – 75%, from urban and rural areas experience some form of violence over the duration of their careers.^{2, 18} This was confirmed by Koritsas et al. (2007) who found no evidence of any significant difference between the number of urban and rural GPs who experienced violence in the previous 12 months.¹⁶

Types of violence experienced

A comparison between the types of violence experienced by GPs over a 12 month period reveals similarities in findings between the three Australian studies and some differences from New Zealand (see Table 2). Commonalities in percentages of Australian GPs who experienced verbal abuse, property damage or theft, physical abuse, sexual harassment and sexual abuse in a 12 month period are evident despite these studies drawing their participants from various regions and in different years.^{2, 16, 18} In addition, studies that compared the percentage of female to male GPs' experiences of different types of violence found significantly more female GPs were sexually harassed compared with male GPs within a 12 month period.^{2, 16, 21} Magin et al. (2005) also demonstrated that significantly more female GPs (75%) compared with male GPs (25%) experienced high level violence, which includes physical abuse, stalking, sexual harassment and sexual abuse, over a 12 month period.¹⁸

Overall, within a 12 month period, between 57 and 64% of GPs reported experiencing some form of violence.^{16, 18}

Table 1. Details of studies examining patient aggression and violence conducted in Australia and New Zealand

	Australia				New Zealand
First author	Tolhurst	Alexander	Magin	Koritsas	Gale
Year	2003	2004	2005	2007	2006
No. of participants	314	85	528	211	1205
Response rate	51.8	61.2	48.7	21.1	52.2
% of female participants	29	36	49.6	34.7	35.5
Recruitment areas	Rural WA Rural Division of GP in NSW Rural Division of GP in VIC	Rural northern area health service NSW	Urban NSW	Metropolitan, regional and rural VIC	National New Zealand

Precipitants of violence

Aside from general practitioner gender, several other factors have been identified as precipitants of different types of violence. Koritsas et al. (2007) identified that GPs who work longer hours are more likely to be verbally and physically abused, and those who have less experience working as a GP are more likely to experience intimidation.¹⁶ Magin et al. (2008) categorised the causes of violence into three groups: underlying causes, proximate causes and GP vulnerability.²² Underlying causes of violence encompasses both individual patient and societal causes, and factors identified are common between studies.¹⁸ A number of individual factors predispose patients to become perpetrators of violence include being male, experiencing psychiatric illness, using or seeking illicit drugs, being under the influence of alcohol, and having sexual motivations.^{2, 22} Proximate causes include frustrations that patients encounter when trying to access medical care such as waiting times and denial of access to care, and a failure on the part of the GP or the practice to discourage or deescalate violent situations.²² The third category, GP vulnerability, arises from GPs' perception that they are at substantial risk from occupational violence due to their duty to care for all individuals of the community.²²

Timing and location of violence

The time and location for incidences of violence to occur may vary according to the type of violence perpetrated. Tolhurst et al. (2003) found that the GPs practice is the most common location for verbal abuse, property damage or theft, stalking and sexual harassment, whereas hospitals and multi-purpose centres are the most common locations for physical and sexual abuse.² Violent incidents occur both during business hours and when providing after hours care.^{2, 18} However, high-level violence has been found to occur significantly more after hours when providing home visits.

Perception of risk of violence

GPs assessment of the risk of violence, while determined by the physical environment of the consultation and the individual characteristics of the patient and the GP themselves, is ad hoc and is frequently based on the GPs' instinct or intuition.²³ In accordance with these factors, notably the physical environment of the consultation, after hours care is perceived by GPs as inherently dangerous to their personal safety.^{19, 24} This perceived risk has caused some GPs to reduce their provision of after hours care and home visits.^{19, 24} Magin et al. (2006) went on to further characterise GPs responses to violence or the risk of violence by developing a tri-level schema. This schema ranged from proactive to reactive actions where primary strategies avoided violence or aggression, secondary strategies prevented aggression and de-escalated potentially violent situations, and tertiary strategies dealt with established violence.²⁵

Table 2. Types of patient initiated aggression experienced by General Practitioners within a 12 month period in Australia and New Zealand

Type of aggression	Australia				New Zealand
	Tolhurst et al. (2003)	Alexander et al. (2004)	Magin et al. (2005)	Koritsas et al. (2007)	Gale et al. (2006)
	%	%	%	%	%
Emotional					
Verbal abuse	45.5	62	42.1	44	15.4
Intimidation	-	-	-	22	11.5
Obscene behaviour	-	24	-	-	-
Threatening behaviour	-	49	-	-	-
Threats	-	-	23.1	-	(included with verbal abuse)
Threats made over the telephone	-	28	-	-	-
Threats to family	-	-	-	-	1.7
Slander	-	-	17.1	-	-
Vexatious complaint	-	-	-	-	7.1
Physical					
Property damage or theft	24.2	-	28.6	23	3.0
Physical abuse	3.2	21	2.7	3	3.5
Injury	-	-	-	-	0.8
Stalking	2.5	**	3.0	-	1.9
Sexual					
Inappropriate touching	-	-	-	-	1.7
Sexual harassment	8.6	**	9.3	8	6.2
Sexual abuse	0.3	**	0.2	1	-

- Not measured in survey

** Measured in survey but results not included in publication

United Kingdom

A number of studies have been conducted in the United Kingdom and Northern Ireland since 1989 investigating violence in general practice. While most studies focused on general practitioners or medical specialists as a whole, there have been three studies which specifically address violence towards medical receptionists working in general practice.²⁶⁻²⁸ Overall, most of the studies originate from various metropolitan and regional areas of England,^{26, 28-33} with two others drawing participants from Northern Ireland.^{27, 34} The Health Policy and Economic Research Unit of the British Medical Association conducted one of the studies in Northern Ireland using the same survey instrument they used four years previously in England.^{30, 34}

Incidence of violence

The incidence of violence experienced by general practitioners in the UK and Northern Ireland is difficult to ascertain due to reporting differences between overall or specific types of violence, and

variations in the time periods for which data was collected. Nevertheless, the consistent use of a survey instrument by the BMA resulted in similar findings where the incidence of violence experienced by general practitioners in the UK and Northern Ireland over a 12 month period was between 44 and 46% despite the surveys being conducted four years apart.^{30, 34} In contrast, a study conducted in 1991 found 63% of GPs recruited from the West Midlands had experienced violence in the previous 12 months.³¹ Whereas, another study also published in 1991 recruited GPs from a wider catchment area from London to Edinburgh, found 54% had experienced violence over an unspecified number of years.³² The percentage of Irish medical receptionists working in general practices who experienced violence was found to be 62% over an unspecified time period.²⁷

Types of violence experienced

The most commonly experienced type of violence directed towards general practitioners and medical receptionists is consistently reported to be verbal abuse. The highest reported percentage for verbal abuse stemmed from a postal questionnaire published in 1989 which found 91% of GPs practicing around Birmingham had experienced verbal abuse.³⁵ While other studies have reported lower percentages of verbal abuse between 54 and 75%, these incidences are still markedly higher than Australian findings.^{27, 29, 33} Other forms of abuse such as physical and sexual are reported less frequently, but studies that have included these figures demonstrate that these incidences of violence occur less frequently than verbal abuse.³⁵

Policy response

Concern about violence perpetrated towards general practice staff resulted in the introduction of a zero tolerance policy by the National Health Service (NHS) in the UK.³⁶ The predominant message of this policy to NHS staff and to the public was that 'attempts to intimidate should no longer be accepted as an occupational hazard'.³⁶ A number of studies either explored the impact of this policy on the incidence of violence or asked participants their views on the policy. In general, the introduction of the zero tolerance policy resulted in no change to the frequency of violence experienced by GPs. Additionally, many GPs viewed a zero tolerance approach to perpetrators of violence as incompatible with their practice due to their professional responsibility to care for all individuals in society, and instead used discretion towards patients who may be more prone to perpetrating violence due to mental illness.^{29, 34}

Perceptions of risk

General practitioners who have experienced violence readily identify that perpetrators of violence are usually male and are frequently patients who have a drug addiction, are under the influence of alcohol or experience mental illness.^{29, 31, 32} The location of the general practice has been found to be significantly associated with the risk of violence, where inner-city or urban estates compared to rural areas, and areas with a higher level of deprivation are associated with an increased risk of violence.^{28, 29, 33, 35} Substantiating this are the findings from a study conducted by Ashworth & Armstrong (1999) that found the fear of violence is a cause of stress for new GP practice principals in inner-city London.³⁷

Fear of violence in the future is frequently experienced by GPs who have already experienced a violent incident, which is compounded by the unpredictability of the occurrence of violence.^{32, 38} Hobbs (1994) found that 58% of GPs were fearful while consulting in their practice and around 75% experienced fear during evening and night calls.³⁸ Similarly, receptionists who had experienced violence at work were significantly more likely than their peers to fear potential future violence.²⁶ GPs who were trained in India or Pakistan had a higher mean level of intimidation during visits at any time of day or night.³⁸ Receptionists who had received training or felt safe and supported in their work place were less likely to fear violence.²⁶

Support and reporting after a violent incident

There is little information about support provided to general practice staff after experiencing violence or how frequently violent events are reported to authorities or professional bodies. Chambers and Kelly (2006) found that generally the only type of support provided to medical receptionists after a

violent incident was from their peers.²⁷ However, the receptionists reported that this support was not provided from their peers very frequently.²⁷ In addition, few receptionists worked in general practices where a policy was in place which addressed violence or had received education about violence in the workplace.²⁷ This lack of acknowledgement of the occurrence of violence is further compounded by significant underreporting of patient initiated aggression and violence by GPs and receptionists.^{30, 32, 34}

North America

There is not a large body of evidence from the United States of America or Canada examining patient initiated aggression and violence towards general practice staff. Of the two studies that have been conducted, one focuses on the sexual harassment of female GPs by patients.³⁹ Phillips and Schneider (1993) mailed a survey to a random sample of female GPs in Ontario, Canada, finding more than 75% had experienced patient initiated sexual harassment during their careers.³⁹ The second study conducted recently in Canada by Meidema et al. (2009) aimed to explore harassment and abusive encounters between family physicians and their patients as well as with other colleagues in the workplace.⁴⁰ This qualitative study had a broader scope by including horizontal workplace violence between colleagues, but found that younger, female GPs who work in more rural areas are more at risk of experiencing violence than their older, male counterparts.⁴⁰

Despite this lack of empirical evidence from North America, patient initiated aggression and violence is clearly an issue, as Sampson and Achololnu Jr (2004) described the introduction of urine toxicology screening for illicit substances.⁴¹ Patients who returned positive tests for illicit substances were referred to substance abuse counselors for substance abuse therapy.⁴¹ As a result of the introduction of this screening measure, the incidence of patient aggression and violence has reduced at this general practice.⁴¹

Europe and the Middle East

In more recent years, there have been five studies published originating in Europe and the Middle East examining patient aggression and violence towards GPs.⁴²⁻⁴⁵ Both Ayranci et al. (2006) and Aydin et al. (2009) conducted studies in Turkey. As Aydin et al. (2009) explains: *'In Turkey, graduates of medical schools are labeled GPs and have the practicing license without postgraduate training.'*⁴² Aydin et al. (2009) received 522 responses from GPs (response rate not provided) and found that 83.7% of female GPs and 82.2% of male GPs had experienced patient aggression and violence during working hours.⁴² They also determined that younger GPs were more likely to experience aggression and violence than GPs older than 45 years of age, and verbal abuse was the most common form of aggression experienced.⁴²

Ayranci et al. (2006) conducted a larger but multidisciplinary study of health care workers employed in 34 healthcare workplaces in Turkey.⁴³ This survey asked health care workers to report 'verbal abuse, verbal threats, physical action with or without injury, sexual violence, or any other form of violence.'⁴³ Of 1209 participants (response rate 88.4%), 79 GPs completed the survey.⁴³ A total of 69.6% of GPs had experienced any form of patient aggression and violence during the previous year, the most of all health care professions represented in the survey.⁴³

Overall findings from empirical research

Prevalence and incidence of violence in general practice

There are no published data of the prevalence and incidence of violence in general practice nationally in Australia, the UK or the USA. Without this data it is impossible to determine the extent to which patient perpetrated violence is a problem within general practice. The reviewed studies do suggest that violence is widespread and directed towards both general practitioners and medical receptionists. However, there is no evidence on whether practice managers and other general practice staff experience violence.

Verbal abuse is consistently documented as the most common form of violence directed towards general practice staff. However other types of violence such as physical abuse and sexual abuse also occur and despite occurring less frequently, are likely to have more damaging effects on the victim. Also concerning is the incidence of sexual harassment of female general practitioners. While this form of violence is infrequent for the whole GP profession, studies indicating that female GPs are significantly more likely to be sexually harassed or experience high level violence compared to their male counterparts has significant implications for female GPs' safety in their workplace.^{2, 16, 18, 21} Other trends suggest that younger GPs are more likely to experience patient aggression and violence in general practice than older GPs.

'Mad' verses 'bad' patients and tolerance towards low level violence

The terms 'mad' and 'bad' patients have been used to differentiate between patients who have mental health issues (mad) and those who have drug or alcohol addictions (bad) and are perpetrators of violence towards their general practice's staff. It is unclear from the literature whether general practice staff make allowances for patients who have mental health issues who perpetrate violence compared with those who are drug-seeking or drug dependent patients. Elston et al. (2002) suggests that general practice staff do exhibit some tolerance towards patients who they consider not wholly responsible for their behaviour, for example, patients who have mental health issues.²⁹ Also of interest is whether proximate causes such as waiting times or lack of access to general practice services is also a cause of low level violence and whether general practice staff are more tolerant in these situations.

Violence perpetrated towards other health professionals

Violence experienced by hospital staff

There exist numerous studies internationally which have investigated hospital staffs' experience of violence in the workplace.⁴⁶⁻⁵² Nurses are the most frequently investigated group of hospital-based health professionals and have been shown to experience more violence than other health professionals.⁵⁰ This has been attributed to the increased patient contact inherent in nurses' roles compared with other health professionals, which has been positively associated with the risk of violence.⁴⁷ Consequently, violence perpetrated in hospitals towards health professionals has been found to have an adverse effect on the quality of care provided to patients.⁴⁶

Studies involving retrospective reports of violence towards health care workers and nurses have found that verbal abuse is the most commonly experienced form of violence: similar to findings from the general practice area.^{48, 50, 51} A large study involving nurses in the USA, determined that the annual incidence of physical assault was 13.2 per 100 persons (95% CI 12.2 to 14.3), in contrast to non-physical assault which includes verbal abuse, was 38.8 per 100 persons (95% CI 37.4 to 40.4).⁴⁸ In contrast, a prospectively driven study reflects markedly different incidences of violence, particularly verbal abuse, towards nursing staff.⁵² Verbal abuse reportedly occurred in only nine per cent of incidents, whereas 88% of reported incidents involved physical abuse towards staff.⁵² The authors acknowledge that the low levels of verbal abuse reported is likely due to physical violence being viewed more seriously, and therefore more frequently reported.⁵² This study is one of few prospectively conducted studies investigating violence in health care and illustrates that a primary flaw with this methodology is that participants may not feel some forms of violence are serious enough to report.

A recent study Australian study demonstrated that there has been a significant increase in violence in the private, public and aged care sectors towards nurses.⁴⁹ While this study included horizontal violence (between staff members), Hegney et al. (2006) found that three quarters of the violence experienced by nurses, while working in aged care and the public system, was perpetrated by patients.⁴⁹

Violence in the emergency department

Violence perpetrated towards staff working within the emergency department (ED) of hospitals is common. Multiple studies investigating violence in EDs internationally have found that the majority of staff have experienced violence, particularly verbal abuse.⁵³⁻⁵⁶ Atawneh et al. (2003) found nurses working in an ED in Kuwait experienced depression, flashbacks of the event, sleeplessness, fearfulness and took time off work after experiencing occupational violence.⁵³ A study from the UK by Hislop and Melby (2003) indicated that nurses received support from their colleagues after a violent incident but perceived managerial support was severely lacking.⁵⁷ In addition, staff who have been assaulted do not always report the incident to the police.⁵⁵

A study in the UK used incident reports from a 12 month period to investigate violence in an ED.⁵⁶ This study characterised the perpetrators demonstrating that of the 187 individuals who were violent towards staff, 14 of these perpetrators were repeat offenders causing 20% of all the incidents in the previous year.⁵⁶ Sixty-five per cent of all perpetrators were male, 88% were patients of the service and perpetrators were significantly more likely to live in socially deprived areas.⁵⁶ In half of all incidents, the perpetrators were thought to be under the influence of alcohol, whereas only 5% of perpetrators were thought to be under the influence of illicit drugs.⁵⁶ Ninety per cent of all incidences involved verbal abuse and 32% involved actual or attempted physical abuse.⁵⁶

Another study asked representatives to complete a survey on behalf of their ED regarding the incidence of verbal and physical violence.⁵⁴ Seventeen per cent of the departments always record verbal abuse and 77% always recorded physical abuse.⁵⁴ The majority of ED staff were found to be verbally abused at least once a week, whereas half the staff experienced physical abuse monthly.⁵⁴ The primary causes of violence was found to be perpetrated by patients who were under the influence of alcohol, who had to wait for a consultation or who were using recreational drugs.⁵⁴ This study also found that nurses are the most commonly abused of all staff.⁵⁴ Another study involving a standardised telephone questionnaire administered to Senior House Officers (junior doctors) working in ED, found that 96% had experienced verbal aggression, 50% had been threatened and 32% had experienced an attempted assault.⁵⁵

Violence experienced by paramedics and other emergency services personnel

Emergency services personnel or emergency medical services (EMS) provide health care in response to emergency situations and comprise ambulance personnel, paramedics and fire fighters. Ambulance personnel, paramedics and fire fighters' experiences of occupational violence have been studied in Australia, Europe and the USA.⁵⁸⁻⁶²

An Australian study found 88% of paramedics had experienced violence in their workplace in the previous 12 months.⁵⁸ While this is a large percentage of paramedics who have experienced violence compared to GPs in Australia, the scope of this survey included horizontal workplace violence perpetrated by colleagues as well as patients, patient's family members and friends.⁵⁸ Similarities of paramedics and other health professionals experiences of violence include that verbal abuse is the most common form of violence directed towards paramedics, and female paramedics experience significantly more sexual harassment and abuse compared with their male colleagues.⁵⁸

In the UK, telephone staff working at the NHS ambulance service control room were surveyed and found to receive, on average, four calls per shift where the caller was abusive.⁶¹ The main causes identified by the staff were that callers were frustrated, anxious or did not understand the tasks the staff must perform.⁶¹ Similarly, in Sweden, verbal abuse was the predominant type of violence experienced by ambulance personnel (78%) but a majority of those who had experienced violence had been physically abused (67%).⁶²

Two studies from the USA examining fire fighters' experiences of occupational violence offer varied information about occupational violence.^{59, 63} These studies contrast because they employed different methodologies. Mechem et al. (2002) used a retrospective analysis of occupational injury reports from

the fire department-based emergency medical services, whereas Mahoney (1991) asked fire fighters to recall violent incidents.^{59, 63} Mechem et al. (2002) present data regarding the frequency that EMS staff report an injury. They found that 44 or 4% of injuries over a two year period were the result of an assault by patients, patient's family members or bystanders.⁵⁹ Almost 60% of these assaults were classified as intentional and in almost all cases, the employee required medical attention due to the assault.⁵⁹ The assaults were nearly evenly divided between day and night shifts, and almost half occurred on a weekend.⁵⁹ However, this method of data collection does not provide any information regarding the frequency that EMS staff experience other types of violence which do not result in injury. In contrast, Mahoney (1991) retrospective exploration surveying fire-fighters from the Albuquerque Fire Department found 90% of fire-fighters had experienced violence perpetrated by patients, patient's family or bystanders during their career.⁶³

Grey literature

Anecdotal evidence of health professionals experiences of violence

The traumatic experience of being abused by a patient has prompted a number of general practitioners, nurses, other medical specialists or their colleagues to publish accounts of the incident. These commentaries serve to highlight the vulnerability of health professionals when faced with an aggressive patient, the difficulties escaping such a situation, and often the lack of support post incident. A commentary published in 1990 by psychiatrists in the UK who conducted many home visits to patients after hours, illustrates how technological progress such as mobile telephones provide some safety measures to health professionals while working away from the surgery or hospital.⁶⁴ These psychiatrists, concerned that their risk of violence was increased by not having any mode of communication to quickly call for help and having to find public telephones to respond to their pagers, argued that they should be provided with a mobile telephone to carry while conducting home visits.⁶⁴

More anecdotal evidence emanating from the UK originates from a female junior GP who was attacked in her consulting room by a psychotic patient who had stopped taking his medication.⁶⁵ He later admitted that his aim was to kill her, however, she was saved by her colleagues who broke through the locked door into the consulting room.⁶⁵ Langmead (2008) made a number of recommendations due to her experience which included ensuring that consulting room doors do not have locks on them.⁶⁵ In another incident, a nurse practitioner working on an NHS hospital ward was attacked by a patient who already had a police escort.⁶⁶

From North America, a Canadian GP related her experience of being stalked by a female patient and as stalking was not considered an offence, the police could not assist.⁶⁷ In the USA, a psychotic patient firstly strangled a nurse using her stethoscope then sprayed many staff with a fire extinguisher while escaping from the hospital via the fire stairs.⁶⁸ Despite the trauma experienced by the nurse and the health implications for the staff who inhaled the fire retardant, there was no support offered by immediate or more senior management at the hospital.⁶⁸

In Australia, there have been numerous incidents publicised through the local medical media. These incidents include a drug-seeking patient who threatened general practice staff with a knife through to the stabbing of a GP in Sydney in 2009.⁶⁹⁻⁷¹ Unfortunately, the most extreme type of violence perpetrated toward GP staff is homicide. In Australia, over the last 12 years, there have been four GPs who have died as a result of violence perpetrated by their patients.¹⁴ Reports from Western Australia about the fire bombing of a medical centre and the public verbal abuse suffered by a GP in Tasmania support empirical evidence that violence towards general practice staff is endemic throughout Australia.^{72, 73}

Available packages, policy documents & publications

International organisations

Collaboration between the International Labour Office, the International Council of Nurses, the World Health Organization, and Public Services International resulted in the production of a report addressing the management of victims of workplace violence in the health sector.⁷⁴ This report, published in 2003, addresses violence perpetrated by clients and colleagues towards healthcare workers and aims to 'contribute towards improving the situation of victims of violence'.⁷⁴

The International Council of Nurses (ICN) have identified their profession which has a particular interest in reducing violence because of they are frequently the front-line health professionals caring for victims of violence and also because they are increasingly suffering from violence in their workplace.⁸ The ICN have therefore published two reports entitled: 'Abuse and violence against nursing personnel' and 'Guidelines on coping with violence in the workplace' to address this issue.^{11, 75}

National organisations

In 2002, the National Health and Medical Research Council identified that there were few resources for health care workers in rural and remote regions of Australia for coping with the effects of violence. In response, the NHMRC developed the manual 'When it's right in front of you. Assisting health care workers to manage the effects of violence in rural and remote Australia'.¹² This manual addresses two different types of violence: 1) occupational violence directed towards health care workers which is perpetrated by clients or colleagues, and 2) violence suffered by clients.¹²

The Royal Australian College of General Practitioners engaged a consultative process with experts and general practice teams to develop the resource consisting of an information booklet and an education module.⁶⁹ This resource was only published in March 2009 and was produced in response to increasing concerns about violence perpetrated towards GPs in Australia.

Regional and state based organisations

There have been a number of resources developed by regional and state based organisations to implement safety systems and manage aggressive and violent situations in health care. In 2003, the New South Wales Department of Health launched a campaign to address the violence against staff working in the public healthcare system.¹³ This 'zero tolerance' campaign was motivated after data was collected indicating there were 340 reported assaults on hospital staff within a two month period in 2004.¹³

Northeast Health Wangaratta joined with Melbourne Health and the Victorian WorkCover Authority, WorkSafe Victoria, to form a rural-metro partnership and produce a toolkit to develop systems which will prevent and manage occupational aggression and violence within the Victorian health sector.⁷⁶ This project was due for completion in 2008 and employed strategies that would minimise the risk of client initiated violence or aggression.⁷⁶ The findings of this project were then used by WorkSafe Victoria to develop the handbook 'Prevention and management of aggression in the health services'.⁷⁷

After the stabbing murder of a female GP who was practicing in the outer south eastern suburb of Narre Warren in Victoria and growing concern within general practice about patient perpetrated violence, the Dandenong Casey General Practice Association developed a safety and security kit for general practice.⁷⁸ This handbook contains checklists to conduct a safety and security risk assessment, factsheets about preventing and controlling violence, and templates for adaptation and use which include behaviour contracts and offender description forms.⁷⁸

Conclusion

In conclusion, patient initiated aggression and violence is not unique to general practice staff but affects most health care professionals and other employees working in healthcare services

internationally. There is much evidence to suggest that verbal abuse is the most commonly perpetrated form of aggression directed towards healthcare workers and younger staffs are more likely to experience patient initiated aggression and violence.

In Australia, there have been a number of regional studies conducted, most of which have found similar incidences of verbal abuse, property damage or theft, physical abuse and sexual harassment. Nevertheless, there are significant limitations with these studies findings due to the differences in definitions used to enquire about types of patient aggression and violence. Additionally, there is limited empirical data about the experience of general practice staff other than GPs. Compounding these limitations, is the lack of national data regarding the prevalence and incidence of patient aggression and violence perpetrated towards general practice staff.

Chapter 4 Stakeholder interviews

Introduction

Australian primary health care is represented by a range of organisations. Some of these organisations relate directly to general practice and others have a broader constituency. In order that the views and experiences of these organisations were represented in this study, DoHa and APHCRI jointly agreed a list of fourteen organisations that should be approached for input. Representatives of these fourteen organisations participated in the stakeholder interviews (Appendix G).

Six organisations reported direct involvement with the general practice setting (AAPM, ACMHN, AMA, GPRA, NAMDS, and RACGP), and seven organisations reported indirect involvement with the general practice setting (ACRRM, ANF, APNA, CRANA, PHCRIS, RCNA, and RDAA). The Australian General Practice Network (AGPN) was included among the stakeholder organisations. Although they did not participate in a stakeholder interview, the AGPN were well-represented on the project reference group. Data from each group were separated to allow comparison of information between type of stakeholder organisation according to their involvement with general practice settings, either direct or indirect. Those organisations whose members predominantly worked in general practice (e.g., the RACGP) were grouped as "directly involved" organisations. Organisations whose members did not work predominantly in general practices were grouped as "indirectly involved". This group included most of the nursing organisations as nurses are also employed in places other than general practices, including hospitals, clinics and aged care facilities.

Research findings are reported according to the following themes that emerged from the data:

1. Stakeholder interviewee's perceptions of violence
2. Organisational response
3. Division activity
4. General practice-level response to violence
5. Incidents of violence reported by stakeholder respondents

Findings

Stakeholder respondents' perceptions of violence

Definitions and reporting

Stakeholder organisation representatives identified various definitions of 'aggression' in the general practice setting. Respondents had a continuum against which they (often subconsciously, as per Magin et al., 2006²³) or their organisation classified an incident as aggressive or not aggressive. The degree of conscious intent behind the act influenced respondents' decisions. If the perpetrator was experiencing an episode of mental illness at the time of the incident, the practitioner generally did not consider behaviour as offensively aggressive but rather as part of the person's illness. The RACGP representative believed there was a general lack of understanding, almost a "naivety", regarding GPs classification of patient behaviour. One stakeholder example of this is the respondent's definition of verbal abuse, "It's not necessarily an attack, it's the community letting loose".

Variations in how aggression was defined among representatives of stakeholder organisations were evident throughout the stakeholder interviews.. Some respondents from both 'direct' and 'indirect' stakeholder organisations believed that general practice staff "are legitimate targets [for aggression] and that violence is part of the job". However, respondents also acknowledged the personal and professional losses associated with workplace aggression and the subsequent reduction in services to

the community.

Another aggression-related theme emerging from the stakeholder interviews and related to individual perception and definition of aggression was that of incident reporting. If an individual did not classify an incident as aggressive that person saw no reason to report the incident. Five respondents spoke about the need to track incidents, and for reporting and sharing the information with other relevant parties. This protocol was particularly important for the medical deputizing services that reinforced the importance of intra- and inter-practice communication. The two-way communication was explained as being essential to staff safety through the minimisation of future incidents.

While the OH & S perspective would advocate reporting and judicial sharing of information, respondents suggested that reporting of violent incidents might also negatively prejudice some aspects of clinical care in some situations. However, without adequate reporting and tracking of incidents, respondents believed it was difficult to obtain a clear picture about aggression and violence in the general practice setting. The lack of clarity in this area may minimise any urgency or need to take action such as the development of policies and procedures that might enhance staff safety and practice security.

Perceived frequency of violence

All six stakeholder organisations with direct involvement with the general practice setting commented on their perceptions of frequency of aggression in the workplace. This ranged from "never", to "[not] in decades", to "about 60%". One organisation could not recall any GPs who had been physically assaulted, but sensed that "probably two or three times a day, at least, where the practice staff are getting a verbal assault". Respondents' definitions of aggression therefore may be affecting their perceptions of aggression in the general practice setting. One respondent believed that the frequency of aggression was not increasing but the type of aggression was becoming more severe. Two respondents attributed the change in aggressive behaviour to a more widespread increase in community unrest.

Stakeholder organisations with indirect involvement with the general practice setting expressed different perceptions about the frequency of aggression in the workplace. Overall, respondents expressed a growing recognition of "considerable issues around violence" over which there has been "ongoing concern" with many suspecting violence was "widespread".

Inconsistent reports of perceived frequency of aggression were received from stakeholder organisations with a substantially rural and remote constituency. One organisation representative believed that aggression was "not all that common... certainly isn't the highest issue on the agenda",. However, one respondent who had worked in community services in rural and remote Australia believed that aggression was "a huge issue".

Perceived type, severity and impact of violence

More respondents from directly involved organisations (83%) than from indirectly involved organisations (28.5%) commented on their perceptions of the type, severity, and impact of patient aggression in the general practice setting. Respondents' comments ranged from "most of it verbal, in person or by phone", through to threats "in various forms", dog attacks, and GP murders.

One respondent perceived that patients seem to actually assault or make physical contact with the GP more than in the past and that there was an increase in the frequency of patients' relatives and family adopting the role of the abuser. Respondents expressed a sense that the 'nastiness' of the aggression was increasing. Several respondents suggested the severity of aggression was increasing as a result of the increased use of drugs in the broader community.

Perceived target of violence

Respondents spoke about who they thought were the target of patient initiated violence in the general practice setting, expressing a sense that front-desk reception staff bore the brunt of any violence or

aggression.

There was a marked variation between the direct and the indirect group respondents regarding the degree to which each group perceived that women were primary targets for violent or aggressive behaviour. Two respondents from the direct group considered that "perhaps the females get it more", but five of the six indirect group respondents believed that women, particularly nurses but also female doctors, are prime targets of violence in this setting. As more of the indirect than the direct group respondents were from nursing organisations, it may be that the large numbers of predominantly female nurses within the health workforce predict the increased likelihood of females reporting a greater degree of violence.

One respondent stated that nurses are frequently in environments that make it easier for them to become targets of violent behaviour but this might not necessarily be in the general practice setting but in any setting in which nurses conduct their work. Similarly, one GP organisation respondent believed that GP Registrars were particularly vulnerable to patient initiated violence or aggression because of their one-off role in the general practice. Another respondent stated that any practice staff that go into patients' homes are vulnerable to violent incidents, hence the reduction in home visiting services by GPs.

Other attributes of likely targets of violent or aggressive behaviour included "the younger the practitioner, the less likely maybe they are to have had exposure to training to deal with these episodes", and "being younger; perhaps not having had the training or the education to deal with it". One medical organisation representative made no comment on the likely target of violence, but believed that at times, individuals place themselves at greater risk of attack through careless work practices.

Perceived contributing factors

Respondents reported social and medical contributors to patient initiated aggression, and expressed varying interpretations regarding geographical contributors to aggressive behaviours.

Social and medical contributors

Table 3 (pg 50) summarises respondents' beliefs of social and medical factors contributing to patient initiated aggression in general practice. Some factors were common to both groups of respondents, but other factors differed between respondents from directly involved organisations and those organisations less directly involved with the general practice setting.

The issue of cultural sensitivity was discussed by respondents with involvement in rural and remote settings. One respondent from remote Australia believed that staff who were insufficiently integrated into the community were at risk of becoming targets of violence. Becoming an integral part of the community became a protective factor, "communities tend to keep their own members safe".

Geographical contributors

Five of the six direct organisation representatives attributed the high risk nature of certain geographical areas to the nature of the population in that geographical location. Of the indirect respondents, only two expressed the same view. Some areas were seen to be of higher risk than others. For example, one respondent believed, "I imagine that inner city practice would be just as at-risk." Indeed, some areas were deemed to be 'out of bounds' for home visits not because of socio-economic factors but due to other factors related to the population and reputation. As one respondent said, "out of city, arid areas of very low socio economic status.... we attend all areas - there are no exclusion areas; whereas in Western Sydney there are three suburbs which are actually excluded from visiting".

Three respondents raised regional, rural, and remote area contributors to patient initiated aggression. These issues were related to geographical isolation. As is well-known, the recruitment and retention of health workers in rural and remote Australia is of national concern and one respondent related how

the workforce shortages in rural and remote Australia can be a contributor to patient initiated aggression.

Table 3: Social and medical contributors to patient aggression

	Organisations with direct involvement in the general practice setting	Organisations with indirect involvement in the general practice setting
Responses	5 respondents	7 respondents
Higher risk patient groups	Patients with substance use/abuse issues (drug seeking behaviours, intoxication, and narcotic use) <hr/> Patients with a tendency to experiencing psychotic states <hr/> Patients with personality disorders <hr/> Patients with an elevated emotional state associated with some physical illnesses <hr/> Patients experiencing trauma	Patients who are afraid <hr/> Patients suffering from grief or stress A carer advocating for their friend/relative
Practice process issues		Staff isolation <hr/> Lack of empathy from staff <hr/> Inadequate staff coverage <hr/> Cultural insensitivity <hr/> Poor inter-relationships within the work environment <hr/> Manager's disinterest
Doctor practice	Patients become frustrated when the doctor disagrees with them <hr/> GPs with less experience	Frustration with treatment options
Patient social issues	General increase in violence in the community as a whole <hr/> Unemployment	
Education and training		Lack of staff training

Organisational response

During stakeholder interviews, direct questions were asked regarding the organisation's publications, these including policies and procedures. Another direct interview question probed the organisation's response to patient initiated violence in the general practice setting. Apart from policy and procedure, and from publications, the remaining areas of organisational response shown in Figure 3 and Figure 4 are those areas volunteered by the interviewees.

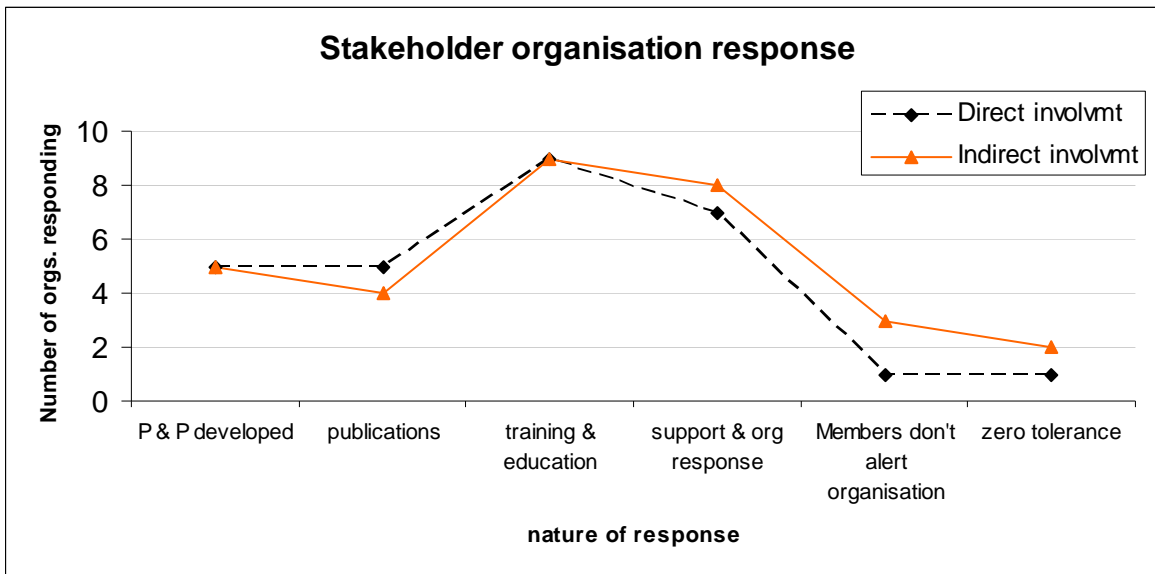


Figure 3: illustrating the number of stakeholder organisations that responded to violence in the general practice setting, and their areas of response.

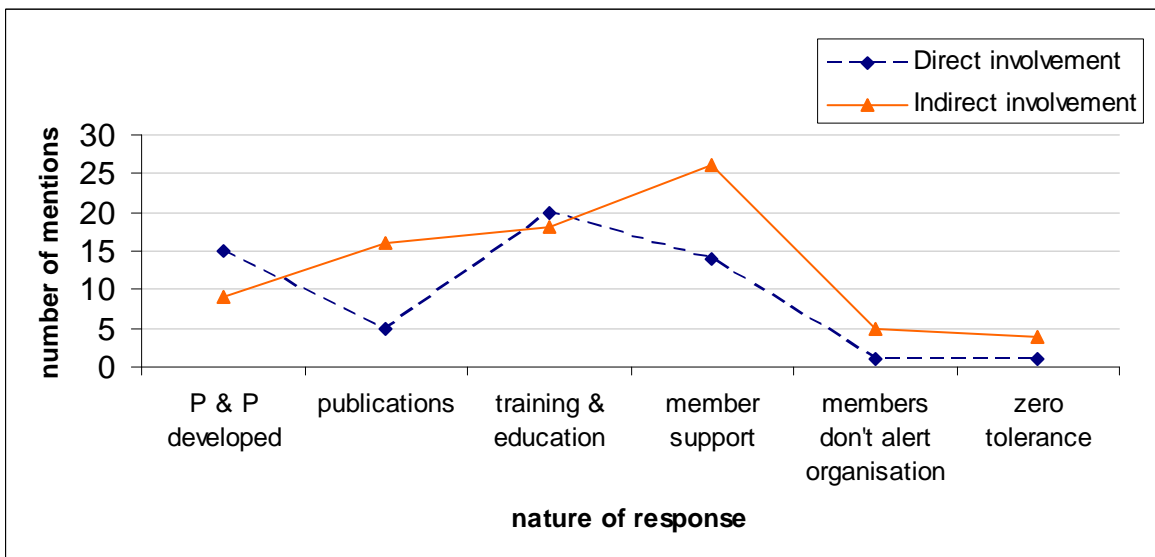


Figure 4: illustrating the number of times stakeholder organization representatives discussed their organisation's interventions related to violence in the general practice setting.

Figure 3 shows that stakeholder organisations with direct and with indirect involvement in the general practice setting had a very similar pattern of response to workplace violence. Figure 4 details the number of times each respondent mentioned each particular area of organisational response. The greatest variations between direct stakeholder organisations and indirect stakeholder organisations can be seen in the area of publications, support to members, and the development of policies and procedures. Each of these areas is discussed below.

Organisations with direct general practice involvement

Policies and procedures

Representatives from five of the six organisations who have direct involvement with, and substantial membership employed in, general practice (direct organisations) discussed policies and procedures for safe practice when working with potentially aggressive or difficult clients. However, only one of these organisations has developed written policies and procedures, particularly regarding home visiting and after hours work. One other organisation representative said, "Protocols will be developed depending

on whether members consider there is a need to do so”.

Two further respondents strongly recommended the development of policies and procedures. Both respondents enforced this practice in their own workplace, but the organisation they were representing had not developed any documents as a guide for their members.

All three of the respondents with written policies and procedures (personal and organisational) emphasised the importance of recording and tracking potentially difficult clients, and of communicating unacceptable patient behaviour to colleagues. Two of these three respondents reported no adverse incidents over a period of several years, attributing this to staff adherence to the policies and procedures. Both respondents had adopted the concept of “constantly risk managing so that you put your systems in place and your protocols in place ... understanding of your practitioners, your staff, and your patients about the way they behave and the way things do work in the practice so that no one is put at risk”. One organisation also reported having a ‘Patient rights and responsibilities charter’ in which the patient, at first presentation to the practice was informed of their rights and responsibilities.

Publications

Four of the stakeholder organisations with direct involvement with general practice had published materials relating to aggressive or difficult patients. One organisation had published patient education materials; one had a research paper in progress scoping the organisation’s future needs in the area of managing difficult patients; one had developed some fact sheets, and the RACGP had conducted a formal research project with external funding to produce a general practice guide.

A fifth organisation had not published any work but their individual members had been active in this regard, publishing journal articles, books, and acting as consultants to World Health Organisation projects in the area of managing workplace violence.

Education and training

Direct stakeholder organisation respondents mentioned the importance of education and training in the areas of workplace violence, but few organisations actually provided education and training to their members. One representative from a leading stakeholder organisation said that their organisation “supports an educative process” but added, “at least if only in principle ... but yes, its not only about information, but it’s about circulating in a way that has a quality of being an educative process”.

When discussing undergraduate medical training, one respondent mentioned, “in their general training, they do scenarios with professional actors, but it never really gets to the stage of violence, the real thing. It’s not enough”. Another respondent who is supported by her organisation to speak at conferences, and to conduct workshops confirmed that GPs overall have little preparation for dealing with violence or difficult patients.

One stakeholder interviewee summarised his views of an ideal level of education and training for general practice staff in this way;

What you really want is a situation where doctors have an educated sixth sense about security related matters and everybody in the organisation - that’s including the call centre operators and everybody else - needs to be very in tune to the sort of messages that you get from patients that could lead to a security issue and all that sort of stuff. But we also train our call centre operators...

Other forms of education provided by stakeholder organisations included member access to online publications, and patient education materials.

Support and organisational involvement

Four direct organisation respondents discussed the importance of support for GPs and practice staff, "especially after an incident". This said, only one of the organisations actually provides practical support to GPs following difficult incidents. One organisation representative said, "our view is that we should support awareness of [aggressive patients] ... yes it's something they have to put up with and that there are ways they can change the physical layout and the structural layout of their practice to decrease the risks and minimise the severity".

Three respondents expressed disappointment with the lack of response, by their own or other key organisations, in relation to patient initiated aggression. Two of the three respondents believed that such aggression was increasing and that the medical profession was slow to respond despite the vulnerability of the staff.

Zero tolerance attitude of organisation

Only one direct stakeholder organisation representative mentioned the 'zero tolerance' approach to managing workplace violence. The RACGP do not advocate a zero tolerance approach which;

...could be very counterproductive and have negative impacts on the community because if we are seeing people who are at risk of violent behaviour, if we shove them out of the medical practice when they actually have a medical condition then we are only deflecting that violence on to other colleagues or we are deflecting it off onto the community.

The AMA perspective on this situation is slightly different, in that;

...we might just have to support GPs who choose not to treat certain groups or individuals. We're not supporting withholding lifesaving or vital medical management, but long term medical relationships should be a choice of the doctor and they should be able to put faith that long term relationship.

Organisations with indirect general practice involvement

Policies and procedures

Five of the seven of stakeholder organisations with indirect involvement with the general practice setting (indirect organisations) referred to policies and procedures to minimise workplace violence against practice staff. One organisation had written policies and procedures for its members; another organisation operated with non-formalised procedures, and the remaining three organisations had not developed any policies or procedures for use by their members.

One organisation reported a "zero tolerance policy to violence and aggression in the workplace "... we encourage people to have a hierarchy of sanctions". This organisation had adopted a proactive approach to harm minimization, with an emphasis on OH & S generally. "We emphasise that practices should be finding certain ways to eliminate the risk of violence".

Publications

Four stakeholder organisations provided information in this area. One organisation cited 12 publications. Not all of these were auspiced by that organisation and it is not known how many were related to violence in the general practice setting. It is clear from this record that patient initiated aggression is very important to this organisation. Another organisation had recently published its zero tolerance policy. Apart from these references, no stakeholder organisation with indirect involvement in the general practice setting reported publishing work related to patient initiated aggression.

Education and training

Education was mentioned by four of the seven indirect stakeholder organisations. Organisations generally recognised the importance of education, but apart from two stakeholder organisations who conducted a broad-scale educational event perhaps annually, respondents did not discuss provision of education to their members in the area of patient initiated aggression.

Two stakeholder organisations reported providing training for their members. One organisation provided online training and the second organisation provided practical training, "clinical and all that sort of stuff, we have cultural awareness training".

Support and organisational involvement

Indirect stakeholder organisation respondents spoke more about providing support to their members than did direct stakeholder organisations. Overall, the type of support advocated by these organisations was personal support, to "make people feel a bit more comfortable, therefore they feel a bit safer".

Five stakeholder organisations discussed the type of support they provide to members working in the general practice setting. Two of the rural organisations expressed difficulty in providing support to their members, believing that the distances in rural and remote Australia hampered any significant responses to patient initiated aggression. "Personally, just from reflection I think it's a really big issue, you know and distance ... even with E-Health and with E-Support, you're still physically a long way away".

Other forms of support provided by stakeholder organisations to their members included the development of comprehensive orientation programs for staff, providing them with "someone to ring when they get into strife". One stakeholder organisation "worked very, very hard to eliminate clinics and health facilities where there is only one nurse present"; and a third organisation has mobilised all of its state and territory branches to collect evidence, and to record and track violence against practitioners. One stakeholder organisation also discussed providing responsive support to their members in the form workplace, legal, and psychological assistance if required.

Comparative summary of findings

All stakeholder organisations discussed a very similar range of responses (Figure 3) to patient initiated violence in the general practice setting. However, the type and level of response varied between organisations. The greatest variations between direct stakeholder organisation and indirect stakeholder organisation responses can be seen in the area of publications, support to members, and the development of policies and procedures (Figure 4) or guidelines available to members. Figure 5 shows the differences between organisations specifically with regard to policies and procedures and guidelines available for their members.

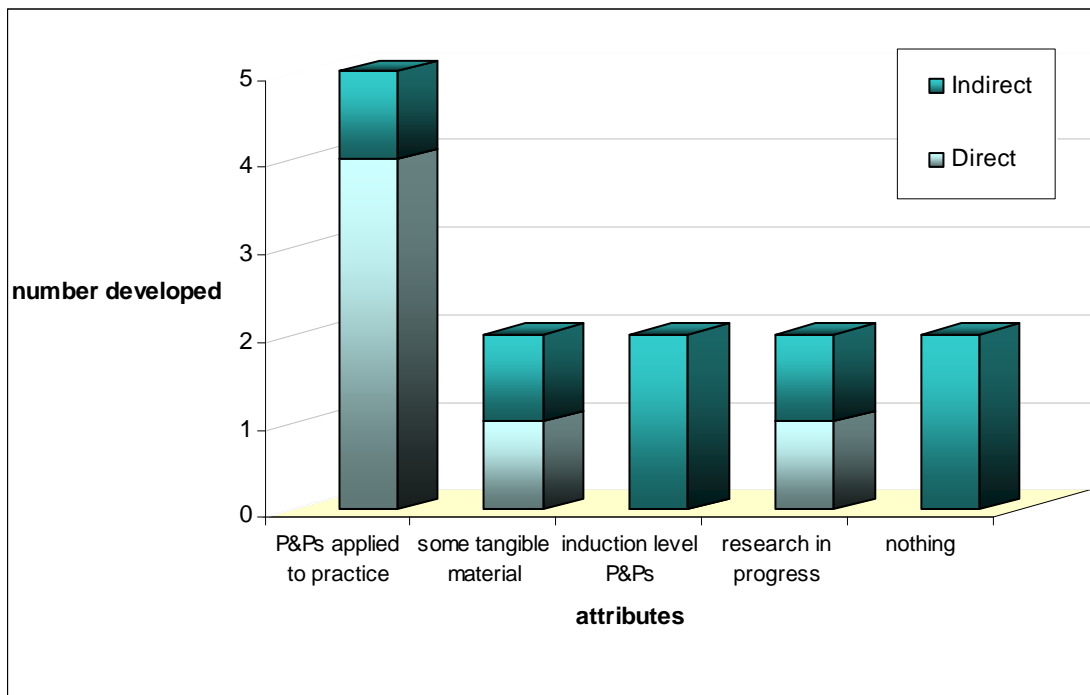


Figure 5: The differences between organisations specifically with regard to policies and procedures and guidelines available for their members.

Stakeholder organisations directly involved with general practice recognised that personal support was necessary, particularly following an incident, but only one respondent reported on practical assistance provided to GPs by his organisation. Three respondents believed their organisations could and should provide direct personal support.

Several respondents believed that policies and procedures surrounding the management of workplace violence need to be prepared by the practice manager specifically for each practice.

A greater number of 'indirect' organisations believed that their members would not raise incidents of patient initiated aggression with them than did 'direct' stakeholder organisations. This was usually a product of the organisation's particular charter.

Divisions of General Practice (DGP) activity

Overall, stakeholder representatives made little mention of DGP activity in the area of patient initiated aggression in general practice.

Five stakeholder respondents made 11 mentions of activity being undertaken at Division level in the area of patient initiated aggression. Several respondents referred to the 'Dandenong-Casey Division Safety and Security Kit for General Practice' (2008), developed in response to the 2006 murder of a GP in that Division. Worksafe Victoria supported this publication. The Dandenong-Casey Division, was frequently cited as being proactive in the education and training of their members.

Several respondents referred to the DoHA-funded RACGP project in response to the Victorian incident of 2006 the development of the 'General practice: A safe place' {Rowe, 2009 #194; Rowe, 2009 #195 }guide for general practices. The RACGP was a stakeholder organisation that provided ongoing education and training for their members and for other practice staff. Several organisations referred to these two projects and publications, and to their involvement in these projects. The Dandenong-Casey publication was distributed to all 90 general practices in that Division. An electronic copy of the kit was sent to all the Victorian Divisions and several of these Divisions reported printing out hard copies for their members and/or uploaded links on their websites. The Kit remains available on the Dandenong-Casey website for general use. In the forthcoming annual member survey, the Division intends to

place a question asking whether or not the responding practice has a safety and security plan. A recent incident in this Division (May 2009) has prompted the Division to remind practices about the kit and the need for a plan.

Other activities reported by stakeholder organisation representatives

The AMA representative spoke of some AMA promotional work by hard-copy mail-out to AMA members following the 2006 Victorian incident. This material was cited by a Division CEO as a "good start, but insufficient".

One respondent, a former policeman, believed that the training needed by GPs was the type he had learned in the Police Force: sound assessment/ recognition skills, and responsive communication strategies. He was not aware of any such training being provided to GPs, suggesting that undergraduate training should include these skills.

Some organisations reported scoping the need for education and training in various Divisions, and other organisations reported regularly providing education and training to Divisions and practice staff. One indirect organisation said that they frequently conduct training sessions for a Division and another stakeholder organisation (direct) suggested potential synergies of their members receiving education and training in the same environment as GP training.

Despite few respondents demonstrating an awareness of existing DGP activities related to management of difficult or aggressive patients, Table 4 (pg 57) provides a summary of 12 such activities conducted by Divisions in 2006-2007 and registered by the Primary Health Care Research and Information Service (PHC RIS):

Table 4: Summary of the PHC RIS list of project-related training and education events conducted by Divisions in 2006-2007.

Division and geographical area	Activity conducted (2006-07)
Division 208, Northern Sydney (NSW)	How to deal with violent patients, OH & S
Division 218, Hunter Rural (NSW)	Resources and education provided on dealing with a violent or aggressive patient
Division 228, Riverina and Primary Health (NSW)	Support practices that develop safety aspects of general practice, including dealing with difficult clients, as part of their accreditation process
Division 304, Southcity (VIC)	Training session on dealing with difficult patients
Division 305, Westgate (VIC)	Workshop in November 2006, " Safety and security for GPs and practice staff". Produced a 'tipsheet' for practice staff personal safety. Also, safety awards were arranged with the local Police station in the catchment area.
Division 306, Western Melbourne (VIC)	Provided education on Safety and security
Division 311, Greater Monash (VIC)	One collaborate event on practice staff safety
Division 315, Dandenong-Casey (VIC)	Safety and Security in the Workplace' Forum conducted in July 2006, attended by 90 GPs and practice managers from three Divisions. Safety and Security survey was distributed to all practices, preceding establishment of the project to identify best practice and develop resources for dissemination.
Division 325, Ballarat and District (VIC)	Security audit of General practices through CPD program
Division 506, Barossa (SA)	Engaged the local Police to undertake an assessment of practice security
Division 702, North (TAS)	Conducted an educational event, 'Managing people with challenging behaviours'
Division 703, North West (TAS)	Provided information and encouraged all practices to participate in free small business OH & S Adviser Program. Conducted an education session on dealing with increasing violence in the general practice

Summary

Five stakeholder organisation representatives mentioned Division activity in the area of education and training to deal with difficult patients and with patient initiated aggression. Two of the stakeholder organisations had direct involvement with general practices, and three had indirect involvement.

Several stakeholder organisations mentioned the same two projects. Some stakeholders reported that their organisations were investigating the need for education and training, but overall, it appears that either stakeholders were not aware of activity being carried out at Division level in the area of education and training to deal with patient initiated aggression or that there has been only minimal activity.

General practice-level response to violence

Three organisation representatives were practising GPs; another respondent was a psychologist working from a general practice, and a further two respondents were practice managers. These six respondents were intimately involved with the general practice setting. Specifically these and other

respondents informed the study of individual practice responses to aggressive or violent patients.

Individual GP definitions of what constituted aggressive or violent patient behaviour underpinned the practice response. Two respondents stated that under-recognition resulted in poor practice response and less support for the abused staff member. One respondent noted that poor (or absent) support and debriefing increases the victim's future vulnerability.

An individual practitioner's definition of violence also influenced the recording and tracking of aggressive or potentially violent patients, on changes or modifications to practice behaviours and services, and on the practices' urgency to develop policies and procedures governing harm minimisation strategies. Seven respondents believed that safety within the general practice setting was an OH&S issue that needed to be managed by the GP or by the practice manager. One respondent believed that it was common sense for staff to adopt "some strategies to look after yourself, so you shouldn't have to be more vulnerable".

Ethical considerations

Organisation representatives expressed mixed responses regarding the ethics of turning away patients, flagging patient records, and the passing on of information regarding potentially aggressive or violent patients. Only one representative made no comment, saying, "It's a tough decision because our Code of Ethics says we can't refuse care". However, this GP respondent also expressed the dilemma of personal safety, "it's hard to prove that we're in danger. So, on what grounds do we say that our safety is at risk, so, we can't provide this treatment?"

Four respondents, two from each of the organisation groups, expressed they had "no problem in sending [difficult patients] to the hospital" or advising a patient that "the practice can no longer provide a service" to them. One GP representative noted;

...we might just have to support GPs who choose not to treat certain groups or individuals. We're not supporting withholding lifesaving or vital medical management, but long term medical relationships should be a choice of the doctor...

One respondent believed that the patient needed to be given a series of chances to improve their behaviour prior to being excluded from that practice. Another respondent voiced concern regarding the ethical issues of negative notation in the medical file possibly influencing future treatment by another professional.

Two stakeholder respondents, one from each of the organisation groups, believed that patients had a right to be informed of their rights and responsibilities and of acceptable behaviour. As part of their policies and procedures, one respondent provided new patients to the practice with patient information explaining the practice's expectations of them with regard to their behaviour. This written patient education information also outlines procedures to be taken by the practice should the patient breach the acceptable code of behaviour.

Clinical management

One respondent noted the different clinical approaches taken to potentially violent patients by older doctors compared with younger doctors. In his experience,

...older doctors usually give in to the patient's demands in preference to running a risk of being assaulted ... They don't want to risk being beaten up over a script. The younger doctors though, they tend to check the clinical indicators and are much less likely to comply with the patient's request if it is contra-indicated. They tend to take their duty of care more seriously.

If such a response is more widespread, then it presents implications for duty of care being breached

in preference to personal safety. Literature reports that less experienced doctors seem to be more vulnerable to patient initiated aggression.

Written policies and procedures

One organisation directly involved with the general practice setting, and one respondent speaking about her own practice rather than providing an organisational perspective, attributed their zero-incident rating to their staff's adherence to practice policies and procedures. Both respondents promoted a system of risk management, and explained proactive, preventative measures that maximised the safety of all staff at the practice, "to deflate or to detour aggressive behaviour". One of these organisations provides after-hours general practice services. The representative listed six of their protocols ranging from a strict "no opiate" policy, through accurate recording, absolute two-way communication of events, use of personal duress alarms and education and training for all staff, medical and administrative

Recording and tracking of aggressive or potentially violent patients

Several respondents flagged patient files of aggressive patients and did not accept further appointment bookings from these patients. When aggression or violence occurred, patients were sent to the hospital, or the Police were called. Three respondents mentioned the variable availability of Police in rural towns and in geographically isolated communities.

Without recording and tracking of difficult patients, protective advice would be limited. Although some practices turn away aggressive patients, one respondent provided the following consideration;

...turning potentially violent patients away from the surgery just deflects the violence back into the community and doesn't really solve the problem or even manage the violence appropriately. In fact, sending the violent patient away may contribute to the level of violence in the community. What we need to do in general practice is do more about assertive clinical management of those groups who are at risk rather than zero tolerance or ignoring that it exists that comes with the fear of stigmatising this group.

GP vulnerability and training

While some respondents believed that the GP was a potentially vulnerable recipient of violent behaviour, one GP respondent believed that "some people make themselves more vulnerable by not thinking in advance". This respondent noticed a lack of general awareness that some specific behaviours, such as one staff member closing the surgery late at night, might place the person at risk.

Respondents generally agreed that GPs "learn to read the signs, and put two and two together" as reported in the literature¹⁹ but according to one respondent, "certainly the younger the practitioner, the less likely maybe they are to have had exposure to training to deal with these episodes". This has also been reported in the literature.⁴⁰

One respondent believed that GP Registrars were particularly vulnerable because "they seldom see the patient often enough to learn how each one will respond. The GP Registrar is travelling blind in that respect". This respondent also believed that GPs are insufficiently trained "in recognition of violence, or in management of potentially violent situations". Another respondent advocated "good training" for every practice staff, including the call centre operator. Such training would contribute to the "assertive clinical management" referred to above, and to the ability of the staff member to manage potentially difficult situations.

Building design

All respondents expressed their awareness of the need for appropriate building design to allow easy emergency exit for all staff from their particular work stations. One respondent from an indirectly involved organisation said their "emphasis is on OH & S, generally on design issues".

One direct organisation respondent, a practicing GP, expressed his concern regarding the burden that might be placed on general practices if they were to amend their building design,

... if the government or other people are serious about supporting safety they would perhaps recognise that ... there are concrete ways that external bodies could support General Practice if they wanted to by rewarding and supporting initiatives internally in a practice. But at the moment GPs add it to the list of 125 things that is their standard of practice, and you do it without extra dollars going in, and if you say of your practice, 'well it's safer working here, so I'm going to charge an extra \$10', that doesn't work. By the time you do all the quality improvements, in the end you say to your patient, 'well I've done 125 quality improvements including safety, so I'm going to charge you \$10', so yeah. So if that was an initiative supported through government programs, it's a very constructive way government can feedback their commitment to it direct to General Practice.

Two organisation respondents, both from indirectly involved organisations discussed emergency call buttons. One GP stakeholder respondent pointed out, "in five minutes, you could be dead. The Police are good, but you still have to be able to get out of the way if you need to". Safe egress was raised by several respondents, concurrently with the high costs of providing this feature in some of the practice buildings.

Miscellaneous

Changes to practice protocols included the shortening of practice opening hours, 'closing the books' to new clients, tighter security, and mixed views regarding physical protective barriers, as below,

...environmental restraints such as barriers, and lots of glass screens to protect staff. Which make the patients feel much worse than they otherwise might have done, as if they were dangerous, nasty people and that people need to be protected against them.

Summary

Several stakeholders reported the implementation of formal and informal policies and protocols governing high-risk areas of practice such as after-hours care and home visits to known drug-dependent patients. Changes in clinical management were noted in some cases. Respondents agreed that GP training did not adequately equip them with the necessary skills to identify and de-escalate potentially aggressive and violent situations.

Respondents expressed mixed beliefs regarding the recording and tracking of aggressive or potentially violent patients, and of sending an aggressive or violent patient directly to the Emergency Department of the local hospital.

The majority of respondents believed that safety within the general practice setting was an OH&S issue that needed to be managed proactively. Stakeholders agreed that minimising risk through building design or practice layout was the most cost-effective approach to minimising and managing potential violence but respondents concurrently identified the prohibitive costs of building modifications to improve the physical safety of the general practice setting.

Incidents of violence reported by stakeholder respondents

Five organisation respondents mentioned the same two female GP murders and female nurse rape. Respondents believed that GPs, front-line reception staff, women doctors, and female rural nurses were at risk of assault. One GP was attacked in her surgery, the second while on a home visit. The nurse was assaulted "in her own quarters" despite the fact that "the union and the workers have been lobbying to have locks put on [the nurses'] premises for a long time, and were unsuccessful". The other two GP murders in Australia in the past 12 years were both male GPs, and both incidents

occurred while the GP was conducting a home visit.

Respondents believed that the perpetrators were predominantly people under the influence of alcohol or drugs, or drug-seeking people, and

...people with a past history of violence, people with an untreated mental illness who can't access the services system or are turned away and they usually are young men as well under 25, it's acute psychosis, untreated borderline personality disorder and untreated drug and alcohol addiction.

One respondent suggested that patient frustration with the doctor's treatment strategy might also induce aggressive behaviour and sometimes violence. Two respondents from directly involved organisations agreed that there was general under-reporting of incidents at practice level, and only the most serious incidents being reported to Police. A respondent from an indirectly involved organisation, however, believed that

...all incidents should be reported internally it is behoves upon the employer to provide ... the necessary reporting measures; encourage all our members to report serious incidents to police.

This respondent was referring to the employer's duty of care under OH&S Legislation.

Conclusions

Respondents reported overall consensus regarding accepted definitions of aggressive patient behaviour, however the professional discretion of each individual GP determined the actual response to patient initiated aggression. Respondents generally reported that their professional organisations were neither proactive in advocating harm minimisation strategies, nor were they responsive in terms of post-incident support. In some instances, it was beyond the current charter of the organisation to provide support, and rural and remote organisations were logistically hindered in the support they were able to provide.

Respondents reported a general sense that professional organisations were not keeping abreast of changes in society and of member needs in the area of patient initiated aggression in the Australian general practice setting. Respondents acknowledged the need for GP education and training but related limited knowledge of DGP education in the area of patient aggression.

Respondents generally believed that response to patient initiated aggression might best be managed through workplace OH & S strategies but there were few examples of formal strategies being operational. The practice response to each incident varied according to their professional judgement at the time. There are problems inherent to this approach, and respondents believed that their professional organisations might have a role in this area. In addition, industry accreditation requirements reportedly overlook this issue.

GP murders are the extreme form of patient aggression and are relatively infrequent. Of concern, however, is the reportedly high incidence of other forms of aggression, with an average of two of every three GPs having experienced some form of violence in the past 12 months¹⁸. On the mildest end of the spectrum of aggressive patient behaviours, respondents generally believed that verbal aggression was so common that it could too easily be dismissed as an issue of concern. What remains concerning is the reported lack of organised professional support for staff affected by aggressive patient incidents. Professional organisations are well placed and have a role to play in providing such support in the future.

Chapter 5 Qualitative interviews, focus groups and affinity groups

Introduction

This chapter presents the findings from qualitative research conducted by CR & C.

A series of focus groups and in-depth interviews were conducted to explore the staff experiences of patient initiated aggression while working in Australian general practices. The qualitative research did not seek precise identification of the incidence or prevalence of patient initiated aggression.

Focus groups

Traditional focus groups were held in each of the eight fieldwork locations (Appendix I), with an additional affinity group held in four of the eight locations. The exception was Alice Springs, where a second affinity group was held in place of the scheduled focus group due to the small number of general practices in the area.

Between five and nine practice staff participated in each focus group, yielding a total of 54 participants. Affinity groups attracted up to five participants per group, with a total of 24 general practice staff participating. This represents a total of 78 participants across all groups. Focus groups participants represented the range of general practice staff, including practice managers, practice nurses, dieticians, allied health staff, diabetes educators, child psychologists and practice receptionists (Table 5).

In-depth interviews with GPs

A total of 20 in-depth interviews were held with equal numbers of male and of female GPs. Half of these interviews were conducted in person and half were conducted by telephone. At least one interview was conducted in each state or territory with the exception of the Australian Capital Territory (Appendix I).

The GPs interviewed for this research reflected a broad cross-section of GP demographics, including a range of age groups; varied years of experience in general practice; roles at practice; and country where their general practice training was received (Table 6).

Table 5: Demographic summary of focus and affinity group attendees.

Demographic variable	Number
Gender	
Male	8
Female	70
Number of GPs at Practice	
Solo	10
2 to 10	44
> 10	5
Years experience	
< 5	23
>5	55
Position in practice	
Manager	23
Practice nurse / nurse	17
Receptionist	28
Psychologist	1
Child psychologist	1
Physiotherapist	1
Diabetes educator	4
Dietitian	2
Massage therapist	1
Practice type	
Sole	12
Group	19
Corporate	22
Other	2
Services	
Home visits (HVs)	20
After hours services (A-H)	13
Both HVs and A-H services	21
Neither HVs nor A-H	6
Working for multiple practices	1

Table 6: Demographic summary of GP interviewees

Demographic variable	Number
Gender	
Male	10
Female	10
Number of GPs at Practice	
Solo	4
2 to 10	13
> 10	3
Years experience	
< 5	3
>5	16
n/a	1
Training	
Australia	12
Overseas	4
Both	1
n/a	3
Practice type	
Sole	4
Group	9
Corporate	6
Other	1
Services	
Home visits (HVs)	2
After hours services (A-H)	3
Both HVs and A-H services	6
Neither HVs nor A-H	8
Working for multiple practices	1

Findings

The qualitative research explored GPs' and general practice staffs perceptions and experiences of patient initiated violence. Overall, the experience with patient initiated violence and aggression was markedly different for the two groups.

Frontline general practice staff (receptionists and practice managers) were far more likely than GPs to be the target of patient verbal aggression and threats. Frequently, verbal aggression was a daily occurrence. Reported incidents of physical violence were rare and where this had occurred, GPs were more likely to have been the target.

Most significantly, neither GPs nor general practice staff related to the term 'patient initiated violence'. To reflect this finding, qualitative data are reported in terms of 'aggression' rather than 'violence', although some of the incidents of aggression are violent, such as an axe attack on a GP. This finding influenced the terminology of the online survey.

Findings from this research are reported below and were used to inform the development of the online survey for all general practices in order to quantify the experiences of Australian General Practice staff.

Incidence / prevalence

In reported order of prevalence, patient initiated aggression towards general practice staff took the form of:

- verbal aggression including in person verbal abuse, abuse over the phone, and intimidation;
- violence against property, particularly within the practice and its immediate surrounds;
- harassment and stalking, particularly of reception staff, and
- physical violence, including attack with or without a weapon.

Only one instance of sexual harassment or sexual assault was discussed during the focus and affinity groups (no instances were raised during interviews with GPs). However, it is acknowledged that this may be a more common occurrence, with instances not raised in a group or interview setting given the sensitive nature of the topic.

Verbal aggression

Verbal aggression was reported by many practice staff to be an almost daily occurrence but was not considered as 'violence'. Many general practice staff claimed that they had never been subject to patient initiated violence, and then proceeded to relate serious experiences of verbal aggression, intimidation and standover tactics from patients visiting their practice.

In addition to raised voices, intimidation and abusive language, a small number of practice staff (typically reception staff) reported that the threatening manner or stance of some patients had caused distress, even though these patients had not become physically violent or abusive, "He came in and he was frightening ... I have never seen such an evil look." And in another example:

He never ... he didn't get violent. He wasn't over-loud, he would not come over to the desk to intimidate you. But the way he spoke, something in his mannerisms. He was just that sort of person.

Many practice staff reported that verbal aggression was just as likely to be instigated (if not more likely) by 'respectable middle-class citizens' as it from patients from low socio-economic backgrounds or those with drug and alcohol issues. One focus group participant considered, "I would suggest that perhaps the more verbally abusive come from the middle to upper class. They are very articulate with their language and very strong - they will stand toe to toe."

Further, verbal aggression was often reported to come from female patients as much as from males. Some male GPs expressed a high level of discomfort and uncertainty when dealing with verbally aggressive female patients. One GP noted, "But I feel the one that's the most intimidating is not a man, it's a woman."

In summary, reported instances of verbal aggression were many times higher than any other form of violence or aggression. Verbal aggression was encountered almost daily by some practice staff.

Violence against property

On a qualitative scale of incidence, participants reported violence against property as the second most common form of aggression. This form of aggression typically occurred after a patient was refused medication or a request to see a doctor immediately. The resulting anger was expressed as aggression either within the practice by behaviour such as throwing chairs and office equipment, or outside of the practice where the patient expressed their anger through behaviour such as hitting walls or damaging cars in the car park, as illustrated below:

We were in a fibro shack as one of the shops had burned down and we were in the fibro shack for a few months and we had a druggie arrive at lunchtime there

was only me and the receptionist there and he walked around the house and was banging the fibro and putting his fists through ... of course we were petrified.

Practice staff reported this form of aggression to be upsetting but indicated that violence against property rarely escalated into physical violence against staff. The offending usually left the premises of their own accord having vented their anger, and generally did not return to the practice. Furthermore, very few participants reported that these incidents were sufficiently significant to impact on their ability to undertake their work.

A small number of practice staff reported theft from the practice as a form of property damage. Theft was reported frequently as drug-seeking behaviour, with patients breaking into the practice after hours to obtain certain drugs. One practice staff member reported that drug seekers had stolen scripts in an attempt to acquire drugs and a GP (Darwin) reported one incident of a patient stealing money directly from her purse when she left the consultation room for a moment.

Stalking

Many practice staff could recall an instance of stalking, however few reported an occurrence of stalking that involved them personally. A small number of interviewed GPs recalled instances where patients had developed an unhealthy obsession with them as their doctor.

Stalking was typically reported to take the form of unrealistically frequent visits to the practice, the sending of inappropriate gifts, and in some rare instances, following a practice staff member after hours. Stalking appeared to be more commonly directed towards reception and other frontline staff who are typically more visible to the public, such as in the following example:

I have heard of an incident where a patient became not necessarily violent but became infatuated with one of the receptionists – that is another thing that happens – quite regularly and obviously stalked her and suddenly at work she got some flowers sent to her one day and she of course carried those flowers out of the office and he has followed her home and it was quite frightening.

Despite the serious nature of the reported incidents, general practice staff considered that aggressive or violent acts such as stalking were so uncommon that it was not really a problem or of concern.

Physical violence

Physical violence was reported as one of the rarer forms of aggression in general practice. The incidence of patient initiated physical violence was reported to be low for most practices and virtually non-existent for other practices. Many practice staff and GPs could recall instances of physical violence, though often these occurrences were some time in the past, and were directed at a colleague. Participants commonly described these as 'once in a lifetime' events, "Very occasionally you get someone who gets physically violent and tries to thump a receptionist, but that is rare."

GPs working in remote communities such as those in the Northern Territory reported more severe forms of physical violence. The social and health issues that affect these remote communities were believed to lead to a far higher threat of physical violence. From a GP who had practiced in remote communities in the Northern Territory, "When you're working in the bush you don't get the opportunity of taking leave. Unfortunately in an aboriginal society there is a lot of violence." In another incident from the Northern Territory, a GP reported:

Getting punched, it all happened that fast I didn't have time to think about it. When I was working out bush I had been attacked by someone with an axe, that was worse than getting punched. [After being punched] I just closed up the clinic and went home.

None of the GPs from metropolitan or regional practices reported this level or severity of physical violence. Metropolitan and regional GPs recalled being physically attacked by patients not in the general practice setting but during their time spent as a Resident Medical Officer in public hospitals.

Practice staff perceived that not all incidents of physical violence were intended to hurt or injure them. Some recalled patient behaviours did not fall neatly into the category of 'physical violence' directly intended to cause bodily harm, but were nonetheless physical in their nature. One such form of physical violence entailed the use of body-language to intimidate practice staff. Participants reported patients commonly 'standing over' staff in reception and elsewhere in the practice in an attempt to have their demands fulfilled. "The aggression. And they will stand over the receptionists. Standover tactics. They will come to the reception desk and they will lean over and try and intimidate you. This is before they even get into the doctor."

One GP reported an instance in which a patient expressed physical violence to 'get a reaction' than to cause bodily harm. This instance provided another example of a form of physical violence where the primary purpose was to cause a psychological effect rather than physical damage. The GP recalled, "There was one incident where a doctor had a knife thrown at him. It clearly missed ... he just wanted to get a reaction."

A small number of practice staff recalled instances where patients had barricaded themselves in the practice and refused to leave until their demands were met. Toilets and other rooms with locks on the doors were reported to be the most common locations for this type of behaviour, "He goes into the toilet and locks himself in, and I am thinking 'what do I do now? ... It took us 20 minutes to coax him out."

Targets of aggression

The focus groups and interviews revealed that experiences of patient aggression appeared to be inversely related to seniority within the practice. Less experienced staff, receptionists and administrative workers were more likely to be exposed to aggression compared with more experienced staff such as practice managers and GPs. 'Frontline' staff (reception area staff) were far more likely to be exposed to patient aggression on a regular basis than were GPs and more experienced staff. GPs acknowledged this, and some GPs expressed thankfulness that they were in some way shielded from the day-to-day aggression of patients. "The girls seem to take it in their stride in some ways they mostly are not ... what's the word ... overly upset by it I mean they are upset but they talk amongst themselves." target

One focus group participant reported, "...the receptionists at the frontline get most of it, and by the time they get to see the doctor, it's all over and they're as sweet as pie". One participant noted, "Its not specific aggression, just a bit of shouting":

Most of the abuse that we see is directed at the receptionist I think. They are polite to the doctors and when they come to the reception, they are either demanding an appointment or they are not happy with the fee they have been charged and they will really be quite aggressive to the receptionists and then you know they are usually told to take up the fee issue with the GP and they are always polite to them.

Triggers

One of the predominant triggers for aggressive patient behaviour in the general practice setting was reported as being: "when a patient does not get what they want". Such refusals were reported to take place commonly at three key time points during a patient visit:

- at the start of the visit when a receptionist may refuse access to a GP, or a patient may have to wait for longer than they perceive to be reasonable; or

-
- during the consultation, when a GP may refuse to provide a script for a particular medication or treatment, a particular issue in the case of 'doctor shoppers' or 'drug seekers', or
 - refusal to bulk bill or otherwise provide services at a cost agreeable to the patient.

In some very rare circumstances, participants reported patient aggression to be triggered by a patient's psychological problems and apart from the provocations mentioned above.

Waiting times and refusal of immediate access to a GP

Reception staff reported that by far the most common provocation for patient initiated aggression was long waiting times as doctors commonly did not keep to scheduling. Participants reported that some patients became increasingly agitated as their appointment time passed, particularly when they observed other patients being shown through to the surgery before them:

A few weeks ago here I had someone who was being given - at the last minute - an appointment for the first thing in the morning. He turned up late for that appointment, and then when the next person who arrived earlier was actually called in first, he left, throwing things and swearing at staff.

In more extreme forms, patients without an appointment were said to become aggressive when they were refused immediate access to a GP upon presentation, as in the following example, "We had an incident similar this morning, 'I want to see the doctor now'. The doctor wasn't available, then the patient started throwing things around and became quite violent."

The systems of appointments and prioritisation of cases was reported to be poorly understood by patients, adding to the risk of aggression resulting from long waiting times.

Refusal of medication

Patients seeking drugs or those addicted to certain prescription medications (particularly methadone and benzodiazepines) were reported to present difficulties for many practice staff. The doctor's refusal to prescribe particular narcotic drugs to these patients commonly led to aggression. "Drug-seeking I suppose is a bigger cause of violence in my office than anything else. Basically for refusing to prescribe the drugs."

Drug-seeking patients were reported to employ variously complex tactics. At the simpler end of the spectrum, drug-seeking patients would simply ask for their drug of choice. "Most of them are quite business-like, 'Can I have the drugs?' 'No'. 'Ok, see you later.' " This type of situation was reported to less frequently lead to aggression.

At the other end of the spectrum, some drug-seeking patients reportedly fabricated elaborate stories to persuade the doctor to write a script for the desired drug. Often, these stories were said to involve very ill relatives in need of particular medications, lost scripts for medications, scripts that had gone through the wash, etc:

... One of the patients that came in on the weekend came in with a special authority script for something or other for his son and he said that the son had lost the medicine and he needed to get some more and the son was visiting family up in [location]. I didn't take any notice of what he was saying I just put him through to see the doctor and the doctor picked up on it and rang the pharmacy and he had come with the same story three times in one day.

Many GPs indicated that refusing medication to demanding patients could be a difficult task. Some GPs reported a conflict between wanting to assist the patient by supplying appropriate support and medication, but at the same time not wanting to support a patient's reliance or addiction on a particular medication. Others reported that they had at times given in to the patients' requests in

order to reduce the risk of an aggressive or violent incident. This was most often described as happening early in a GP's career, when they had been less experienced.

Aggression arising from refusal of medication or treatment was not limited to drug-seeking patients. One GP related a story when she had been subject to aggression following a misunderstanding about a patient's access to a diabetes educator. This patient was not drug seeking but became very agitated and aggressive when the GP would not allow him to use certain medical services:

He wanted to see the diabetic team at a low cost. ... I didn't know about it, I mentioned the name of the diabetic educator who is here and that is when he turned violent, very violent, aggressive, he was very aggressive, would not stop. I was thinking, 'What am I going to do now?'

Participants in one focus group noted that this type occurrence was particularly prevalent for overseas trained doctors in their practice. In this case, practice staff were often called in to the consultation room to act as a mediator when patients became aggressive towards an overseas trained doctor who had refused to provide a requested prescription or service. These patients would question the GP's authority based on their accent and English skills.

Financial issues including refusal to bulk bill patients

Patient initiated aggression occurred either before a consultation with a GP, or during a consultation with a GP, or as a disgruntled patient departed the surgery. The other common point of aggressive behaviour occurred when the patient was paying for the consultation. Practice staff reported that some patients became aggressive when told the amount they were to be charged for the consultation. This situation could be exacerbated when bulk-billing was denied, particularly if the patient had expected this; if fees had increased, or if an additional charge was added for an unexpected procedure, test or extended consultation. A focus group participant reported:

There was a patient who was unhappy with their billing and was on the phone and said he wanted to see the manager and he threatened me and he said I am going to come in and I want my money back and was going on like this.

Practices are now commonly charging a 'no show' or 'missed appointment' fee that also incites aggression from patients. In some locations, general practice staff reported that the resulting risk of aggression or abuse from patients asked to pay a 'no show' fee was so high that the practice had abandoned the policy.

Risk factors

Previous studies have identified a range of factors contributing to violence and aggression in general practice^{16, 23, 25, 79}. These factors include high numbers of drug users attending the practice and low socio-economic status of patients. Fieldwork locations for this research intentionally included high-risk areas to maximise data from practice staff who had experience working with these types of patients.

In addition to these known factors, practice staff identified a number of other potentially high-risk situations. These included:

- the employment of young, inexperienced staff and/ or staff whose personality is not well matched to the role;
- certain times of day, and
- the physical location of the practice and its facilities.

Experience and staff suitability

Participants agreed on personality traits of both frontline practice staff and GPs that had the potential to increase the risk of patient aggression. Experienced and mature staff demonstrated the skills to

pre-empt potentially aggressive incidents. Practice staff believed that these skills had been learned through life experience as well as formal training, "I guess through experience and training we recognise certain things".

For many GPs, the ability to set boundaries about what they would and would not do for patients, and what constituted appropriate patient behaviour were reported to be key factors in minimising the risk of patient aggression:

So, I think the most important thing is stick to your guns and don't give from the very beginning and then you don't attract them to come. Once you help them, they'll follow you. They'll all come, one after the other. 'Ah, he's an easy one' 'He's sympathetic'.

Some GPs however, recalled instances of their own naivety during their early years of practice, and confirmed that as experienced practitioners, "I'd rather write the script and get the patient out of the surgery than have an incident." Two GPs mentioned that they will write the script, but for a limited dose and duration to maintain the best health decision for the patient.

Reception staff reported that the ability to remain calm and not aggravate or escalate a tense situation was vital. Some reception staff reported having an innate ability to diffuse or otherwise de-escalate an aggressive patient. Other staff seemed to lack this ability and were therefore deemed unsuitable for work in general practice. A focus group participant recalled a colleague, "I think it can depend on a person ... the poor junior, she was pretty shaken up about it - limited life experience can limit how you deal with someone who is particularly aggressive."

Certain times of day

Practice staff in the focus groups identified common times of the day when they felt more vulnerable to patient-aggression. A frequently mentioned time of increased patient aggression was close-of-business on Friday when patients would present requiring 'immediate' assistance from a GP, "... but we do unfortunately call our Friday night specials ... "I want to be bulk billed" you try to explain, and they blow up".

Other periods of greater staff vulnerability were when few staff were on duty, such as lunch times, at daily practice opening or closing times, and week-end opening times. Periods when no GPs and/ or no males were on the premises were also thought to be particularly risky, as were times when cash or medicines were being sorted and stored:

We had an incident ... during the lunchtime there was only three of us ... no doctors and a woman and her boyfriend came in ... the woman was very volatile from the time they walked in ... we were preparing our banking, he tried to pinch our banking, it was on the back desk at one stage, but we caught him.

Two practice staff also perceived that the phase of the moon can influence patient behaviour, "All the loonies come out - full moons", with erratic or aggressive behaviour more likely during a full moon. This phenomenon is well documented in the psychiatric literature.

Location of general practice

The physical location of the practice, beyond the demographic profile of the neighbourhood was thought to positively influence patient aggression.

Practice staff reported a greater number of drug-seeking and walk-in patients demanding immediate access to a GP when the practice was located on a major street with doors that opened directly onto the street footpath. According to one focus group participant, "Because we're in the main street we

get quite a lot of people dropping in. We tend to get the lower socio-economic status people because they think 'there's a doctors there, we'll just go looking'." A practice with high visibility on a major road was thought to increase the risk of after-hours break-ins. Practices with a lower level of visibility situated in quieter, suburban streets were thought to be at a lesser risk.

Practices in close proximity to a hospital emergency department were reported to be more vulnerable to patient aggression. Staff from such practices reported high instances of patients expecting immediate attention after being sent away from the emergency department, and of patients who had simply become impatient with hospital waiting times.

Practice staff perceived that practices located within a shopping centre or similar facility benefited from the presence of security guards who appeared to deter aggressive patient behaviour. However, the actual efficacy of security guards in assisting with aggressive patients was questioned by some practice staff. "Then there is the little security guard who is completely unarmed ... but they weren't around ... it took an hour to get the cleaner" to assist practice staff with an aggressive patient.

Perhaps ironically, proximity to a police station was not generally seen as being an advantage when it came to minimising risk of harm from patient aggression. Response times by police were often seen to be too slow to make any meaningful difference in a very dangerous situation:

It is across the road from the police station ... you could ring up and say 'this guy is very aggressive but don't worry I have just shot him'. That might be the only way to get service and we are right next door, they are so close yet so far away.

Other specific situations of increased risk

Other factors that increased the risk of patient initiated aggression included cultural difficulties encountered by overseas trained doctors, and gender-based issues encountered by female GPs. Focus group participants reported that some patients reacted poorly to overseas trained doctors, particularly when the doctor's English-speaking skills were low. Cultural differences relating to how medicine was practiced, language barriers and inter-personal dynamics between GP and patient were cited as factors increasing the risk of aggression:

We try and get overseas trained doctors into our program, we don't have that many of them ... from what I understand, from what they tell me, practicing 'at home' is very, very different. You see huge numbers of people who are very respectful. You tell them what to do and they walk out the door, and so the negotiating skills and the confronting boundaries are completely different [in Australia] and there is also a language barrier, when English is not your first language.

Not all general practice staff reported increased risk of patient aggression associated with overseas trained doctors. Cultural, communication and inter-personal issues were often reported to be specific to an individual GP and to the individual patient, rather than generally applicable to overseas trained doctors.

Some female GPs indicated that they had felt particularly at risk when confronted by men who were generally larger, stronger, and perceived as being more aggressive than women. Some female GPs also reported feeling a heightened sense of vulnerability during pregnancy.

Research findings suggested a contrast between the manner in which male and female GPs explained experiences of aggression. Male GPs typically explained how they had *handled* or *resolved* situations involving aggression. Female GPs were more inclined to relate how intimidated and scared they felt, or how they had not handled a situation well out of fear. A female GP recalled;

In my first couple of months in being in general practice it was a man that had just gotten out of jail, he came in wanting some Valium. Physically he was a very intimidating looking man, close to 7 foot, covered in tattoos. I was pretty young so looking at him was scary. I just gave him a script and never saw him again either. On those occasions I felt, this is an unpredictable person and I felt unsafe.

Whether female GPs are genuinely at higher risk was not directly addressed in this research.

Trends in violence

Practice staff participating in the research generally expressed no overall sense as to whether and how patient aggression was changing in nature, frequency or prevalence. While there was a general yet unquantified sense that aggression was increasing in the community, some staff reported that violence had decreased at their practice due to factors such as refusing to see new patients. Other practice staff linked rising global aggression to consumer education and to the changing role of general practice within society.

Some focus group participants described the younger generations of general practice patients as coming from an 'immediate society', where gratification was expected and demanded immediately and regardless of whether or not their requests were reasonable. One focus group participant reflected:

... they are a spoilt generation. They want and want it now, 'And I have a young child and I deserve to get in over you because' ... it is that same age group every time, and you know as soon as they come in the door. You think yep, here we go again.

Compounding the 'fast-food' generation phenomenon, some practice staff believed that the authority of the GP has become eroded. These staff reported that some patients will not take the GP's word as final but expected that all requests for medication, appropriate or otherwise, should be met. One GP reflected, "Doctors are no longer seen as a holy grail or untouchable and it's a bit of an instant society so people want everything now and they want it dealt with straight away."

Consequences and outcomes of violence

The reported consequences of aggression and violence in the general practice ranged from no or little effect, to changing jobs and reducing service provision. Broadly, responses could be categorised into three outcomes:

- For the most part, practice staff did not perceive serious impacts of violence on their mental or physical health, or on their ability to provide services. These practice staff were typically only subject to verbal abuse with little or no experience of other forms of violence.
- In the middle of the continuum, some practice staff admitted that constant verbal aggression 'wore them down' and contributed to staff turn-over and absenteeism.
- At the far end of the spectrum, some GPs indicated that aggression and the threat of aggression led to burn-out, the need to reduce services and in some instances move practice to escape from aggressive behaviour. This scenario was rare.

Practice staff commonly reported delayed effects of exposure to patient aggression. Some staff reported "going to pieces" shortly after dealing with patient aggression, while other staff did not recognise the impact of the aggressive incident until some months later, as reported by this male GP, "He just stood over me with an axe ... It wasn't until six months later that it hit me. I had to see someone about it."

Although study participants described many variables and compounding factors affecting their response to patient initiated aggression, research findings suggested two broad categories of outcomes of patient aggression expressed against practice staff. As can be expected, direct and unexpected exposure to a violent incident tended to immediately challenge practice staff views of their work area. Depending on the severity of the violence, practice services and/or protocols were amended accordingly. However, repeated exposure over a long period of time, even exposure to 'lower level' forms of violence such as verbal abuse could build over time and lead to delayed reactions and the need for staff to take time off, to seek counselling, or to change their employment.

Little or no perceived impact of patient initiated aggression

Many practice staff reported zero incidence of violence or aggression in their practice, or that their practice considered patient aggression as a 'normal' part of general practice. Where staff took this attitude that aggression was 'just part of the job', the impact of aggressive incidents was equally non-remarkable.

Mid-spectrum impact of patient initiated aggression

Some practice staff reported that the constant verbal abuse from frustrated patients became noticeable over time. These participants described a feeling worn down or burnt out following many years of managing and coping with aggressive patients.

Other participants reported being in a near-constant state of fear of the risk of patient aggression, and worked with an ever-present anticipation of the next difficult patient. For these staff, patient initiated aggression had a detrimental impact on their mental and physical wellbeing. One receptionist reported, "It is really hard to keep down sometimes because you are really angry, upset - you are frightened. I feel I can't talk to the staff at work about how I feel because they are coming to me."

Another outcome of patient initiated aggression on staff stemmed from having 'normalised' and accepted aggression in the practice. "We just dismiss it but it is not normal. It does leave an impact." This insight from a focus group participant illustrates the insidious and long lasting effect of unacknowledged aggression.

The mental exhaustion resulting from the stress of long-term exposure to constant patient aggression was reported to lead to high levels of staff turn-over and difficulties recruiting new staff for some general practices. One GP recalled, "We started to get a high impact of turn over of staff. People didn't want the job. People complained all the time, people going off on sick leave all the time. They weren't sick, they were upset; it was not fair on them."

Serious psychological impact and service reduction

A small number of those GPs interviewed reported that exposure to patient aggression had become so severe that it negatively affected their psychological and physical health. Some of these GPs reported depression and anxiety as major health problems resulting from ongoing exposure to patient aggression. These GPs reported that depression and anxiety were exacerbated by a feeling of helplessness to change the situation, either because the GP was unable to introduce measures to reduce the risk of violence, or a feeling of fatalism that aggression was going to increase over time.

Effective strategies to minimise the risk of harm from patient initiated aggression

Practice staff participants reported a wide range of strategies already in place to minimise the risk of harm caused by patient aggression. These strategies generally fell into one of three categories:

- *Interpersonal strategies*: training and selective hiring of staff to be able to manage and cope with patient aggression;

-
- *Procedural strategies*: policies and other documentation on how to deal with patient aggression, and
 - *Structural strategies*: modifications or enhancements to the practice building such as locks, alarms and barriers.

Great variance was noted in both the number and extent of strategies implemented. In addition, the degree to which any strategies had been adopted did not seem to directly relate to the risk of patient aggression at a given practice. Some practices where patient aggression was reported to be frequent seemed to have few strategies to address the risk of patient aggression or to minimise harm resulting from aggressive patient behaviour. As with many measures to reduce harm (such as OH & S systems etc), the extent to which practices were addressing patient aggression seemed to depend more on the 'safety culture' that existed within each individual practice, a culture generally driven by higher levels of management.

Interpersonal strategies

Training and education

Many general practice staff reported that they had received training on management of aggressive or difficult patients; however, the courses did not necessarily directly refer to violence. The courses were typically run by the local DGP. A few practice staff mentioned having attended seminars supported by drug companies.

The Division-run courses were generally well received. They aimed to teach skills to manage difficult patients and to cope with aggressive behaviour. However, many practice staff reported that the courses were infrequent, were sometimes over-subscribed and overly-targeted at the GP or the practice manager, rather than focused on frontline reception staff needs.

Staff personality

All practice staff readily described the personal qualities of effective and efficient general practice staff. Several staff described staff selection and retention based on these qualities, which included:

- The ability to display confidence:
If they pick up any tremor in your voice ... if I had given him the opportunity to notice how I felt inside it would have been a lost case ... if that patient can hear in your voice that you are nervous or you are going to back down, you have had it.
- Listening and communication skills:
If you want to reduce the likelihood [of aggression], have friendly front staff, be polite and listen to them and don't shove them out the door too quickly ... I remind the staff of that: just take a step back and listen.
- Knowing when to set boundaries for patient care:
Yes have those boundaries. You have to. It was only a couple of weeks ago a middle aged fellow in the waiting room - and there were a lot of patients in there and it was very sexually inappropriate ... So I just said to him 'look excuse me this is a family practice, it is completely inappropriate to be speaking in such a manner it stops now'.
- The ability not to reciprocate:

Not being aggressive towards patients and – and speaking quietly and slowly in a manner that's not likely to arouse their anger is I guess, an important technique.

The ability to defer a situation to more senior staff

Many practice staff emphasised the importance of knowing when to progress the management of a difficult situation to a more senior staff member, or to an external agency such as security or the police. Practice staff described many situations when aggressive patient was successfully managed by a more senior staff member. Conversely, some practice staff also explained the negative outcomes of continuing to try to manage a difficult situation, "I wish I had called the police *then*".

Another staff skill was the ability to ease a direct refusal of a patient by citing the law or a practice policy as the reason why a patient demand could not be met. This skill was particularly useful when refusing requests for patient information. Some practice staff saw the restrictions placed on the release of information as a source of frustration and aggression for patients.

Humour

Staff emphasised the importance of maintaining a sense of humour, "You deal with it with laughter. You are not being rude or disrespectful to them but why go through being a grumble bum all the time?"

Procedural strategies

Participants reported minimal implementation of procedural measures to minimise the risk of harm from patient aggression or violence. Generally, these measures included policies, incident reporting, meetings and signage. In the majority of practices, these measures had been only partially implemented, or were un-written and practiced ad hoc. A small number of practices indicated that measures were absent and not even under consideration.

Policies and protocols

Most participants indicated that some form of policy or procedure relating to staff safety was incorporated into the OH & S section of a practice procedures manual. However, not all practice staff believed that these policies were adequate. While many stated that some form of policy or procedure had been implemented at the practice, these staff felt that the documents were neglected and under utilised.

Where clear and well documented policies and procedures existed, practice staff described documentation of:

- Protocols for communicating with and managing aggressive patients;
- Appropriate means of referring a situation to senior staff and external agencies such as police;
- Escape routes from certain risky areas of the building to the outside, and
- Protocols for the minimum number of staff to be on the premises at times of increased risk.

Practice staff rarely mentioned formal counselling and support mechanisms but acknowledged the importance of internal, informal support mechanisms. Informal group support often occurred very independently of the GP staff and senior management. GPs appeared to use support mechanisms external to the practice.

Staff induction

Most practice staff described some form of induction for new staff but many expressed that training and familiarisation with policies and procedures was inadequate in the area of patient aggression, "We don't have the opportunity to spend enough time with them to shadow them".

Staff meetings

Participants reported varying degrees of discussion of incidents at staff meetings. Some practices had staff meetings but others didn't: " 'We have a practice meeting' ... 'We don't have any' ... 'I'm so shocked' ... 'We used to have ward meetings all the time' ... 'We're supposed to but we don't' ".

Identification of aggressive patients and incident reporting

Many practices employed procedures for identifying aggressive patients in order to minimise future risk. Notification was both formal through patient notes and informal *via* a warning circulated among reception staff.

A small number of practice staff described broader advanced telephone warning systems between other practices and pharmacists in the local area. However, this process seemed to be limited to smaller communities.

Participants reported a system of progressive patients warnings until, if the behaviour persisted, the patient was barred from the practice. Some practices developed contracts with aggressive patients, particularly those with drug addiction problems, as a tool for ongoing monitoring of acceptable behaviour.

A number of the larger corporate practices in metropolitan regions kept an incident register – maintaining a record of any incidents deemed significant. One large corporate practice reported that any degree of patient aggression was recorded into an incident register that was incorporated into the OH & S Procedures. In this practice, any significant incidents would go through the same processes as a workplace injury.

We've got a corporate structure so [the incident report] travels up through this structure. Workers talk to their supervisors and their supervisors refer it to their branch manager who is sort of the section head who sends it up to corporate services, who puts it through the OH & S committee. Very bureaucratic.

Incident registers were less common in practices in regional and rural areas, as well as in small or solo practices.

Other than occasionally seeing a note on a patient's file GPs, especially those working as employees of a practice, were generally unaware of methods for recording violent or aggressive incidents. In addition, these GPs were unlikely to report incidents to other general practice staff unless physical violence had occurred. This was especially the case for male GPs.

Signage

Practice staff had different perceptions about the efficacy of the use of signage within waiting rooms and consulting rooms. Many practices had posted a policy phrasing a simple, blunt message regarding the practice's zero tolerance of violence. Some general practice staff saw the signs as being somewhat effective in reducing risk but other staff believed that aggressive patients were most unlikely to read signs, thus rendering the measure redundant: "If they are violent [and] they are not listening, they are not going to read the sign."

Changes to services provision

Many practice staff indicated that their particular general practice no longer accepted new patients or 'walk ins' (those people walking in off the street without an appointment). While these measures were

sometimes taken through necessity because the practices' books were full, practice staff also explained that this measure also reduced the risk of patient aggression. Patient aggression was greatly reduced when the practice only accepted known and non-aggressive patients.

Some practices had implemented similar policies that minimised attendance of drug-using patients. These practices displayed prominent signs stating that particular drugs (usually S8 drugs) would not be prescribed to new patients.

Some participants believed that refusal to see new patients became a source of patient frustration rather than a means to mitigate it. Some practice staff reported times when new patients or 'walk ins' became aggressive when the practice policy was explained and access to a GP denied:

The first one was someone walking in wanting an appointment and we don't take new patients. He flicked everything off the counter, he kicked a hole in the wall and put his hand through the door – sorry, he shut the door that hard that the glass broke. So we called the police ...

Many focus group participants suggested that denying services to certain types of patients was, at best, a temporary solution to the problem. Patients were known to simply move to the next general practice to continue their pursuit of drugs, treatment, immediate access to a GP etc. Participants agreed that these patients could become more agitated as they moved from GP to GP, and that these patients could end up at a GP who is least able to manage aggressive patients.

Strategies for out of hours home visits

The majority of participants indicated that their GPs no longer conducted home visits after-hours, primarily for safety reasons. A small number continued to provide this service but only for existing patients and patients known to be non-aggressive. One GP described a range of strategies to minimise the risk of harm from patient aggression. These included taking a partner who would remain in the car; the use of mobile phones to notify others of distress, and the pre-arranged code words that staff could use in the incidence of aggression:

They (partner) never leave the car, they always stay in the car. And we have an agreement, don't, even if I call you to come up, don't come up there, I never call you to come up unless there's something wrong. And if I call you to come up, you know I'm in trouble. And after certain time period, you call me and you can tell me there's an emergency call and say you've got to go, or something like that, if I give the code word or something, you know I'm in danger

Structural strategies

Research participants listed many structural measures implemented to minimise the risk of harm from patient aggression. However, implementation of effective structural measures was not universal. Many practices had few or no structural measures in place and some reported partial and/ or ineffectual implementation. A small number of practice staff demonstrated a wide range of modern and well implemented structural measures. The majority of practice staff perceived the structural measures implemented at their practice to be insufficient.

Consulting room layout

Many practice staff expressed concern regarding the physical layout of the GP's consulting rooms. In most instances, the patient sat between the doctor and the door, reducing the doctor's chances of a quick escape if necessary. Most saw the layout as a risk.

Some practices had implemented changes to the practice room layout to allow the GP an escape route unobstructed by an aggressive patient. However, some participants reported that rearranging the rooms was difficult due the placement of power-points and other factors, and reluctance on the part

of some GPs to change. One practice staff described an innovative new layout incorporating two entrances/ exits that allowed for easier escape from a potentially dangerous patient.

'Safe spaces' and 'cool down' rooms

Some practices maintained certain designated rooms that could be used either as a safe space for staff under threat from an aggressive patient, or as an area where agitated and potentially aggressive patients could be taken to 'cool down'. This latter strategy was thought to be particularly effective as a means to diffuse potentially harmful situations, particularly if the GP was able to check on the patient from time to time between other appointments. Agitated and potentially aggressive patients were reported to generally calm down quickly when removed from the reception environment, and given at least some attention from a GP or other practice staff.

However, not all practices had 'safe' space or the means to provide such a room, as described by one participant, "I've had to lock the door, lock patients in, from someone that we told to leave, because we thought they'd come back and kill us."

Control points and escape routes

Some practices had implemented a system of control points that allowed certain sections of the practice to be sealed off with locked doors to prevent access to aggressive patients. However, the presence of such organised and defined 'control points' was rare, and other practices had "a policy that the doors are locked if there is only one person there so nobody gets in and usually they are not left on their own".

'Panic buttons' and other forms of alarm

Many of the practices utilised some form of 'panic button' or duress alarm'. These alarms were either mobile carried on the person, or fixed to a wall at strategic points around the practice. The alarm itself was triggered either within the practice only, or to an external security company. Few practice staff or GPs reported the need to use the alarms and therefore could not comment on their effectiveness in an emergency situation. However, many participants had set off the alarm in error and received a fairly rapid response.

Several practice staff commented on the ineffective placement of wall-mounted panic alarms. Portable or 'wireless' systems were favoured, though such systems were perceived to be very expensive:

'Now you all have to go out and spend five thousand dollars on this system', some of them will say 'no we're not doing it', and they won't do it; but I guess ideally if I had my wish list, the government would say 'we will fit, install these' and it would go through.

Other less commonly reported systems for alerting aggressive patient behaviour included harnessed computer networks that provided the facility to raise an alarm. By entering a specified keystroke or mouse click, any staff member on a networked computer could alert other staff members at a networked computer to a difficult situation.

Elevated reception desk

A final and fairly common form of minimising risk of harm from patient aggression was an elevated reception desk. This structural barrier was thought to have a number of advantages, including providing a position of power in a dispute and preventing aggressive patients from reaching over the counter in a physical assault. Further, elevated reception counters prevented patients from viewing confidential information on computer screens or notes: "One thing I noticed at one of our clinics the girls are higher, so they ... are quite protected in that sense ... and it does make a difference".

Barriers to implementing strategies

Participants identified a number of barriers to the implementation of risk and harm minimisation measures in the general practice setting. These included attitudinal barriers, or perceptions that

aggression and the threat of harm was not applicable to individual practitioners or practices. This attitude was compounded by a related view that aggression was inherent in general practice and something that should instead be tolerated.

Other reported barriers were financial and logistical in nature. Some practice staff indicated that practice owners were unwilling or unable to implement structural measures to reduce the risk of harm from aggression. One participant suggested, "Putting profits ahead of safety". More commonly, practice staff indicated that the ageing nature of practice buildings made it impossible to improve safety using structural means.

A small number of practice staff indicated that a lack of meaningful support and input from government hampered their ability to implement measures to minimise risk of patient aggression.

Indifference: "Patient-aggression does not apply to us"

Many practices where staff had only been exposed to no or to low levels of patient violence did not consider precautions and risk minimisation strategies as necessary or relevant to their needs. One GP stated, "Yeah I think, you know, catching whatever diseases the patient ... I would rate that as slightly higher than violence in my practice ... sort of concern but I mean, I don't rate that as super ..."

Throughout the groups and interviews, practice staff generally indicated that they had not reflected upon the issue of violence and aggression to a great extent before participating in the research. Indeed, as each group progressed, many practice staff who initially considered the topic as unrelated to their personal experience began to develop a heightened awareness of the extent of aggression and violence in general practice.

The majority of participants were aware, through national media coverage, of the murder of the Victorian GP in 2006. Many practice staff had also heard reports of violence perpetrated against others in general practice. However, this indirect or anecdotal exposure to violence seemed insufficient to generate real concern or meaningful action on their behalf. This attitude was far less apparent for practice staff that had experienced violence, particularly violence beyond verbal abuse or verbal aggression.

In the absence of exposure to aggression beyond verbal abuse, practice staff did not perceive a need to implement pro-active measures to minimise the risk of violence in their own practice.

Inevitability: "It's just part of the job"

Many participants viewed patient aggression as a normal part of everyday life in general practice. Whilst not necessarily viewed as acceptable, aggression was seen as unavoidable given the requirements of working in a frontline position in general practice and with people who were stressed through having a medical problem.

Rather than advocating strategies to minimise patient aggression in general practice, some frontline staff took a strong stance on who should and should not work in general practice. These staff (often senior administrative staff) bluntly stated that if a particular individual was not able to cope with aggression, then that person should not consider seeking employment in general practice. One focus group participant stated, "In medical practice I believe you have to have that personality, it's something that you need to have", and another reported:

We have lost a lot of receptionists because they just don't cope. We had one leave just last week. She lasted three months and she was gone. She couldn't hack it. You have to have the right personality to be working as a receptionist at a doctor's surgery.

Two key factors were thought to feed the inevitability of aggression in general practice: The nature of the client base attending practices: almost by definition, patients are sick and thus practice staff "see

them at their worst". "Sick people get angry and upset because they are sick." Secondly, the under-resourced and over-stretched nature of general practice necessitates that patients will not always be able to see a medical professional of their choice, at a time that they would like, or to receive the medicines or other treatments that they would like:

We do actually see people obviously with medical conditions or with other stresses that go on, so we do see people who are very vulnerable and distraught. We've got factors contributing to aggression and violence.

Given these two relatively unchangeable aspects of general practice, practice staff believed that patient aggression will occur regardless of preventative measures. Some practice staff stated that violence and aggression had become so commonplace that it was simply accepted and not meaningfully addressed. One GP noted, "The last thing we actually think about is our safety and well being, this is the honest truth. It's the last thing. A lot of GPs just accept it."

Financial: The practice owner can't afford it/ won't pay for it

A small number of GPs related high levels of concern for their safety, but stated that the practice owner was not prepared to invest financially to upgrade facilities and policies to ensure staff safety. The GP who described this scenario in the most detail had personally been subject to violence in the past. She had raised her concerns with the practice owners about the neglect for her safety, but received no response.

Structural: 'old buildings can't be upgraded'

Many of the participants worked in practices situated in older buildings. These staff indicated that the age, structure and layout of the buildings made the implementation of structural measures to promote staff safety impossible, despite practice staff and owners desiring to make such modifications. These limitations were said to impact on the ability of the practice to arrange consulting rooms and adjoining corridors to allow for adequate escape routes for GPs and other practice staff.

Perceived lack of Government and community support

While many practice staff appreciated the support of their local Division of General Practice with regard to management of aggressive patients, some participants expressed a lack of meaningful support directly from the Australian Government. A small number of GPs expressed their frustration that the Government did not appear to be taking seriously the wellbeing of GPs, both in terms of the risk of violence as well as mental and physical wellbeing of GPs who work in stressful environments. One GP stated:

The government isn't going to do anything about it. I've seen it; it should be at least policed. Some GPs are depressed or have chronic anxiety problems. They can't cope; the requirements of the job are increasing and increasing. I don't believe our well being is at all considered by the government.

Suggested strategies to further reduce violence

The measures reported by participants for reducing the risk of patient aggression and subsequent harm in general practice have been described above. However, while some practices had implemented these measures, many participants expressed that preventative measures to reduce the risk of aggression were either too expensive to be purchased without financial support (in the case of alarms for example), or in too short supply to be effective (in the case of training provided by local Divisions).

To remedy this situation, many participants suggested that the Australian Government had a potentially stronger role to play in supporting general practices to minimise violence. Logistical, financial and policy support were among participant suggestions for greater Government contribution to staff safety, as was making certain measures mandatory under general practice accreditation. Some participants considered that accreditation was perfunctory rather than meaningful, "They

(accreditors) don't ask 'how did you handle this?' ... they don't go into aggressive patients or drug addicts or anything like that. (Only) which way to put photocopy paper in".

Another participant suggested that government or Division purchasing power could make the procurement of structural measures such as duress alarms easier and cheaper for general practices, "Panic buttons, ... if they could source it at a reasonable price, that it wasn't to the open market where it became, you know, ridiculously expensive. Yeah, you could say that for accreditation".

Conclusions

The qualitative analysis of data from GP and practice staff interviews and focus groups yielded information regarding staff perceptions of incidence, prevalence and trends of patient initiated aggression and violence, targets of aggressive behaviour, triggers and risk factors, and some measures taken by practices to mitigate harm resulting from incidents.

Data suggested two categories of practice staff perceptions based on each practices' experience with aggressive or violent patients. One group of practice staff, including GPs, had not experienced aggressive patient behaviour so believed that precautionary measures were unnecessary. Within this group were a sub-group of practice staff who had experienced verbal abuse but no incidents of physical violence. These participants did not classify verbal abuse as aggression but as a factor inherent in general practice work hence saw no need to instigate precautionary measures.

The second category of practice staff were those who had experienced patient aggression and /or violence, and those who believed that even verbal aggression was unacceptable. These practice staff reported a variety of harm minimisation measures that were in various stages of implementation across practices. Staff also reported a range of barriers that hampered optimum measures, but generally, they believed that some action had been taken to maximise their safety in the workplace.

Segueing both categories of practice staff were those staff who had heard about violent incidents and were concerned at the lack of response from their employers. This group of staff has been shown in literature to be constantly aware of potential danger, hence imminently less effective during aggressive incidents, more severely affected by such incidents, and more likely to seek alternate employment.

All participants agreed that frontline staff were the principal recipients of patient aggression. In addition, participants agreed that drug-affected and drug-seeking patients were the most common perpetrators of aggressive incidents. Participants made little mention of mental health patients becoming aggressive, although this did occur from time to time. Staff were usually aware of the potentially volatile nature of these patients, so responded to their needs in a different manner.

Triggers to patient initiated aggression included procedural issues such as long waiting times to see a doctor, unavailability of the doctor of choice, and refusal of specific patient-requested medication or treatment. Other triggers of aggression included issues of payment and refusal of bulk-billing.

Although some practices had made effort to protect staff and to minimise the risk of harm through patient initiated aggression, other practices reported barriers preventing them from taking action in this area. Barriers included the enormous cost of renovating old practice buildings, the cost of purchasing alarms or security devices, and 'head-in-the-sand' attitudes of practice owners.

Overall, participants agreed that patient initiated aggression was a problem in general practice, and many staff welcomed education, training, and other measures to maximise their safety, to maintain maximum possible service delivery and to ensure safety for other patients attending their practice.

Chapter 6 National online survey

Introduction

The national online surveys aimed to determine the national prevalence and incidence of patient initiated aggression perpetrated towards GPs and general practice staff. Two surveys were administered online: one for GPs to complete and the other for practice managers, or another representative from the general practice, to complete on behalf of the other practice staff. The practice staff were likely to include receptionists, practice nurses, practice manager, and other allied health staff.

The surveys were composed of four key sections:

1. Demographics
2. Frequency of patient aggression
3. Trends in patient aggression
4. Impact of patient aggression

The second section examining the frequency of patient aggression was further subdivided to enquire about:

- verbal aggression
- stalking
- physical assault
- damage or theft of property
- sexual harassment
- sexual assault.

This chapter is divided into two sections. The first section presents results from the online GP survey and the second section presents results from the online practice manager survey.

Online General Practitioner Survey Results

General practitioner demographics

A summary of GP demographic characteristics from the survey is provided in Table 7.

Table 7: General Practitioner profile

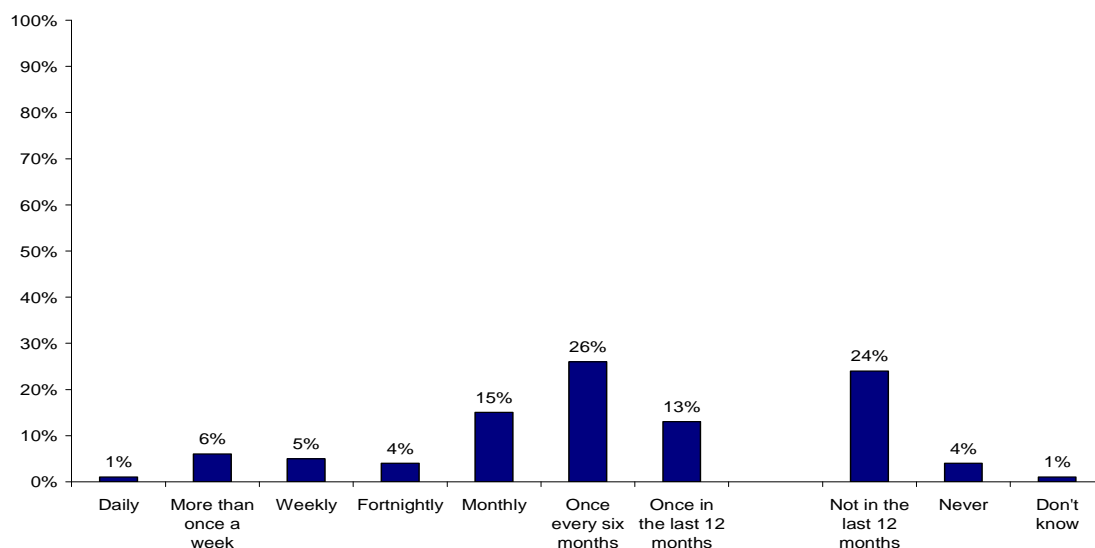
	(%)
Gender	
Male	60
Female	40
Age	
Average	49.6
Standard deviation	10.5
Years in general practice	
Average	20.2
Standard deviation	10.7
Full/ part time	
Full time	67
Part time	33
Practice composition	
Sole general practitioner	13
Group practice	63
Corporate practice	9
Other	15
Practice location	
Metro	42
Non metro	58
Practice state	
NSW	31
Vic	29
Qld	7
SA	10
WA	4
Tas	3
NT	11
ACT	5
Services provided	
Home visits during hours	66
Home visits after hours	49
After hours consultations weekdays	37
After hours consultations weekends	48
None of the above	15

n = 178 GP respondents

Incidence of verbal aggression

Almost all (95%) GPs had experienced some form of verbal aggression from patients and 70% had experienced verbal aggression in the last year (Figure 6).

Most commonly, GPs (15%) experienced verbal aggression on a monthly, six-monthly (26%), or yearly (13%) basis. Few GPs experienced verbal aggression once a fortnight or more frequently.



Survey Q8. In the last 12 months, how often have you been exposed to verbal aggression from patients, or people associated with patients?
n=178, General Practitioner respondents

Figure 6: Experience of verbal aggression

Male GPs, younger GPs and full-time GPs were each more likely to have experienced verbal aggression than their counterparts:

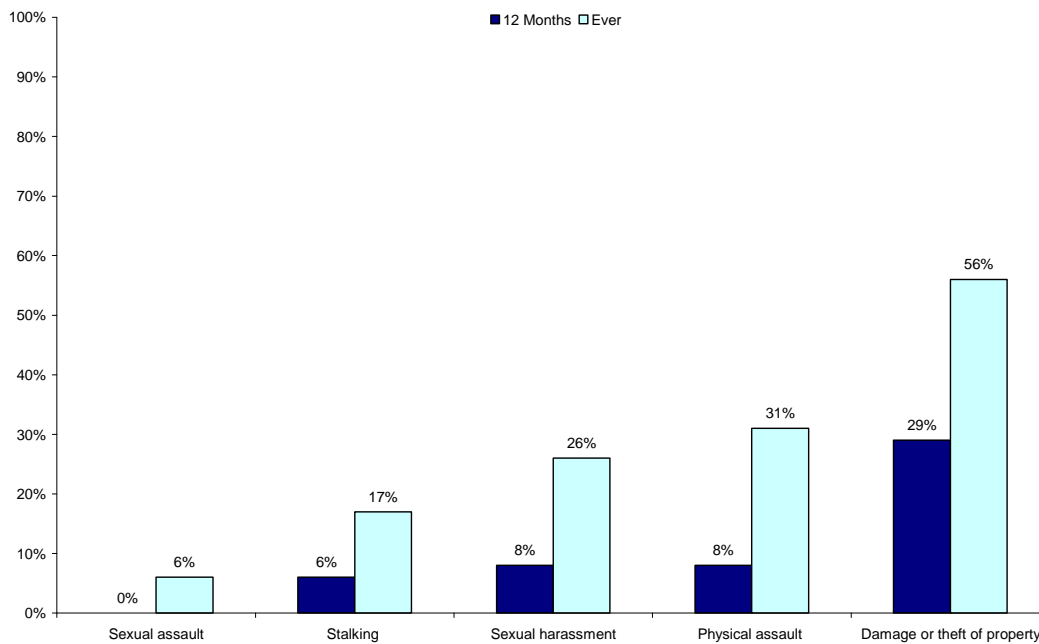
- 78% of male GPs had experienced verbal aggression in the last 12 months compared with 63% of female GPs;
- 80% of younger GPs (up to 50 years of age) compared with 64% of older GPs (50 years plus), and
- 77% of full time GPs compared with 62% of part time GPs

Incidence of physical aggression

Figure 7 provides a summary of the incidence of the different forms of physical aggression in the past 12 months, and the incidence of GPs who had ever experienced physical aggression. In descending order, incidence of physical aggression was reported to be:

- Highest for damage or theft to property (56% of GPs had ever experienced this form of aggression, 29% in the last 12 months);
- Physical assault (31% ever, 8% in the last 12 months);
- Sexual harassment (26% ever, 8% in the last 12 months);
- Stalking (17% ever, 6% in the last 12 months), and
- Sexual assault (6% ever, none in the last 12 months).

Detailed accounts for the incidence of these types of physical aggression follow.



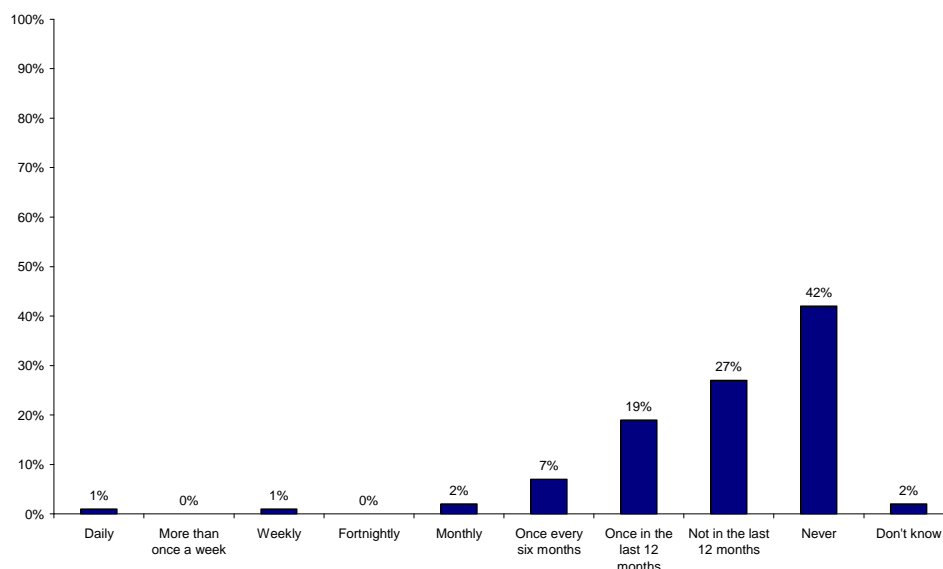
Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients... sexual assault ... stalking ... sexual harassment ... physical assault ... damage of theft of property?

n= 178 General Practitioner respondents

Figure 7: Summary of physical aggression incidence

Property theft or damage

Four in ten (42%) GPs had never experienced damage or theft of property by a patient or someone associated with a patient. One quarter (27%) had experienced damage/theft during their career, but not in the last 12 months. One fifth (19%) experienced damage/theft in the last 12 months, and a small remainder reported more frequent damage or theft in the last year (Figure 8).



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients ... damage or theft of property?

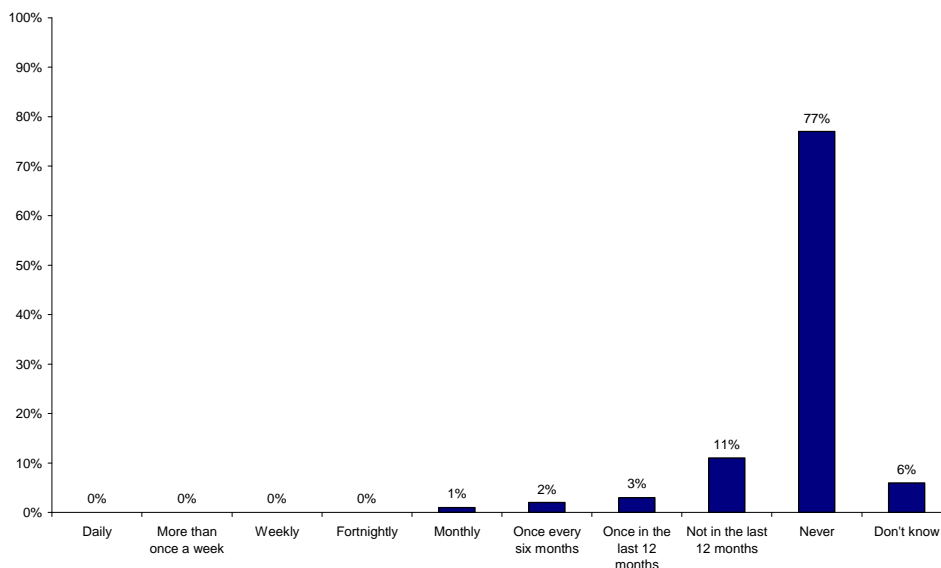
n=178 General Practitioner respondents

Figure 8: Experience of damage or theft of property

As with stalking and physical assault, full-time GPs were more likely to report experience of damage or theft of property compared with part time GPs. A higher proportion of full-time GPs (62%) reported any incidence of damage/theft compared with part-time GPs (41%). No other demographic differences were identified.

Stalking

Most (77%) GPs had never experienced stalking by a patient (Figure 9). One in ten (11%) had experienced stalking, but not in the last 12 months, with one in twenty reporting that they experienced stalking once every 12 months. Compared with other forms of physical aggression, a relatively high proportion (6%) of GPs did not know if they had been stalked by a patient.



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients... stalking?
n=178 General Practitioner respondents

Figure 9: Experience of stalking

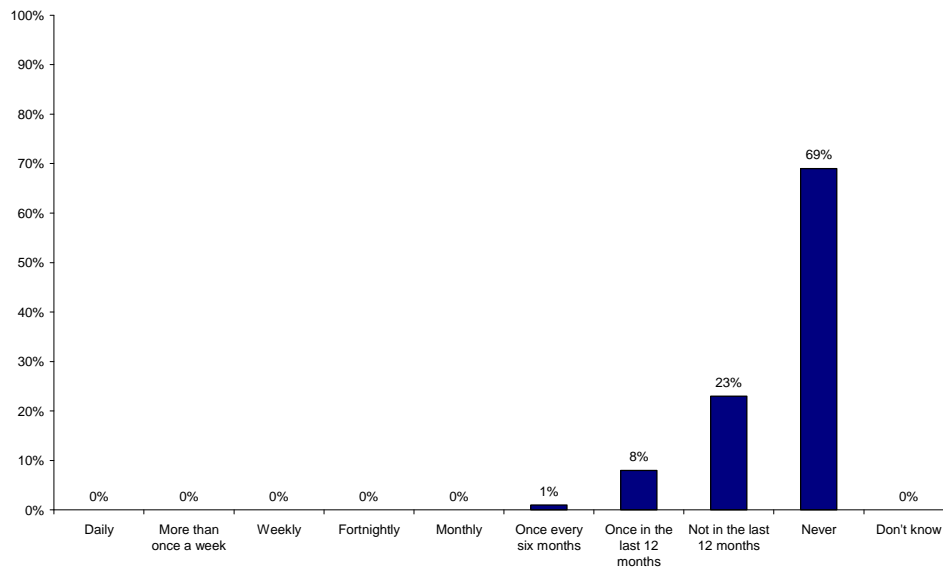
Full-time GPs were more likely to experience stalking compared with part-time GPs and male GPs were more likely to have experienced stalking compared with female GPs. Respectively:

- 8% of male GPs had experienced stalking in the last 12 months compared with 1% of female GPs, and
- 22% of full-time GPs had *ever* experienced stalking compared with 7% of part-time GPs

No other significant demographic differences were identified.

Physical assault

Seven in ten (69%) GPs had never experienced physical assault by a patient (Figure 10). Almost one quarter (23%) had experienced physical assault during their career, but not in the last 12 months. One in ten (8%) had experienced physical assault once in the last year and one in 100 (1%) had experienced physical assault once in the last six months.



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients ... physical assault?
n=178 General Practitioner respondents

Figure 10: Experience of physical assault

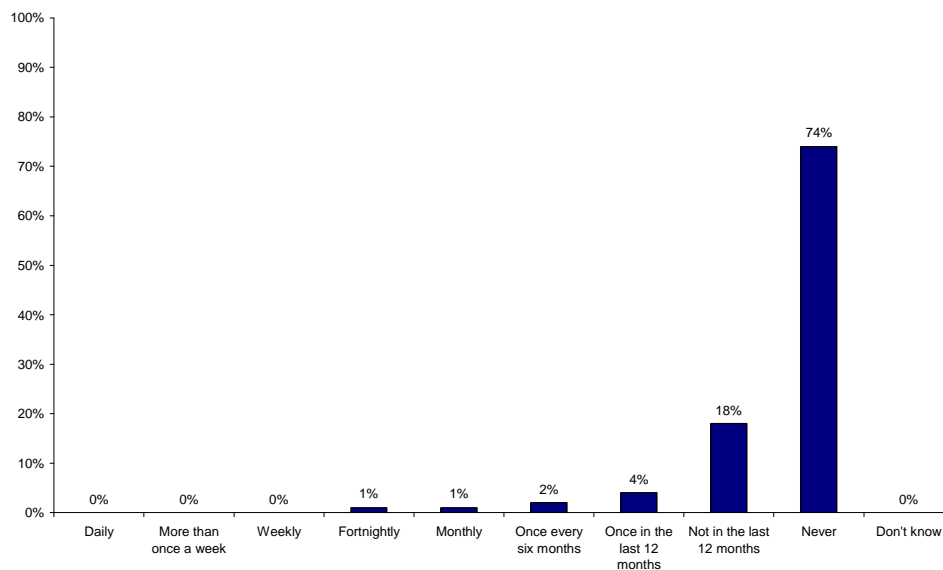
Full-time GPs were more likely to have experienced physical assault compared with part-time GPs, male GPs were more likely to have experienced physical assault compared with female GPs. Respectively:

- 37% of full-time GPs had *ever* experienced physical assault compared with 19% of part-time GPs, and
- 38% of male GPs had *ever* experienced physical assault compared with 21% of females.

No other significant demographic differences were noted.

Sexual harassment

Three quarters (74%) of GPs had never experienced sexual harassment (Figure 11). One fifth (18%) had experienced sexual harassment, but not in the last 12 months.



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients ... sexual harassment?
n=178 General Practitioner respondents

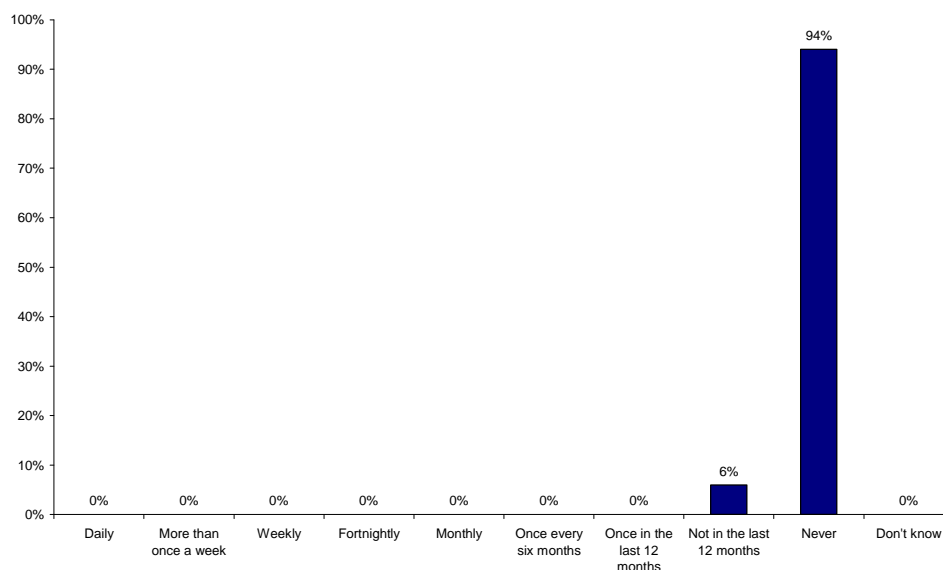
Figure 11: Experience of sexual harassment

Females GPs and younger GPs appeared to be more likely to have experienced sexual harassment than their counterparts. Respectively:

- Four in ten (38%) female GPs reported that they had *ever* experienced sexual assault compared with two in ten (18%) male GPs, and
- Three in ten (34%) GPs aged 50 or over reported that they had experienced sexual assault compared with two in ten (18%) GPs aged 50 or less.

Sexual assault

Sexual assault was the least common form of physical aggression with almost all (94%) GPs reporting that they had never experienced sexual assault by a patient (Figure 12). The remaining 6% of GP respondents reported that they had experienced sexual assault, but not in the last 12 months.



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients ...
sexual assault
n=178 General Practitioner respondents

Figure 12: Experience of sexual assault

GPs aged 50 or more were more likely to have experienced sexual assault (10%) compared to GPs aged 50 or less (1%).

Other forms of aggression

GPs identified a range of other forms of aggression either related to or not listed among the specified survey definitions. In all, 178 comments were received (GPs could make more than one comment). The majority were either reports that no other forms of aggression had been experienced (83 comments), or general commentary or re-iteration of responses already made to the survey (57 comments).

Where other or related forms of aggression were noted, the most common forms of aggression were:

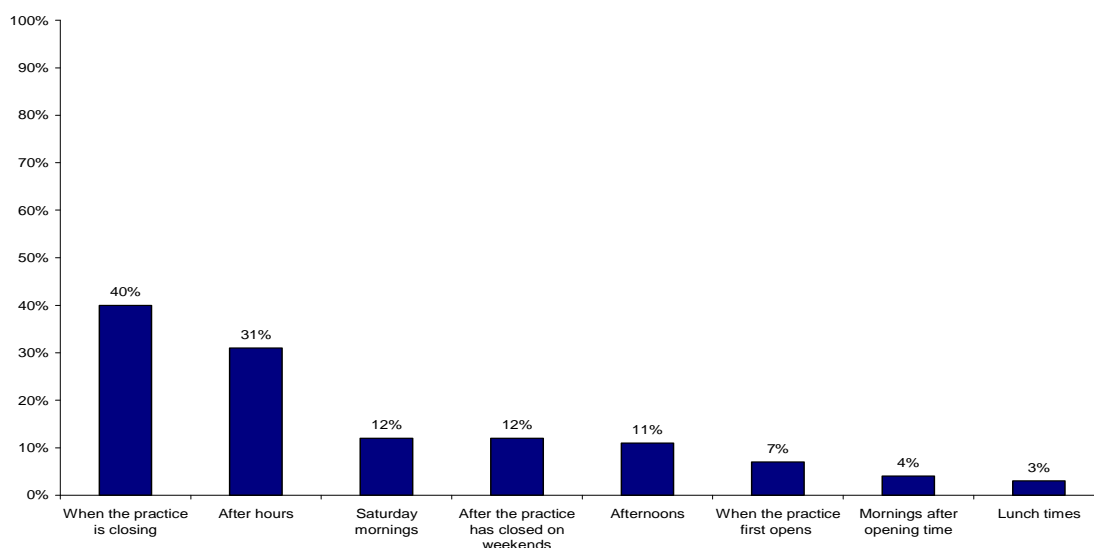
- Threats of legal action (9 comments);
- Aggression related to drug seeking behaviour (8 comments);
- Raised voices, coarse language or rudeness (6 comments);
- Other types of threat (6 comments);
- Death threats (3 comments);
- Collateral damage or upset, for example harm to other patients or staffs' family (2 comments);
- Slamming of doors with no damage to the practice (2 comments);
- Patient frustration or anger (1 comment);
- Intimidation (1 comment);

- Hostage taking, or rioting (1 comment), and
- Patient impatience such as queue-jumping (1 comment).

Trends

Times of particular risk

GPs identified particular times of day when they considered that they were at increased risk of aggression (Figure 13). The most commonly reported times were when the practice was closing for the day (40%), and when staff were at the practice after-hours (31%). A far smaller proportion of GPs indicated other risky times such as closing time on the weekends (12%), Saturday morning (12%), in the afternoons (11%), when the practice first opens (7%), mornings after opening time (4%) and at lunchtime (3%). Four in ten (40%) GPs indicated that none of these periods represented times of particular risk for practice staff.



Survey Q11. Are there any times of the day or week when you feel at particular risk of aggressive patient behaviour
 Figures do not sum 100% because multiple choice was accepted for this question.
 All General Practitioners: 178.

Figure 13: Risky times of day

Metropolitan-based GPs (55%) were more likely to identify closing time as a risky period compared with non-metro-based GPs (29%).

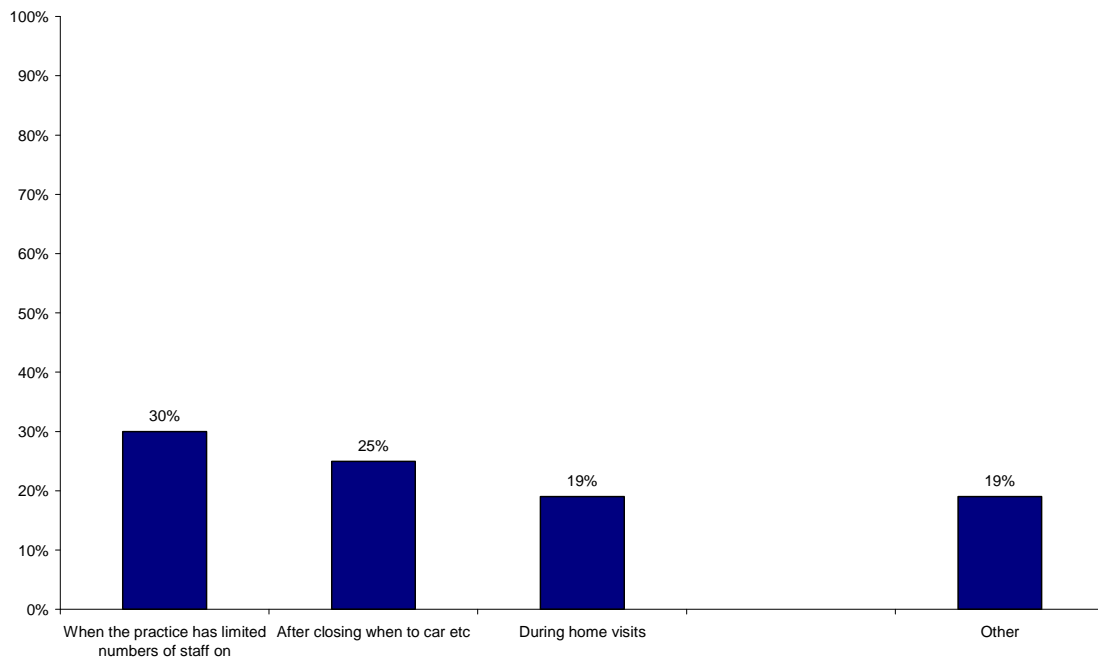
No other demographic differences were identified.

Other times of risk

GPs also identified other periods of high risk including (Figure 14):

- Home visits (19%);
- When staff are walking to their cars, public transport or home after work (25%), and
- When limited numbers of staff are present at the practice (30%).

Four in ten (37%) practices indicated that none of these periods represented times of particular risk for practice staff.



Survey Q12. Are there any other times when you feel at particular risk of aggressive patient behaviour?
n=178 General Practitioner respondents

Figure 14: Other times of risk

Similar to the risks identified at closing time metropolitan-based GPs (35%) were more likely to identify the period after closing as staff walk to their cars as risky compared with regional and rural-based GPs (29%).

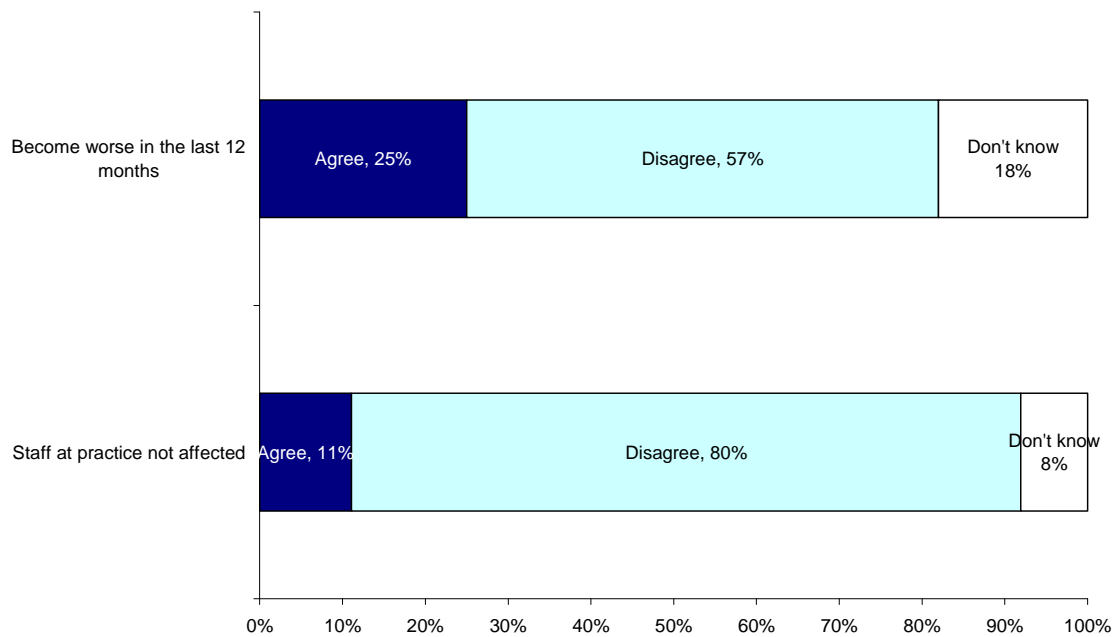
GPs made 37 comments regarding other risky times of day. Those most commonly made were:

- When attending to patients who are intoxicated (8 comments);
- When the GPs are running late (4 comments);
- When the practice is short-staffed (3 comments);
- When a patient is denied medicines/ drugs (3 comments);
- When attending to a patients with psychological issues (3 comments);
- Friday afternoons (2 comments);
- Not specific - aggression can happen at any time (2 comments);
- On home visits/ call-outs (2 comments);
- When a patient is denied services (1 comment);
- Atmospheric conditions/ phase of the moon (1 comment), and
- When a new GP starts at the practice (1 comment).

Impact and perceptions of patient aggression

Perceptions of trends in patient initiated aggression

The majority of GPs did not perceive an increase in patient aggression over time (Figure 15). One quarter (25%) perceived that patient aggression had become worse at their practice in the last 12 months.



Survey Q13. Would you agree or disagree with the following statements?
n=178 General Practitioner respondents

Figure 15: Perceptions of aggression

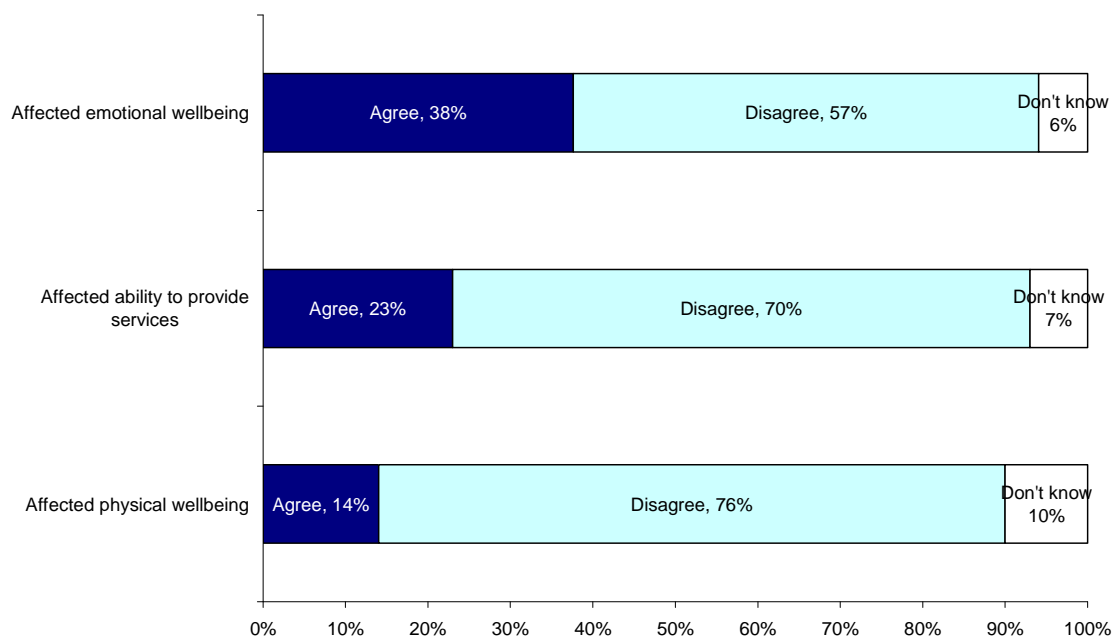
As with many other items in the questionnaire, perceptions of change and impacts of patient aggression varied by gender and employment arrangements:

- Male GPs were more likely to agree that aggression has become worse in the last 12 months compared with female GPs (31% and 17% respectively), and
- Full-time GPs were more likely to agree that aggression has become worse in the last 12 months compared with part-time GPs (30% and 16% respectively).

No significant differences were observed in terms of staff *not* experiencing negative impacts from aggression.

Impact of aggression

Some GPs indicated that patient aggression had affected their wellbeing and professional capacity (Figure 16). GPs were most likely to indicate that aggression had negatively affected their emotional wellbeing (38%), but were less likely to agree that aggression had affected their capacity to provide services (23%), or their physical wellbeing (14%).



Survey Q13. Would you agree or disagree with the following statements?
n=178 General Practitioner respondents

Figure 16: Impact of aggression

Male GPs were more likely to identify negative impacts of patient aggression than were female GPs. Further, full-time GPs were more likely to identify negative impacts than were part-time GPs.

- Female GPs were more likely to *disagree* that patient aggression had impacted on their physical wellbeing compared with male GPs (85% and 71% respectively)¹;
- Male GPs were more likely to agree that patient aggression had affected their ability to provide services compared with female GPs (29% and 14% respectively);
- Part-time GPs were more likely to *disagree* that patient aggression had impacted on their physical wellbeing compared with full-time GPs (90% and 70% respectively), and
- Full-time GPs were more likely to *agree* that patient aggression had impacted on their emotional wellbeing compared with part-time GPs (45% and 22% respectively)

Practice environment

GPs were asked about a range of structural and organisational measures at their practice that may affect the incidence of aggression (Figure 17). GPs were most likely to agree that:

- The practice takes the safety of its staff seriously – 80% agreed, though it is noted that nearly one in ten (9%) disagreed;
- The physical layout of the practice helped to minimise the risk of harm from aggression; five in ten (49%) agreed, and four in ten (39%) disagreed;
- The practice maintains adequate procedures to address patient aggression; five in ten (48%) agreed, and four in ten (42%) disagreed, and
- The practice has adequate security to minimise harm from patient aggression; five in ten (48%) agreed, and four in ten (44%) disagreed

¹ Comparisons for the 'disagree' response option were significantly different, however comparisons by the agree response option were not significantly different, thus some of these findings are phrased in the negative.

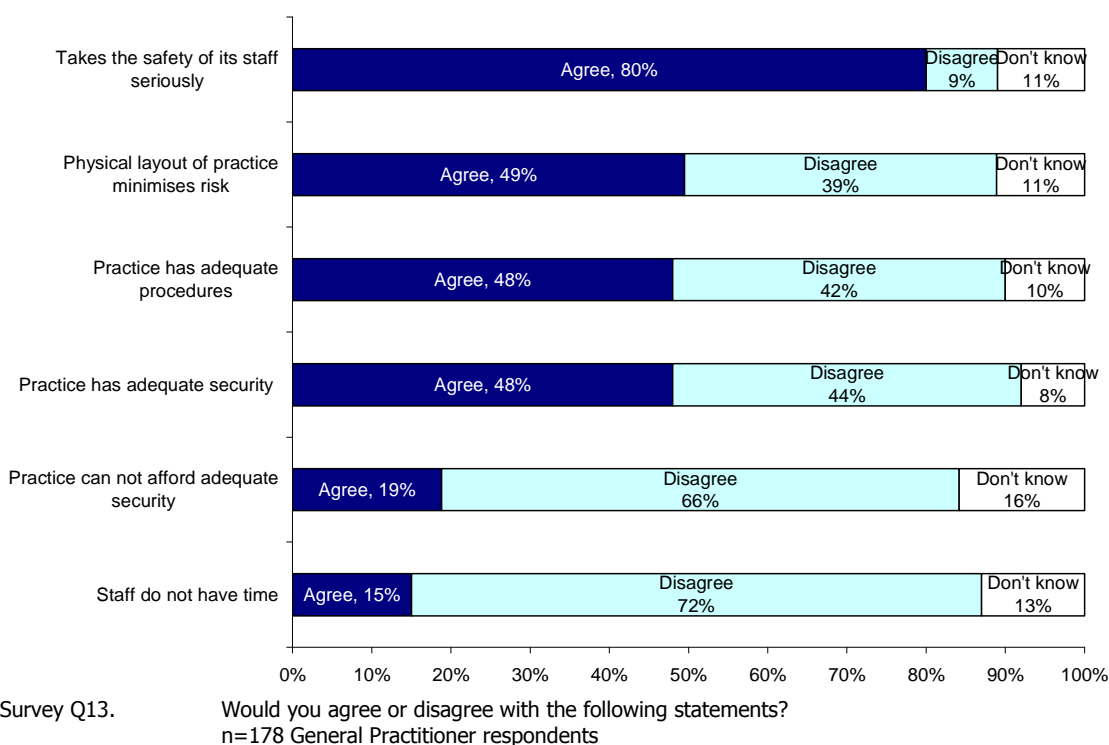


Figure 17: Practice environment

Financial and time constraints were not reported as issues preventing most GPs from minimising harm from aggression. Nearly seven in ten (66%) *disagreed* that their practice could not afford to provide adequate security, and over seven in ten (72%) disagreed that staff do not have time to implement measures to minimise risk of harm from patient aggression.

Only sporadic significant differences were noted between the attitudes of GPs from different demographics, with no clear pattern emerging:

- Older GPs were more likely to agree that their practice had adequate procedures in place to minimise harm from patient aggression compared with younger GPs (57% and 38% respectively), and
- Male GPs were more likely to agree that their practice could not afford adequate security compared with female GPs (23% and 11%) respectively).

Other

In total, GPs provided 186 comments about other impacts as a result of patient aggression (GPs could make more than one comment). Most information provided by GPs simply stated that there had been no other impacts outside those described in the questionnaire (92 comments). A further 25 GPs provided general commentary on patient aggression, or re-iterated a response they had already given in the survey. Where GPs provided additional information about the impacts of violence, the most common themes to emerge were:

- General increase in anxiety/ stress/ fear (16 comments);
- Denial of services for specific patients (14 comments);
- Staff are less willing to help patients in general (13 comments);
- Structural staffing changes (6 comments);
- The need to increase security (and costs associated with increasing security, 6 comments);
- Diminished capacity/ productivity of staff (3 comments);
- Wishing to retire or change professions (3 comments);
- The need for further training of staff (1 comments);
- Staff are more guarded/ less confident (1 comments);
- Extra time required to attend to legal matters (1 comment);
- Diminished morale for all staff (1 comment);
- Negative impact on staffs' family (1 comment);

-
- Difficulty in recruiting staff (1 comment);
 - Time spent on legal matters (1 comment), and
 - The possibility of having to discontinue care in the area (1 comment).

Online Practice Manager Survey Results

General practice demographics

Table 8 provides a summary of general practice demographics. These demographic variables are used as the basis for comparative findings throughout the report.

Table 8: General practice profile

Average number of staff	
General Practitioners	5.6 (range 1-11, SD 4.1)
Practice Nurses	2.7 (range 0-6, SD 2.8)
Allied Health professionals	1.8 (range 0-25, SD 3.3)
Practice Managers	1 (range 0-3, SD 0.3)
Receptionists	4.8 (range 0-28 SD 3.4)
State	
NSW	20
Vic	28
Qld	21
SA	9
WA	14
NT	3
ACT	4
Tas	0
Practice location	
Metro	38
Non-metro	62
Practice composition	
Sole general practitioner	12
Group practice	58
Corporate practice	17
Other	12
Services provided	
Home visits during hours	75
Home visits after hours	75
After hours consultations weekdays	47
After hours consultations weekends	51
None of the above	8

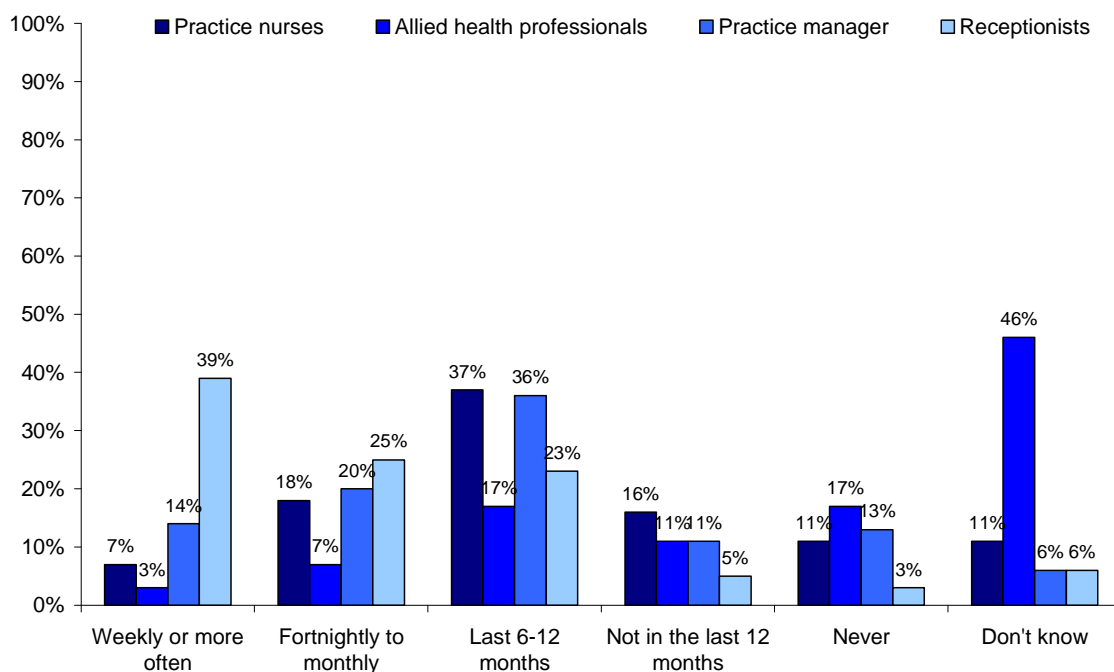
Incidence of verbal aggression

Receptionists were by far the most likely practice staff members to experience frequent occurrences of verbal abuse (Figure 18). Otherwise, reported experience of verbal abuse varied greatly across time periods and staff type. Practice managers reported that staff experienced verbal abuse:

- Weekly or more often (7% practice nurses, 3% allied health professionals, 14% practice managers, and 39% receptionists);
- Fortnightly or more often (18% practice nurses, 7% allied health professionals, 20% practice managers, and 25% receptionists), and
- In the last six to twelve months (37% practice nurses, 17% allied health professionals, 36% practice managers, and 23% receptionists).

Between 6% and 16% of practice staff had experienced verbal abuse, but not in the last 12 months. A minority (between 11% and 17%) of practice nurses, allied health professionals, and practice managers had never experienced verbal abuse. Only 5% of receptionists were reported to have never experienced verbal abuse.

Notably, practice nurses were relatively unaware of the experience of allied health professionals (46% don't know). This finding is repeated across the different forms of aggression, and implies that results for allied health professionals should be interpreted with caution.



Survey Q7. In the last 12 months, how many times have staff at this practice been subject to verbal abuse or threats by a patient or someone associated with a patient?
 n= 216 Practices with practice nurses n=127 Practices with allied health professionals
 n=243 Practices with practice managers n= 243 Practices with receptionists

Figure 18: Verbal abuse

Sporadic differences were noted for increased likelihood of verbal aggression for different types of practice:

Practice managers from metropolitan-based practices were more likely to have experienced verbal aggression in the last 12 months compared with practice managers from non-metro practices (78% and 66% respectively), and

- Receptionists from larger practices were more likely to have experienced verbal aggression in the last 12 months compared with receptionists from smaller practices (93% and 82% respectively)

No other notable differences were observed.

Incidence of physical aggression

Property theft or damage

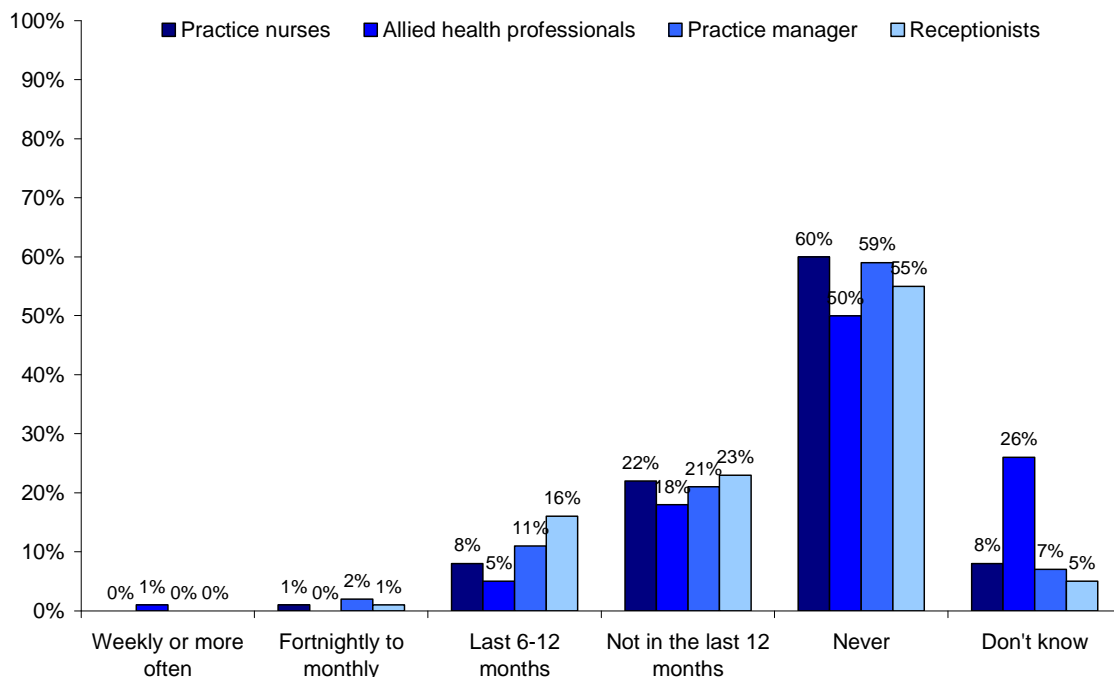
Approximately one in five practices were reported to have ever experienced property theft or damage but not in the last 12 months, and approximately one in ten in the last 12 months (Figure 19).

Specifically, practice managers reported that property theft or damage was experienced:

- Very infrequently at the weekly or monthly level (reported rates of 0%-2%);
- Six monthly/ yearly (8% practice nurses, 5% allied health professionals, 11% practice managers, and 23% receptionists), and
- At some stage, but not in the last 12 months (22% practice nurses, 18% allied health professionals, 21% practice managers, and 23% receptionists).

Practice managers reported that between 50% and 60% of practice staff had never experienced property theft or damage.

Experiences of allied health professionals were relatively little known to practice managers; one quarter (26%) of practice managers reported that they did not know how often allied health professionals experienced property damage.



Survey Q10. In the last 12 months, how many times have staff at this practice been subject to property damage or theft by a patient or someone associated with a patient?
 n= 216 Practices with practice nurses n=127 Practices with allied health professionals
 n=243 Practices with practice managers n=2443 Practices with receptionists

Figure 19: Property theft or damage

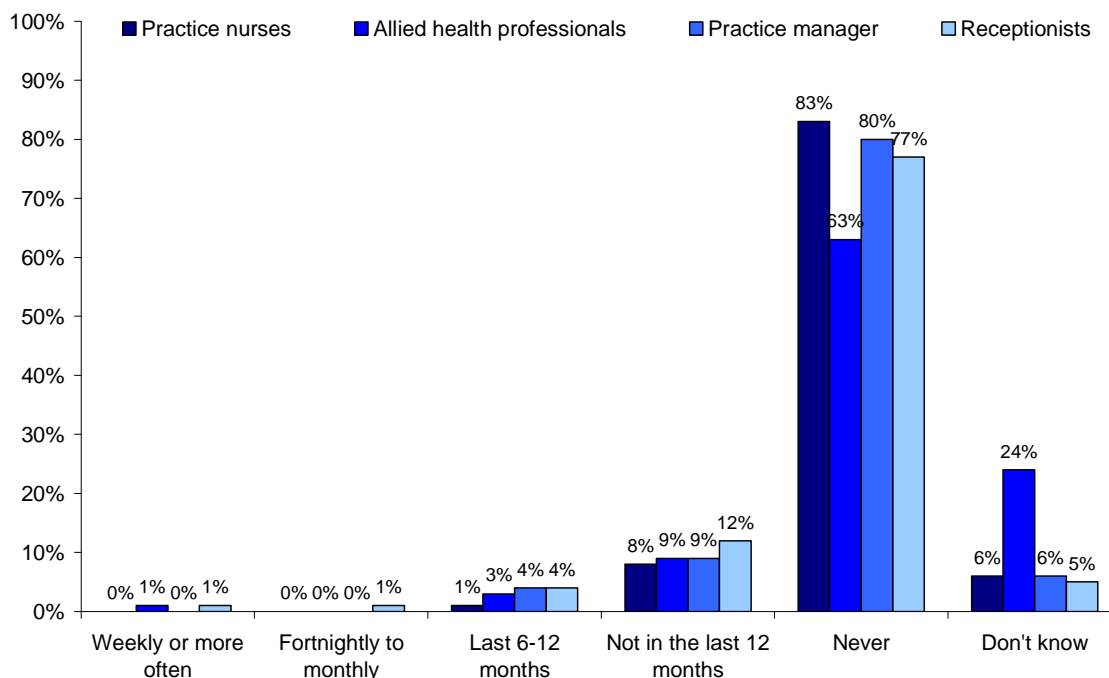
No clear pattern emerged regarding which practice staff members were more or less likely to experience property theft or damage. Few differences were noted for increased likelihood of property theft or damage for different types of practice. Practice nurses from larger practices were more likely to have experienced property theft or damage in the last 12 months compared with practice nurses from smaller practices (13% and 4% respectively).

Stalking

Practice managers reported that approximately one in ten practice staff had ever experienced stalking, but not in the last 12 months, and that approximately one in twenty had experienced stalking in the last 12 months (Figure 20). Specifically, practice managers reported that:

- A very small proportion (1% or less) of practice staff had experienced stalking on a weekly or monthly basis;
- Less than one in twenty experienced stalking in the last six to twelve months, and
- One in ten had experienced stalking, though not in the last 12 months (8% practice nurses, 9% allied health professionals, 9% practice managers, and 12% receptionists).

The experiences of allied health professionals were generally not well known to practice managers.



Survey Q13. In the last 12 months, how many times have staff at this practice been subject to stalking by a patient or someone associated with a patient?
 n=216 Practices with practice nurses
 n=243 Practices with practice managers
 n=127 Practices with allied health professionals
 n=243 Practices with receptionists

Figure 20: Stalking

No clear pattern emerged regarding which practice staff members were more or less likely to experience stalking. Small differences were noted for increased likelihood of stalking for different types of practice.

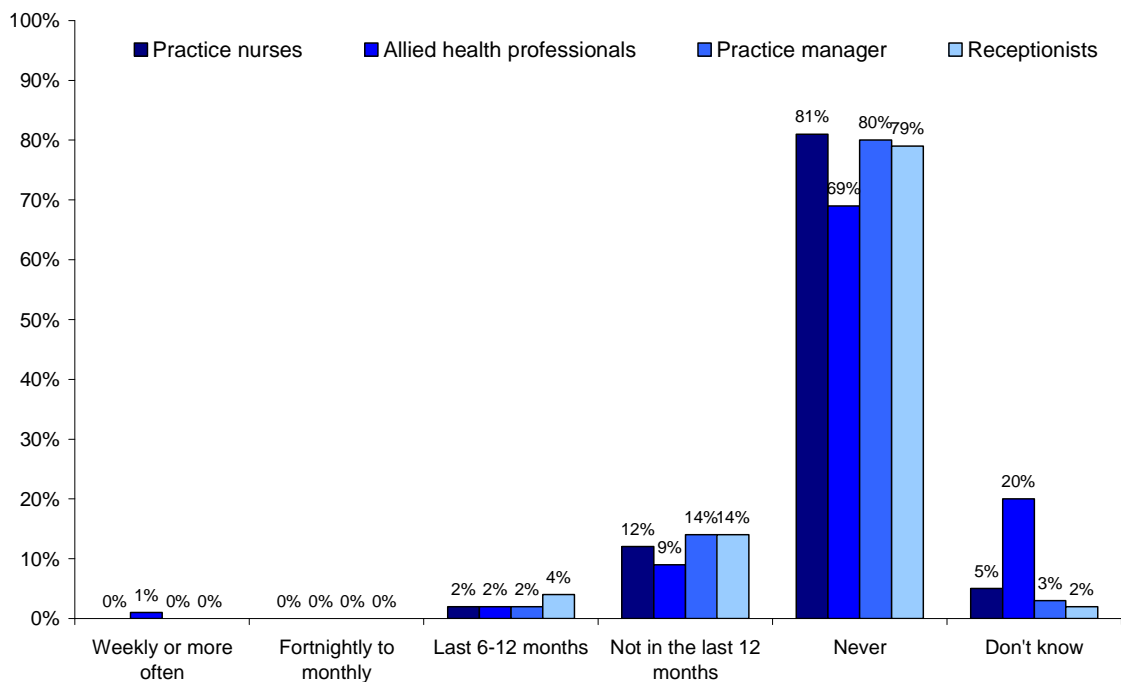
- Receptionists working at corporate practices were more likely to have experienced stalking in the last 12 months compared to those employed by group practices (12% and 3% respectively), and
- Practice managers working at corporate practices were more likely to have experienced stalking in the last 12 months compared to those employed by group practices (10% and 1% respectively).

Physical assault

Between four in ten and five in ten practice staff had ever experienced physical assault (Figure 21). Specifically, practice managers reported that:

- Less than 1% of practice staff members experienced physical assault on a weekly basis;
- No practice staff experienced physical assault on a fortnightly to monthly basis;
- Between 2% and 4% were reported to experience physical assault on a six to twelve monthly basis, and
- Around one in ten were reported to have experienced physical assault, but not in the last year (12% practice nurses, 9% allied health professionals, 14% practice managers, and 14% receptionists).

Between seven and nine in ten practice staff had reportedly never experienced physical aggression.



Survey Q16. In the last 12 months, how many times have staff at this practice been subject to physical assault by a patient or someone associated with a patient?
 n=216 Practices with practice nurses n= 127 Practices with allied health professional
 n=243 Practices with practice managers n = 243 Practices with receptionists

Figure 21: Physical assault

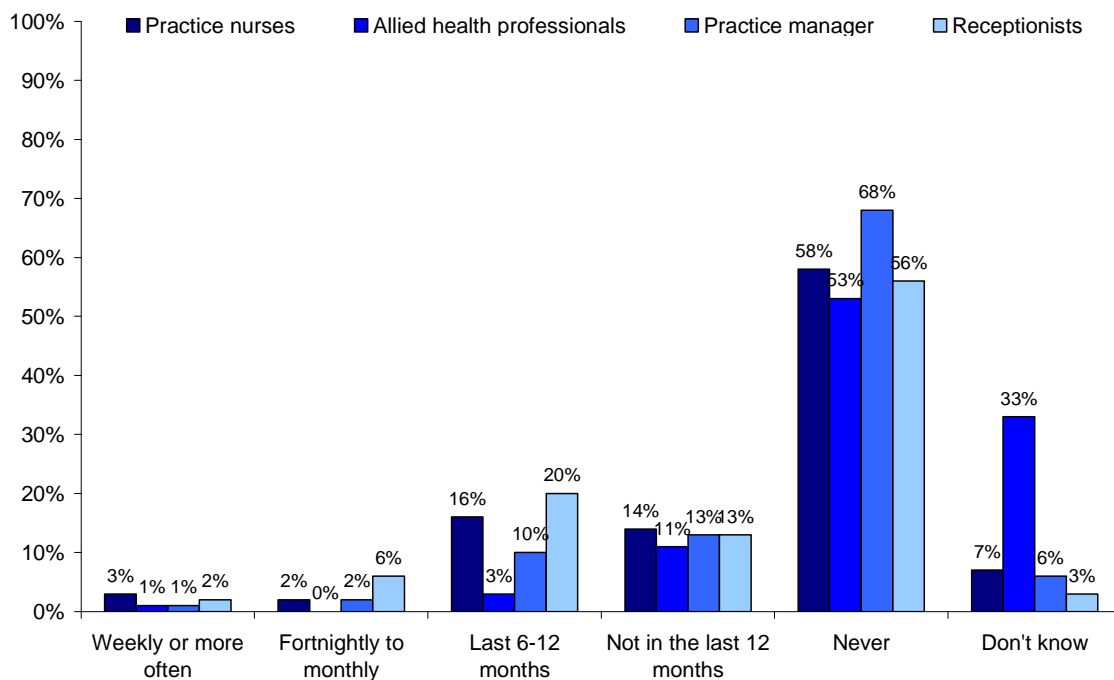
Practice staff appeared to be equally at risk of experiencing physical assault, with no particular type of staff appearing more at risk. Practice size seemed to play some role in determining the likelihood of staff experiencing physical assault. While significant differences were not noted for experience in the last 12 months, receptionists employed at small practices were more likely to have *never* experienced physical assault compared with receptionists employed at large practices (85% and 74% respectively). Receptionists at larger practices appeared to be at a higher risk of physical assault than those at smaller practices.

Sexual harassment

Practice managers reported that between one and four in ten practice staff had experienced sexual harassment at some stage in their career (Figure 22). Specifically, practice managers reported that sexual harassment was experienced:

- On a weekly basis for a very small proportion of staff (0%-3%);
- On a monthly basis for a similarly small proportion of staff (0%-6%);
- On a yearly basis (16% practice nurses, 3% allied health professionals, 10% practice managers, and 20% receptionists), and
- Ever, but not in the last 12 months (14% practice nurses, 11% allied health professionals, 13% practice managers, and 13% receptionists).

As with many other measures in this research, practice managers seemed relatively unaware of the experiences of allied health professionals (33% don't know).



Survey Q19. In the last 12 months, how many times have staff at this practice been subject to sexual harassment by a patient or someone associated with a patient?
 n=216 Practices with practice nurses n= 127 Practices with allied health professional
 n=243 Practices with practice managers n = 243 Practices with receptionists

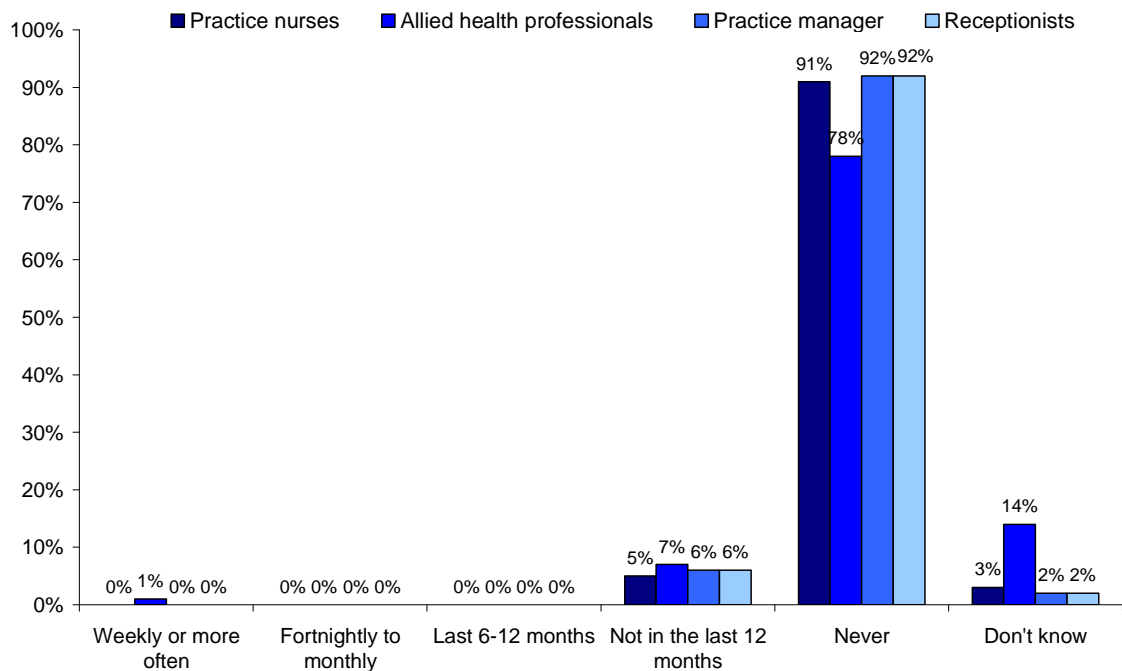
Figure 22: Sexual harassment

No significant differences by practice type were noted for experience of sexual harassment.

Sexual assault

Approximately one in ten practice staff was reported to have ever experienced sexual assault (Figure 23). Specifically, practice managers reported that sexual assault:

- Was almost never experienced weekly, monthly or yearly (1%, a single allied health professional), and
- Had been experienced, but not in the past 12 months by approximately one in twenty practice staff (5% practice nurses, 7% allied health professionals, 6% practice managers, and 6% receptionists).



Survey Q22. In the last 12 months, how many times have staff at this practice been subject to sexual assault by a patient or someone associated with a patient?
 n=216 Practices with practice nurses n= 127 Practices with allied health professional
 n=243 Practices with practice managers n = 243 Practices with receptionists

Figure 23: Sexual assault

No significant differences by practice type were noted for experience of sexual assault, most likely due to the relatively low incidence of this type of aggression.

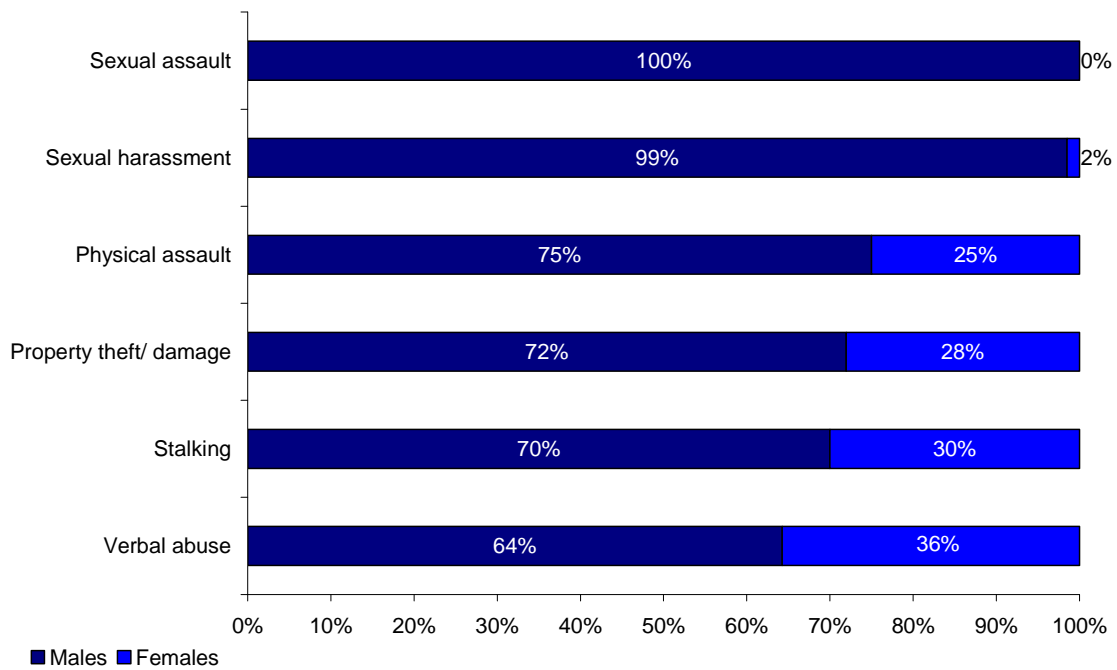
Patient initiated aggression by demographic

Practice managers were asked what proportion of aggression was perpetrated by males vs. females; and patients vs. people accompanying patients.

Males and females

Overall, males were perceived to be more likely to behave aggressively than were females (Figure 24). For each type of aggression, the majority of incidents were reported to have been perpetrated by males, specifically:

- 100% of sexual assault;
- 99% of sexual harassment;
- 75% of physical assault;
- 72% of property theft or damage;
- 70% of stalking, and
- 64% of verbal abuse.



Multi survey questions Overall, how much of this <aggression type> threats comes from males, how much from females?

Reported aggression in the last 12 months

Verbal: n = 153

Property theft or damage: n = 36

Stalking: n = 18

Physical: n = 17

Sexual harassment: n = 53

Sexual assault: n = 1

Figure 24: Male vs. female patient aggression

Patients and people accompanying patients

Overall, patients were perceived to be more likely to initiate aggression than were people accompanying patients (Figure 25). For each type of aggression, patients were responsible for the majority of incidents, specifically:

- 100% of sexual assault;
- 96% of sexual harassment;
- 83% of stalking;
- 82% of verbal abuse;
- 81% of physical assault, and
- 76% of property theft or damage.

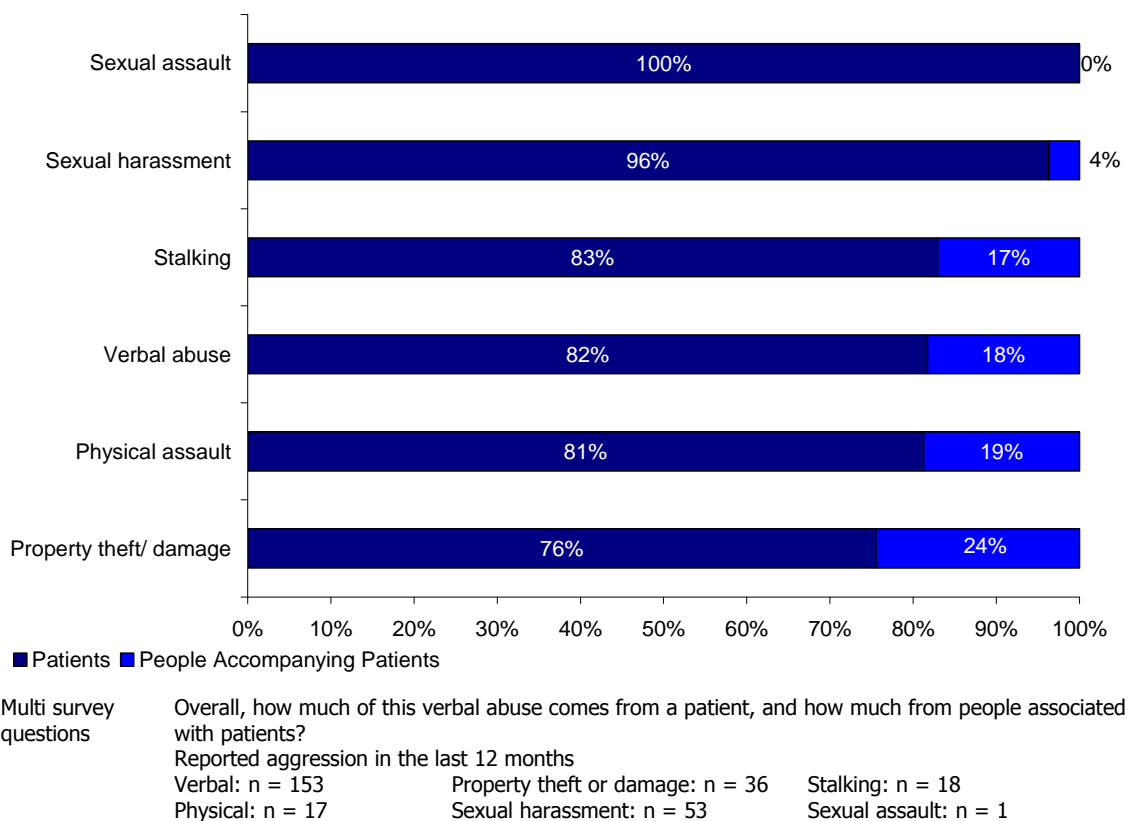


Figure 25: Patient vs. Person accompanying Patient Perpetrated Aggression

Trends and periods of particular risk

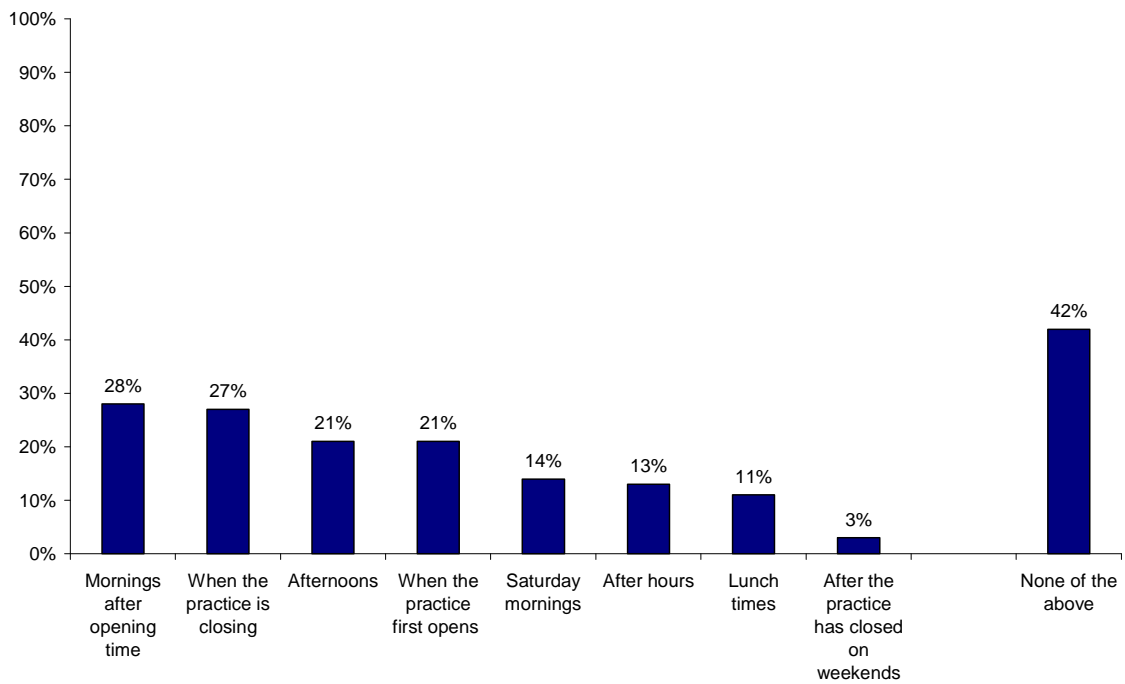
Practice manager’s perceptions of times of particular risk were assessed.

Times of particular risk

Practice managers were most likely to identify the times immediately after practice opening and closing as periods of particular risk (Figure 26). Specifically, practice managers reported the following daily times of particular risk of patient initiated aggression:

- Mornings after opening time (28%);
- When the practice is closing (27%);
- When the practice first opens (21%);
- Afternoons (21%);
- Saturday mornings (14%);
- After hours when the practice has closed (13%);
- Lunch times (11%), and
- After the practice has closed on weekends (3%).

Four in ten (42%) practice managers reported that none of these specific times represented elevated risk.



Survey Q26. Are there any times of the day or week when staff are at particular risk of aggressive patient behaviour?
 Figures do not sum 100% because multiple choice was accepted for this question.
 n = 247 practices

Figure 26: Times of particular risk

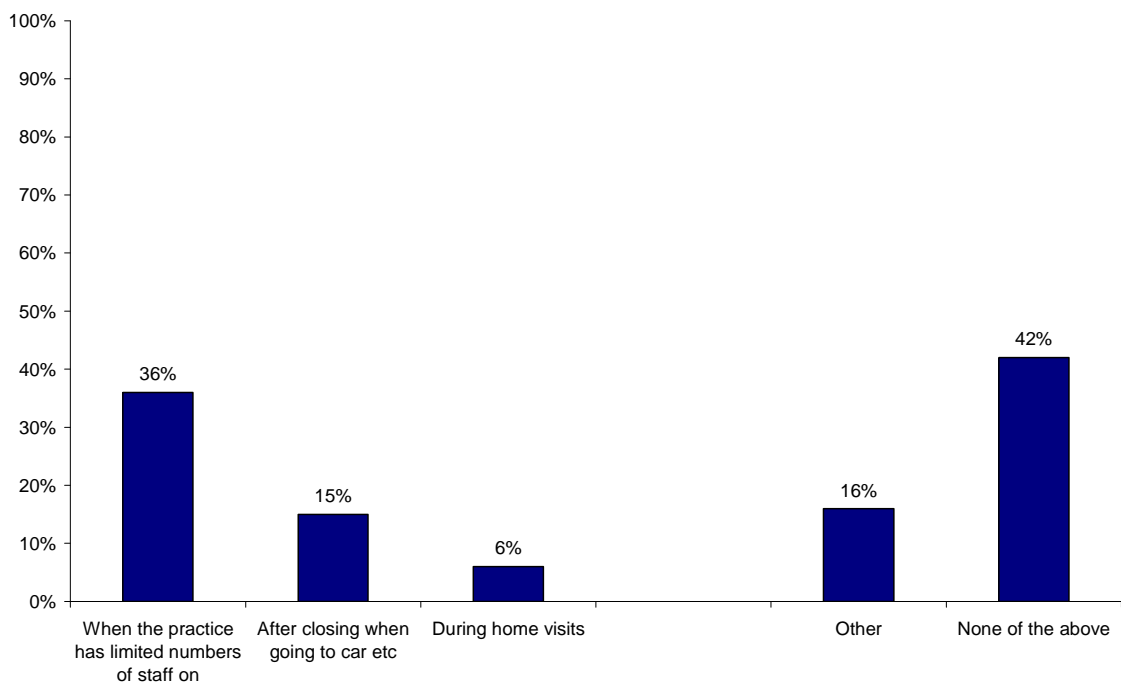
Sporadic differences were noted by practice type in terms of particular daily times of increased staff risk:

- Practice managers employed at larger practices were more likely to perceive elevated risk after hours compared with practice managers employed at smaller practices (18% and 7% respectively), and
- Practice managers employed at group practices were more likely to perceive elevated risk after hours compared with practice managers at corporate practices (24% and 10% respectively).

Practice managers were also asked about other times of day when staff were at particular risk of aggression (Figure 27). These times were reported to be:

- When the practice has limited number of staff on (36% - the highest indicated period of risk);
- After the practice had closed and staff were walking to their car (15%), and
- During home visits (6%).

Four in ten (42%) practice managers indicated that none of these periods represented a time of particular risk.



Survey Q27. Are there any other times when staff are at particular risk of aggressive patient behaviour?
n = 247 practices

Figure 27: Other times of particular risk

Few significant differences were noted by practice type for perceptions of other times of increased risk of patient initiated aggression. Practice managers employed at non-metropolitan practices were more likely to perceive elevated risk after closing as staff walk to their cars compared with practice managers employed at metropolitan practices (18% and 9% respectively). No other notable differences were observed.

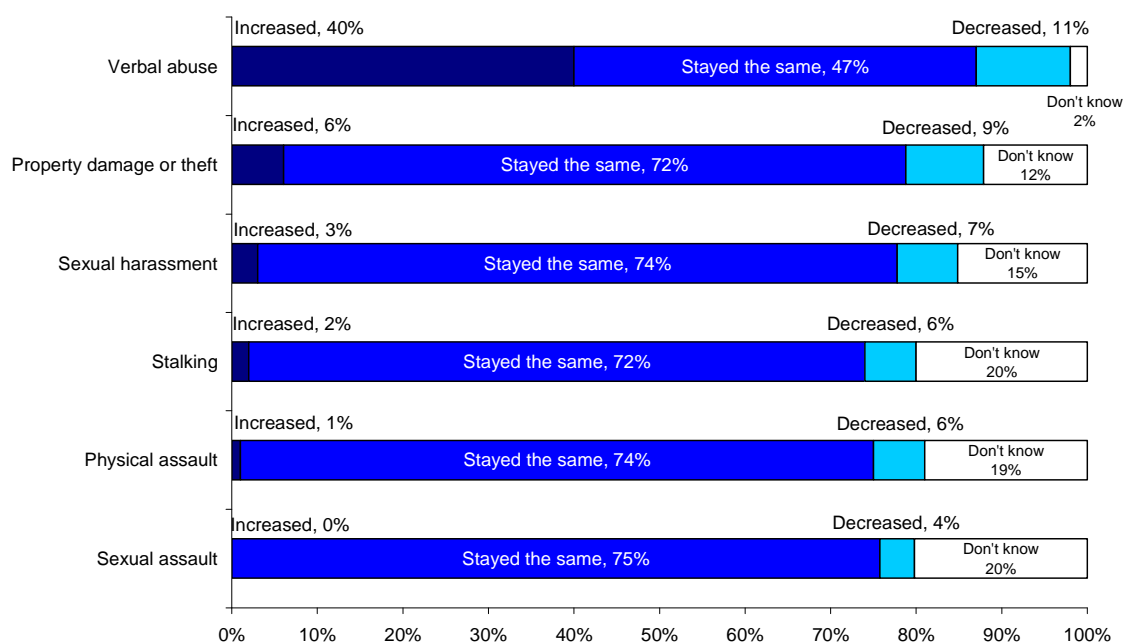
Other times of risk

Practice managers identified a range of other times of elevated risk of patient initiated aggression. Forty comments were made on the issue (practice managers could make more than one comment). Ten of these comments related to general discussion about risk, and not about specific periods of risk. Where times of increased risk were identified, the most commonly reported periods were:

- When the practice is short-staffed (10 comments);
- When the GPs are running late (5 comments);
- Patient intoxication (4 comments);
- When a patient is denied medicines/ drugs (4 comments);
- When a patient is denied services (3 comments);
- Patient distress (2 comments), and
- Atmospheric conditions/ phase of the moon (2 comments).

Perceived change in the incidence of aggression

Practice managers were asked whether they thought the incidence of aggression had changed in the last 12 months. With the exception of verbal aggression, few practice managers perceived a change in levels of patient aggression (Figure 28).



Survey Q28. In the last 12 months, has aggressive patient behaviour increased, decreased or stayed the same at this practice?
n = 247 practices

Figure 28: Change in the incidence of aggression

Specifically, for each form of aggression:

- Four in ten (40%) practice managers perceived verbal aggression to have increased (47% perceived no change, 11% decreased);
- Less than one in ten (6%) perceived property theft or damage to have increased (72% no change, 9% decreased);
- Less than one in twenty (3%) perceived sexual harassment to have increased (74% no change, 7% decreased);
- Less than one in twenty (2%) perceived stalking to have increased (72% no change, 6% decreased);
- One in one hundred (1%) perceived physical assault to have increased (74% no change, 6% decreased), and
- Less than 1% perceived sexual assault to have increased (75% no change, 4% decreased).

Many practice managers did not know whether the different forms of aggression had changed in the last 12 months, particularly for low-incidence forms of aggression such as sexual aggression. A small number of significant differences were observed by practice type for perceptions of change in the level of patient aggression:

- Practice managers employed at larger practices were more likely to perceive an increase in verbal aggression compared with practice managers employed at smaller practices (47% and 32% respectively), and
- Practice managers employed at sole practitioners were more likely to perceive an increase in stalking compared with practice managers employed at group practices (7% and 1% respectively).

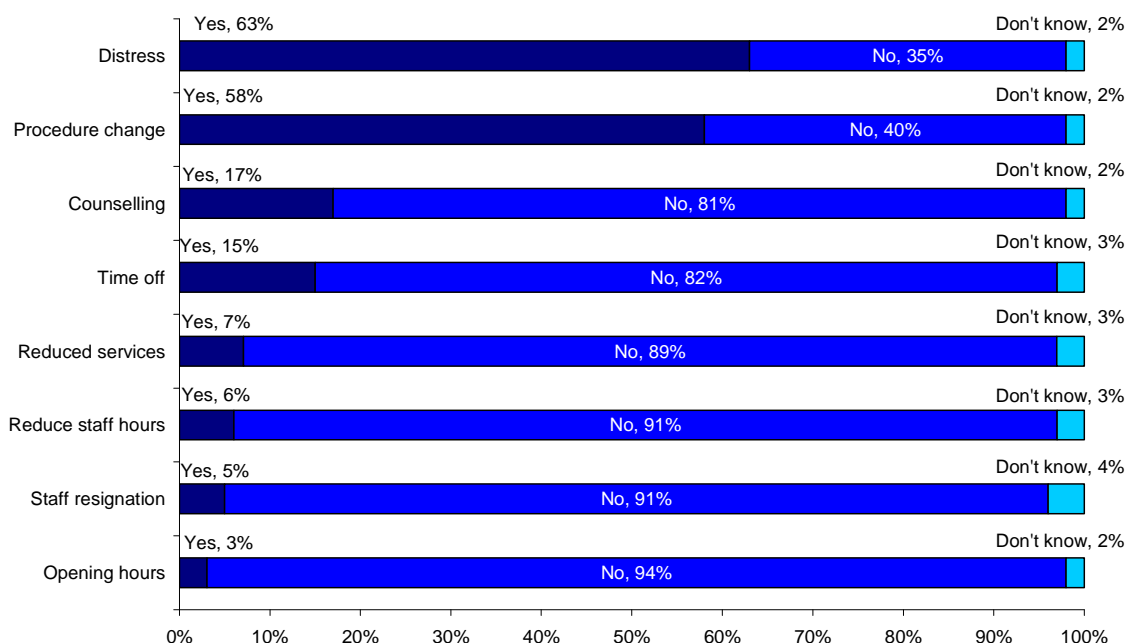
Impact of aggression

Practice managers' perceptions of the impact of patient initiated aggression on staff were assessed.

Impact of verbal aggression

By far the most common form of negative impact of verbal aggression was staff distress (Figure 29). Specific impacts of aggression in the last 12 months were reported to be:

- Staff distress (63% of practice managers replied 'yes' when asked if patient aggression had led to this impact);
- A change in the practice's procedures (58%);
- The need for staff counselling (17%);
- The need for staff to have time off (15%);
- The need to reduce health services at the practice (7%);
- The need for staff to reduce their hours (6%);
- Staff turn-over/ staff resignation (5%), and
- The need to reduce the practice's opening hours (3%).



Survey Q28. In the last 12 months, has verbal aggression by patients or people associated with patients resulted in ...
n = 247 practices

Figure 29: Impact of verbal aggression

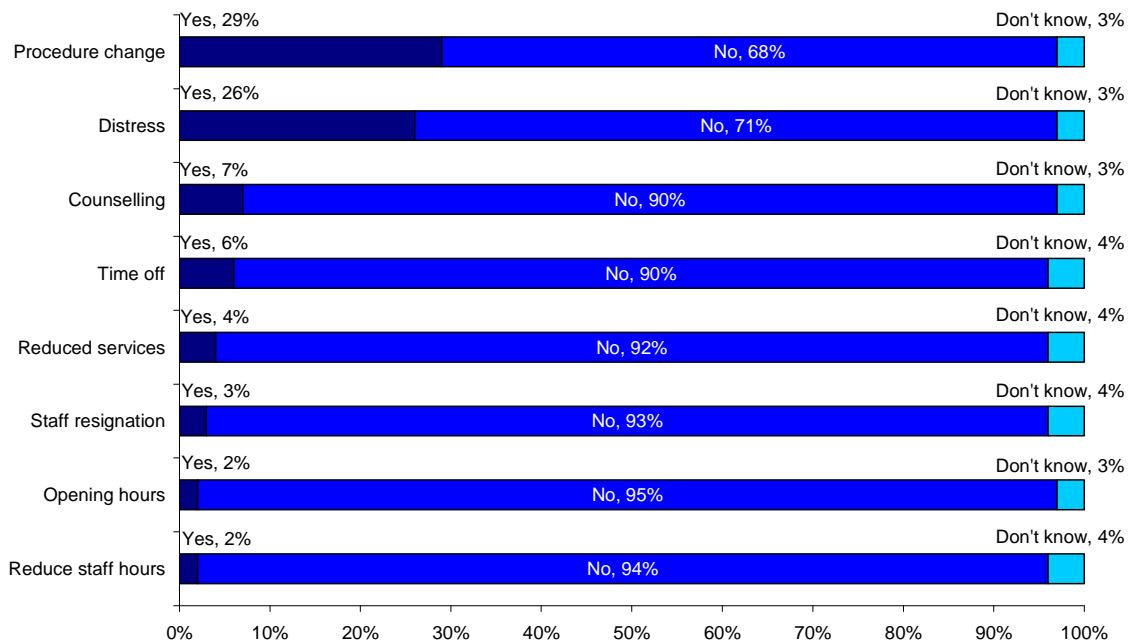
Practice size appeared to be the key driver behind risk of negative impact of verbal aggression on staff:

- Staff at larger practices were more likely to have experienced distress as a result of verbal aggression compared with staff at smaller practices (71% and 54% respectively), the same effect was seen for sole practices vs. group and corporate practices (the effect of practice size being notable in each case);
- Larger practices were more likely to have needed to change their policies or procedures as a result of verbal aggression compared with smaller practices (64% and 51% respectively), the same effect was seen for group practices vs. sole practitioners;
- Sole practices were more likely to have needed to change their opening hours as a result of verbal aggression compared with group and corporate practices (10%, 2% and 0% respectively);
- Sole practices were more likely to have needed to reduce services offered as a result of verbal aggression compared with group and corporate practices (20%, 7% and 5% respectively), and
- Sole practices were more likely to have had staff resign as a result of verbal aggression compared with group and corporate practices (13%, 2% and 5% respectively).

Impact of physical aggression

The most commonly reported impact of physical aggression was the need to change practice procedures (Figure 30). Specific impacts of aggression in the last 12 months were reported to be:

- A change in the practice's procedures (29% of practice managers replied 'yes' when asked if patient aggression had led to this impact);
- Staff distress (26%);
- The need for staff counselling (7%);
- The need for staff to have time off (6%);
- The need to reduce health services at the practice (4%);
- Staff turn-over/ staff resignation (3%);
- The need to reduce the practice's opening hours (2%), and
- The need for staff to reduce their hours (2%).



Survey Q29. In the last 12 months, has physical aggression by patients or people associated with patients resulted in ...
n = 247 practices

Figure 30: Impact of physical aggression

Overall, far fewer impacts were reported for physical aggression compared with verbal aggression. Relatively few differences by practice type were noted for the impacts of physical aggression, compared to the impacts reported for verbal aggression. This lack of differentiation may be due to the reported relatively low incidence of physical aggression. Staff at group practices were less likely to have required time off as a result of physical aggression compared with staff at sole practices and corporate practices (2%, 13% and 10% respectively). No other remarkable differences were noted.

Other

In total, 138 comments were made about other impacts of patient aggression (one participant could make more than one comment). Many of these contributions were of a general nature, and did not describe additional or other impacts (52 comments). Where additional or other impacts were identified, most commonly reported were:

- General increase in anxiety/ stress/ fear (30 comments);
- Other changes to practice or staffing at the practice (9 comments);
- Staff are less willing to help patients in general (8 comments);
- Diminished morale for all staff (6 comments);
- Diminished capacity/ productivity of staff (6 comments);
- Staff are more guarded/ less confident (5 comments);
- Denial of services for specific patients (5 comments);
- Staff can not be left alone (4 comments);

-
- Short-term disruption to the practice (3 comments);
 - Anxiety/ stress/ fear relating to one particular patient (3 comments);
 - The need for further training of staff (3 comments);
 - The need to increase security (and costs associated with increasing security (2 comments));
 - Staff depression (general) (1 comment), and
 - Extra time required to attend to legal matters (1 comment).

Summary of online survey findings

Data from 178 GP respondents and from 247 practice staff respondents has been analysed to present the following key findings of the online survey:

Verbal abuse

Almost all GPs and practice staff had experienced verbal aggression at some stage in their career. 72% of GPs had experienced verbal aggression in the last year, but frontline practice staff experience patient initiated verbal aggression more frequently than do GPs.

Physical aggression

GPs more than other practice staff experience physical aggression. For GPs, damage or theft to property was the most frequently occurring expression of physical aggression with 29% of GPs having experienced this form of patient initiated aggression in the last 12 months. Eight per cent of GPs had reported experiencing each of physical assault and sexual harassment in the last 12 months, and 6% had experienced stalking in the last 12 months.

Practice managers reported that property theft or damage was experienced infrequently. Approximately one in five practices had *ever* experienced property theft or damage and approximately one in ten had this experience in the last 12 months. Of all responding practice staff, receptionists reported the highest rates of theft or property damage.

A very small proportion ($\leq 1\%$) of practice staff had experienced frequent stalking with receptionists being the greatest non-GP staff target. Practice managers reported that less than one in twenty staff experienced stalking in the last six to twelve months.

Between 40% and 50% of practice staff had ever experienced physical assault, and between 2% and 4% were reported to experience physical assault in the last six to 12 months.

Practice managers reported that between 10% and 40% of staff had ever experienced sexual harassment with the majority of experiences occurring about once per year. Approximately 10% of practice staff were reported to have ever experienced sexual assault. Only one case of sexual assault was reported for the last 12 months.

GPs identified a number of times of day when they considered that they were at increased risk of aggression. The most commonly reported were when the practice was closing for the day (40%), and when staff were at the practice after hours (31%). The riskiest periods identified by practice managers were those when the practice had limited numbers of staff on duty (36%); and the times immediately after opening and closing (28% and 27% respectively).

GPs most commonly reported that aggression had negatively affected their emotional wellbeing (38%), but were less likely to report that aggression had affected their capacity to provide services (23%), or their physical wellbeing (14%). Practice managers most commonly reported that aggression had caused staff distress (63%) and/or the need for the practice to change policies and procedures (58%).

The majority of GPs did not perceive that patient aggression had increased in recent years, and only quarter (25%) perceived that patient aggression had become worse at their practice in the last 12 months. With the exception of verbal aggression (40% reported an increase) few practice managers perceived change in levels of patient aggression (6% reported increase or less).

Overall, males were perceived as more likely perpetrators of aggression compared with females and patients more so than those accompanying patients were more likely to express aggressive behaviours.

Full-time GPs overall were more likely to experience aggression compared with part-time GPs. Male staff were more likely to have experienced physical aggression compared with female staff. Staff at larger practices were at greater risk of both aggression, and negative impact from aggression, compared with staff from small practices.

Chapter 7 National paper-based survey

Introduction

After the low response rates generated by the online surveys, the surveys were redesigned in paper-based format and mailed to GPs and practice managers nationally. The two surveys were identical in content to the original online versions. As was previously stated in chapter 6, the surveys were composed of four key sections:

1. Demographics
2. Frequency of patient aggression
3. Trends in patient aggression
4. Impact of patient aggression

The second section examining the frequency of patient aggression was further subdivided to enquire about:

- verbal aggression
- stalking
- physical assault
- damage or theft of property
- sexual harassment
- sexual assault.

This chapter is divided into two sections. The first section presents results from the paper-based GP survey and the second section presents results from the paper-based practice manager survey.

Paper-based General Practitioner Survey Results

A total of 3090 surveys were sent to GPs in 19 Divisions nationally (see Chapter 2). Twenty-one surveys were undeliverable and six surveys were returned blank. Therefore, a total of 782 surveys were received from GPs resulting in a response rate of 25.5% (782/3063).

General practitioner demographics

A summary of GP demographic characteristics from the survey are provided in Table 9.

Table 9: General Practitioner profile

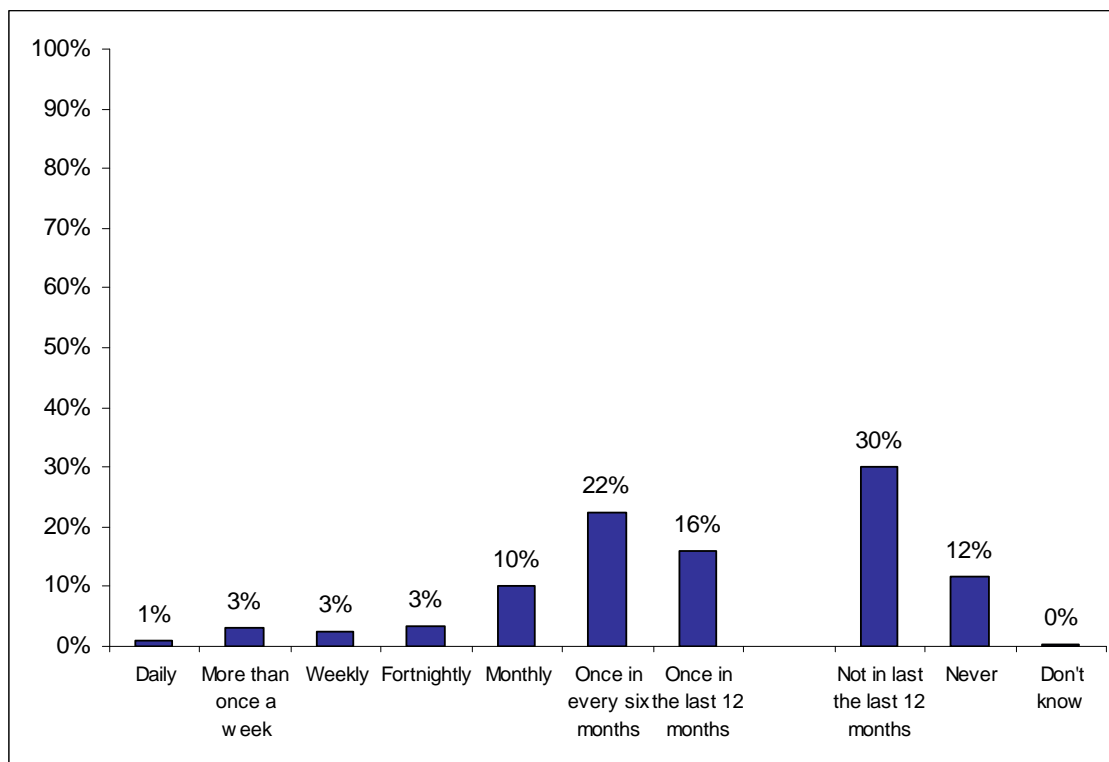
	(%)
Gender	
Male	50
Female	50
Age	
Average	51.1
Standard deviation	10.9
Years in general practice	
Average	21.6
Standard deviation	11.5
Full/part time	
Full time	64
Part time	36
Practice composition	
Sole general practitioner	11
Group practice	60
Corporate practice	20
Other	9
Practice location	
Metro	58
Non metro	42
Practice state	
NSW	19
Vic	17
Qld	11
SA	11
WA	9
Tas	16
NT	4
ACT	12
Services provided	
Home visits during hours	65
Home visits after hours	48
After hours consultations weekdays	28
After hours consultations weekends	35
None of the above	18

n = 781 GP respondents

Incidence of verbal aggression

Almost all (88%) GPs had experienced some form of verbal aggression from patients and 58% had experienced verbal aggression in the last year (Figure 31).

Most commonly, GPs experienced verbal aggression on a monthly (10%), six-monthly (22%), or yearly (16%) basis. Few GPs experienced verbal aggression once a fortnight or more frequently.



Survey Q8. In the last 12 months, how often have you been exposed to verbal aggression from patients, or people associated with patients?
n=781 General Practitioner respondents

Figure 31: Experience of verbal aggression

Male GPs, younger GPs, full-time GPs and non metropolitan GPs experienced more frequent verbal aggression than their counterparts (Table 10).

Table 10: GPs' experiences of verbal aggression

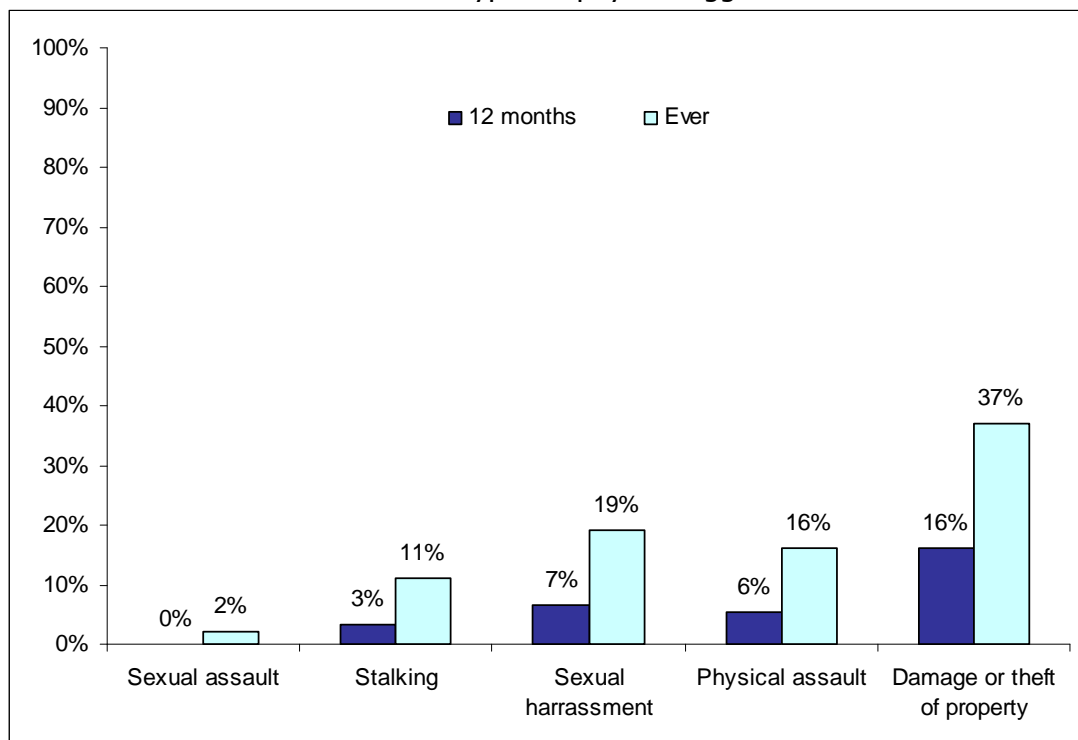
	12 months (%)	Ever (%)
Gender		
Male	59.5	87.4
Female	56.6	89.0
Age		
Less than 50 years	63.9	91.4
50 years or more	52.9	85.3
Full or part time		
Full time	63.4	90.1
Part time	48.4	84.8
Practice location		
Metro	55.7	87.1
Non metro	61.7	89.6

Incidence of physical aggression

Figure 32 provides a summary of the incidence of the different forms of physical aggression in the past 12 months, and the incidence of GPs who had ever experienced physical aggression. The incidence of physical aggression was reported to be:

- Highest for damage or theft to property (37% of GPs had ever experienced this form of aggression, 16% in the last 12 months);
- Physical assault (16% ever, 6% in the last 12 months);
- Sexual harassment (19% ever, 7% in the last 12 months);
- Stalking (11% ever, 3% in the last 12 months), and
- Sexual assault (2% ever, none in the last 12 months).

Detailed accounts for the incidence of these types of physical aggression follow.



Survey Q9.

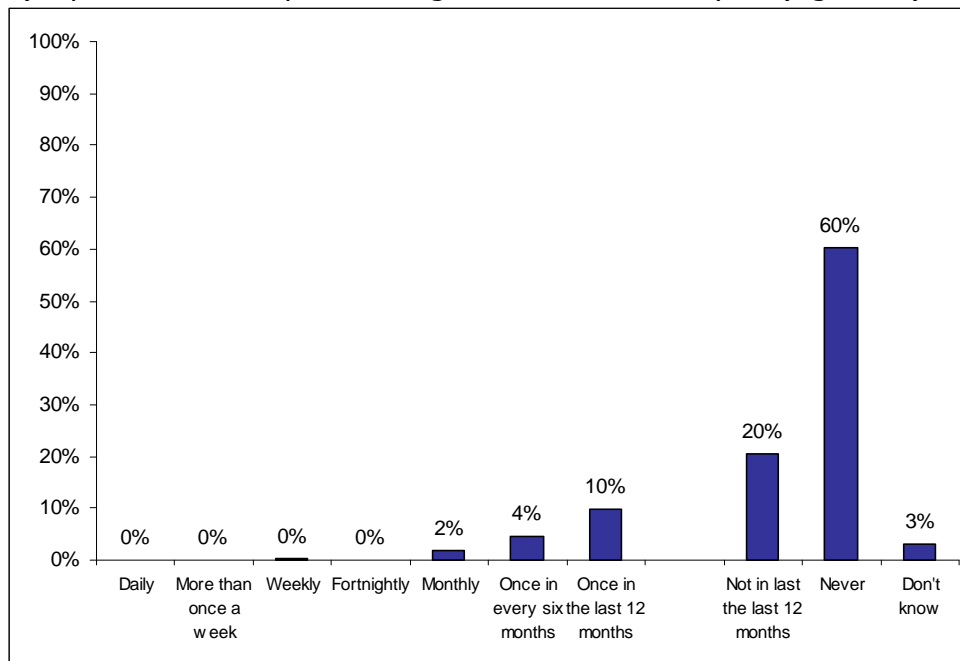
In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients... sexual assault ... stalking ... sexual harassment ... physical assault ... damage of theft of property?

n= 781 General Practitioner respondents

Figure 32: Summary of physical aggression incidence

Property theft or damage

Six in ten (60%) GPs had never experienced damage or theft of property by a patient or someone associated with a patient. Approximately one third (37%) had experienced damage/theft during their career. One tenth (10%) experienced damage/theft once in the last 12 months, and a small remainder (6%) reported more frequent damage or theft in the last year (Figure 33).



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients ... damage or theft of property?
n=781 General Practitioner respondents

Figure 33: Experience of damage or theft of property

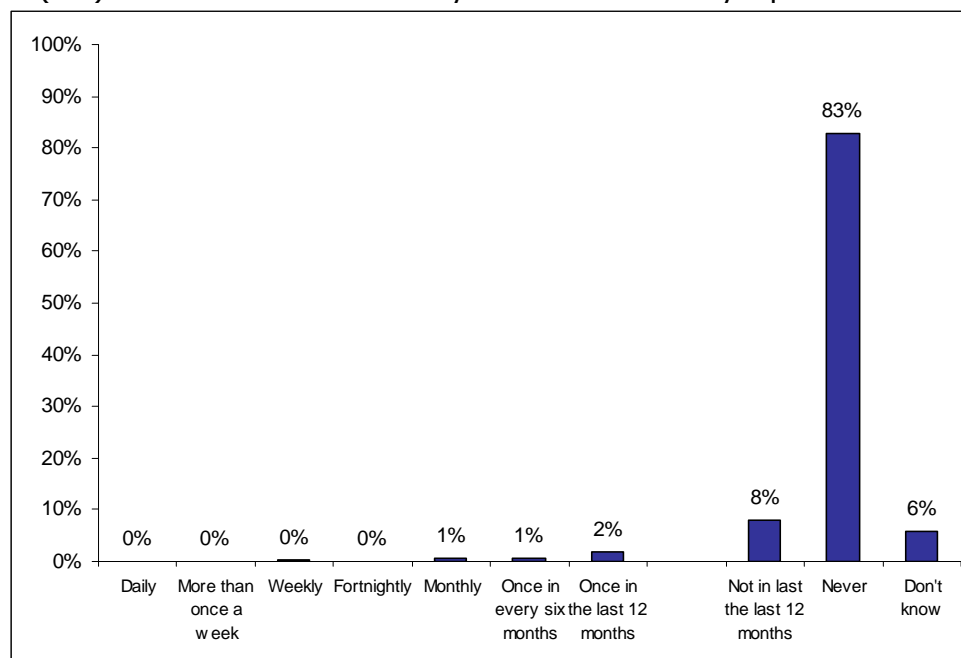
Male GPs, full-time GPs and metropolitan GPs experienced more frequent property damage or theft compared with their counterparts (Table 11).

Table 11: GPs' experiences of property damage or theft

	12 months (%)	Ever (%)
Gender		
Male	19.3	39.4
Female	13.3	33.9
Age		
Less than 50 years	41.4	33.4
50 years or more	28.5	39.9
Full or part time		
Full time	20.5	41.4
Part time	9.0	28.5
Practice location		
Metro	19.3	41.4
Non metro	12.6	30.4

Stalking

Most (83%) GPs had never experienced stalking by a patient (Figure 34). One in twelve (8%) had experienced stalking, but not in the last 12 months. Two per cent reported that they experienced stalking once in the last 12 months. Compared with other forms of physical aggression, a relatively high proportion (6%) of GPs did not know if they had been stalked by a patient.



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients... stalking?
n=781 General Practitioner respondents

Figure 34: Experience of stalking

There was little difference between gender, age, part time or full time work and practice location with regard to the percentage of GPs who had been stalked in the previous 12 months (Table 12).

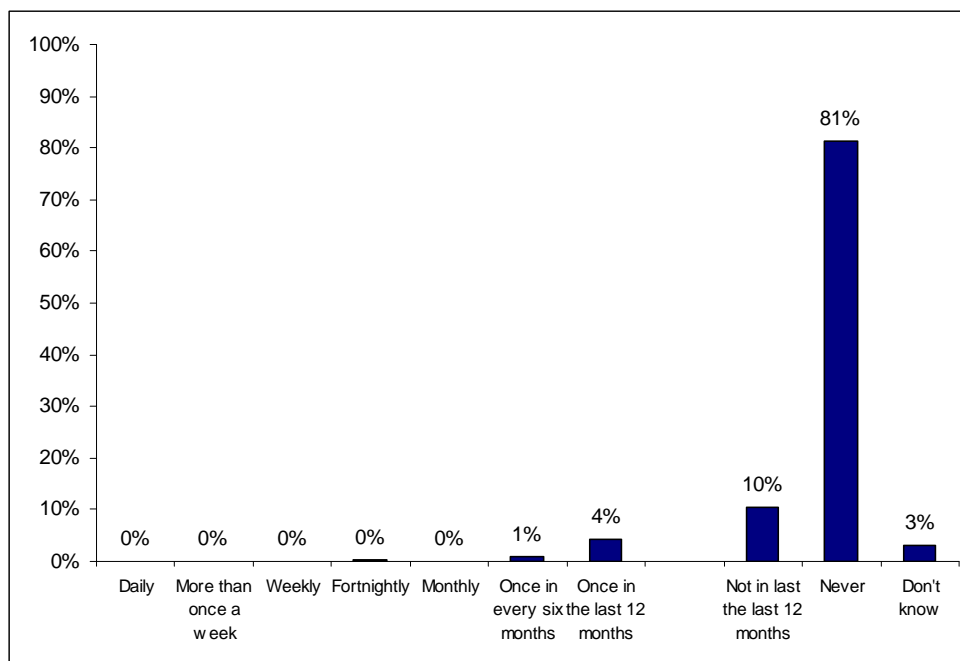
However, a greater percentage of female GPs had been stalked at some time compared to their male counterparts.

Table 12: GPs' experiences of stalking

	12 months (%)	Ever (%)
Gender		
Male	3.6	1.8
Female	2.8	11.7
Age		
Less than 50 years	3.7	9.4
50 years or more	3.0	12.7
Full or part time		
Full time	4.0	11.3
Part time	2.2	11.6
Practice location		
Metro	3.3	12.9
Non metro	3.4	9.5

Physical assault

Eight in ten (81%) GPs had never experienced physical assault by a patient (Figure 35). One in ten (10%) had experienced physical assault during their career, but not in the last 12 months. Four per cent had experienced physical assault once in the last year and one in 100 (1%) had experienced physical assault once in the last six months.



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients ... physical assault?
n=781 General Practitioner respondents

Figure 35: Experience of physical assault

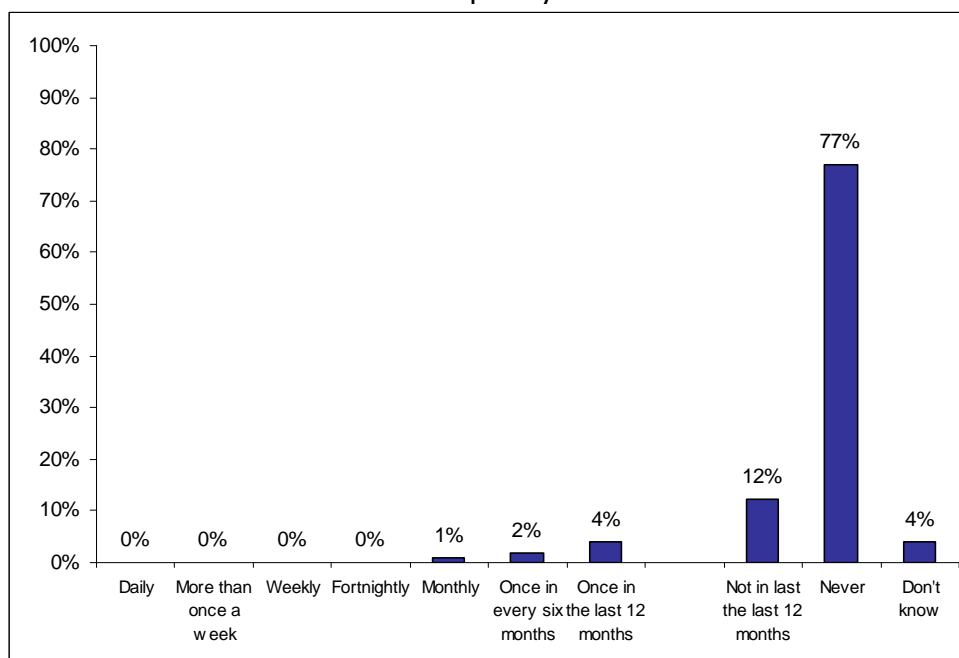
A greater percentage of male GPs and older GPs (50 years or older) experienced physical assault at some time compared with their counterparts (Table 13).

Table 13: GPs' experiences of physical assault

	12 months (%)	Ever (%)
Gender		
Male	6.7	19.3
Female	4.1	12.2
Age		
Less than 50 years	6.2	12.8
50 years or more	4.3	18.2
Full or part time		
Full time	4.8	16.3
Part time	6.2	15.2
Practice location		
Metro	5.5	15.5
Non metro	5.5	16.6

Sexual harassment

Three quarters (77%) of GPs had never experienced sexual harassment (Figure 36). One in ten (12%) per cent had experienced sexual harassment, but not in the last 12 months. Seven per cent had experienced sexual harassment once or more frequently in the last 12 months.



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients ... sexual harassment?
n=781 General Practitioner respondents

Figure 36: Experience of sexual harassment

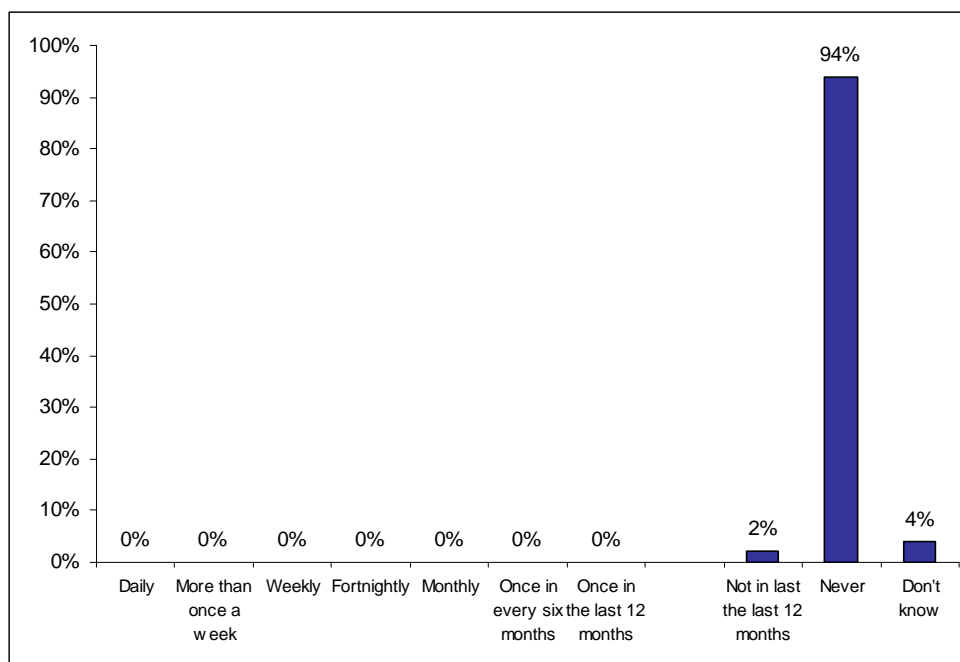
Greater percentages of females GPs and younger GPs reported experiencing sexual harassment compared with their counterparts during the previous 12 months and at some time during their career (Table 14).

Table 14: GPs' experiences of sexual harassment

	12 months (%)	Ever (%)
Gender		
Male	2.6	10.3
Female	10.5	27.6
Age		
Less than 50 years	9.6	21.9
50 years or more	4.0	16.0
Full or part time		
Full time	6.2	16.5
Part time	7.6	23.8
Practice location		
Metro	5.8	18.6
Non metro	8.0	19.9

Sexual assault

Sexual assault was the least common form of physical aggression with almost all (94%) GPs reporting that they had never experienced sexual assault by a patient (Figure 37). Two per cent of GP respondents reported that they had experienced sexual assault, but not in the last 12 months.



Survey Q9. In the last 12 months, how many times have you personally experienced the following types of physical aggression from patients or people associated with patients ... sexual assault
n=781 General Practitioner respondents

Figure 37: Experience of sexual assault

There were few differences between the demographics of GPs who had experienced sexual assault (Table 15).

Table 15: GPs' experiences of sexual assault

	12 months (%)	Ever (%)
Gender		
Male	0	2.1
Female	0	2.6
Age		
Less than 50 years	0	1.1
50 years or more	0	3.0
Full or part time		
Full time	0	2.4
Part time	0	2.2
Practice location		
Metro	0	2.9
Non metro	0	1.5

Other forms of aggression

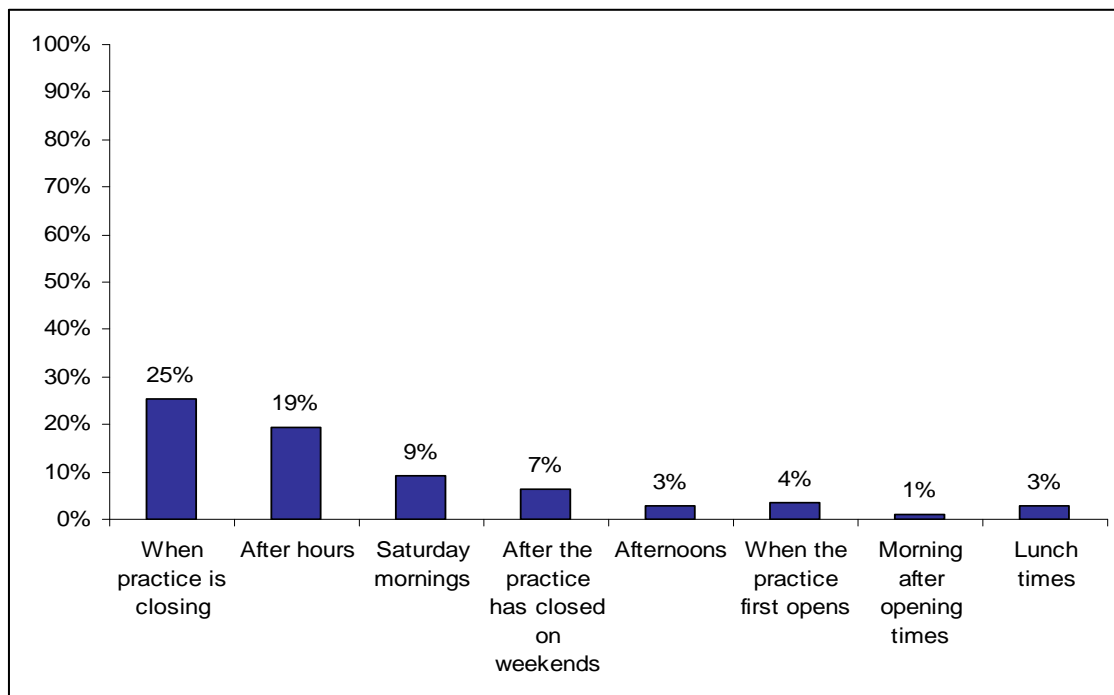
GPs identified a range of other forms of aggression either related to or not listed among the specified survey definitions. In all, 141 comments were received. The most common forms of aggression noted included:

- Raised voices, coarse language or rudeness (30 comments);
- Threats of legal action (15 comments);
- Demands for medical rebates, workers compensation, medical leave or other unreasonable requests (13 comments);
- Other types of threat (12 comments);
- Threats to family, personal property (car) (10 comments);
- Death threats (10 comments), and
- Aggression related to drug seeking behaviour (9 comments).

Trends

Times of particular risk

GPs identified particular times of day when they considered that they were at increased risk of aggression (Figure 38). The most commonly reported times were when the practice was closing for the day (25%), and when staff were at the practice after-hours (19%). A far smaller proportion of GPs indicated other risky times such as Saturday morning (9%), closing time on the weekends (7%), when the practice first opens (4%), in the afternoon (3%), mornings after opening time (1%) and at lunchtime (3%). Six in ten (58%) GPs indicated that none of these periods represented times of particular risk for practice staff.



Survey Q11. Are there any times of the day or week when you feel at particular risk of aggressive patient behaviour
 Figures do not sum 100% because multiple choice was accepted for this question.
 All General Practitioners: 781.

Figure 38: Risky times of day

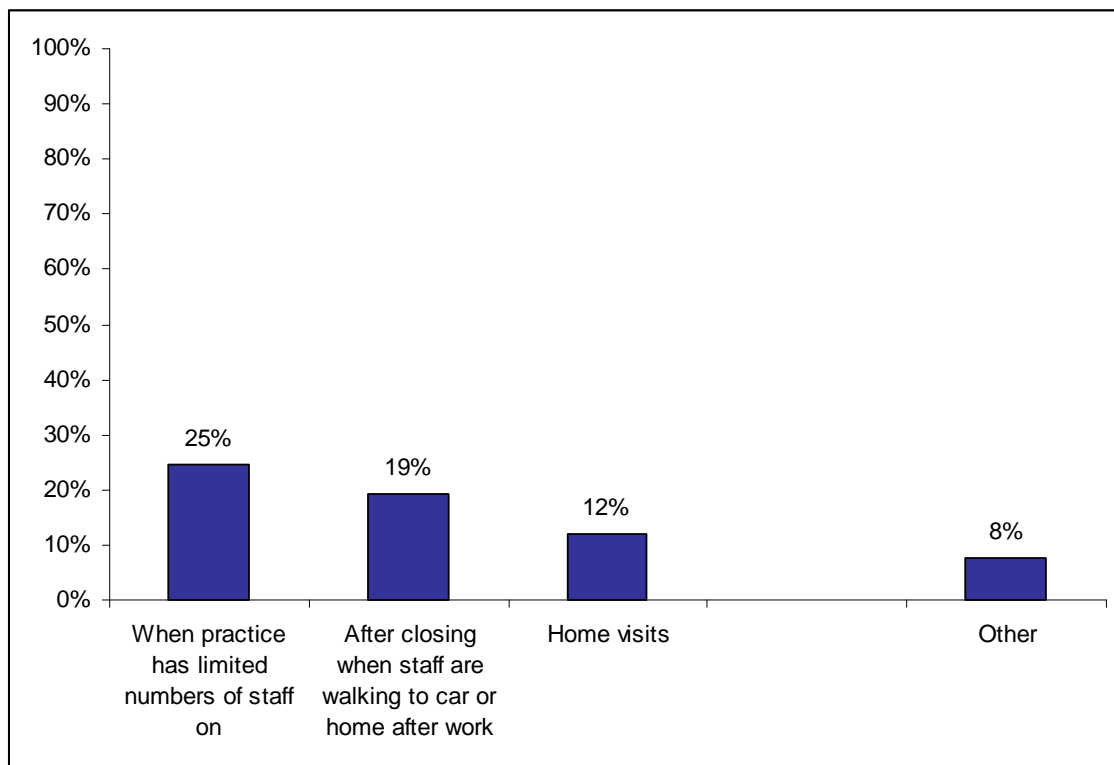
Metropolitan-based GPs (30%) were more likely to identify closing time as a risky period compared with non-metro-based GPs (20%).

Other times of risk

GPs also identified other periods of high risk including (Figure 39):

- Home visits (12%);
- When staff are walking to their cars, public transport or home after work (19%), and
- When limited numbers of staff are present at the practice (25%).

Half of GPs (54%) indicated that none of these periods represented times of particular risk.



Survey Q12. Are there any other times when you feel at particular risk of aggressive patient behaviour?
n=781 General Practitioner respondents

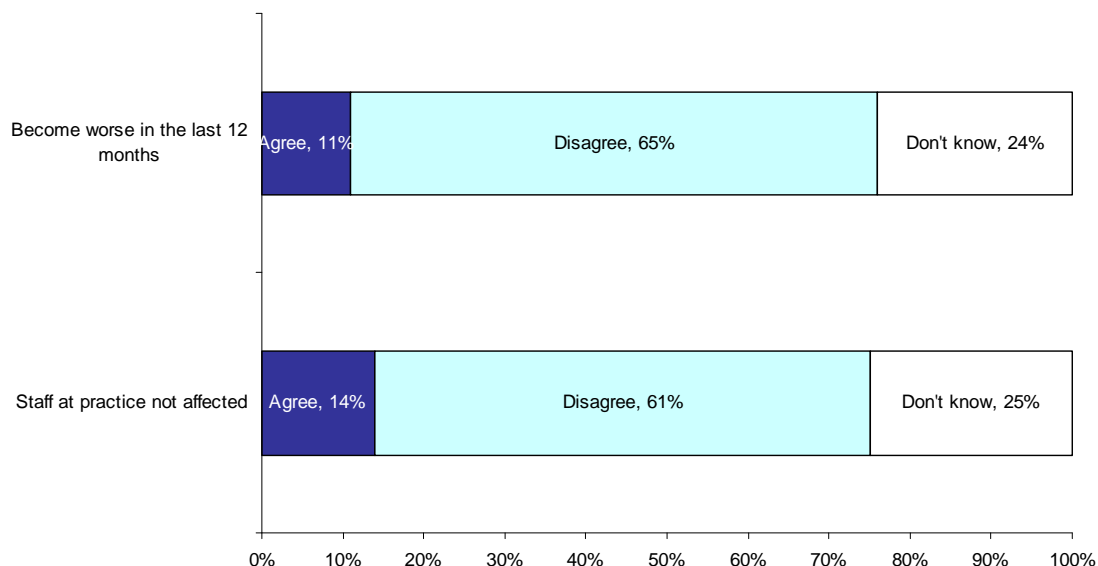
Figure 39: Other times of risk

Similar to the risks identified at closing time, metropolitan-based GPs (30%) were more likely to identify the period after closing as staff walk to their cars as risky compared with regional and rural-based GPs (20%).

Impact and perceptions of patient aggression

Perceptions of trends in patient initiated aggression

The majority of GPs did not perceive an increase in patient aggression over time (Figure 40). One in ten (11%) perceived that patient aggression had become worse at their practice in the last 12 months.



Survey Q13. Would you agree or disagree with the following statements?
n=781 General Practitioner respondents

Figure 40: Perceptions of aggression

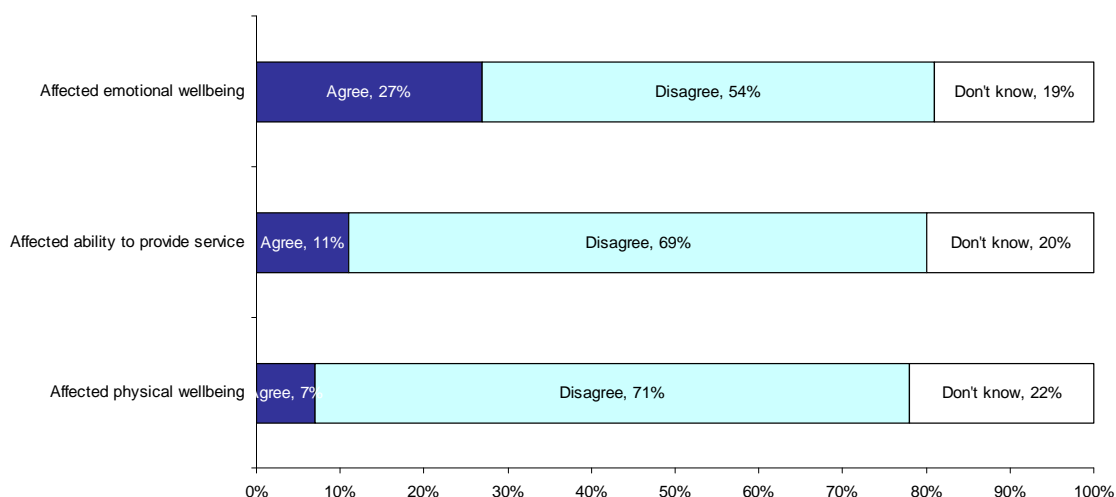
Male GPs were more likely to agree that aggression has become worse in the last 12 months compared with female GPs but that the staff at the practice were not affected (Table 16).

Table 16: GPs' perceptions of trends in patient aggression

	Worse in previous 12 months (%)	Staff at practice not affected (%)
Gender		
Male	12.6	16.8
Female	9.2	10.5
Age		
Less than 50 years	10.2	11.8
50 years or more	11.7	15.5
Full or part time		
Full time	12.3	16.1
Part time	8.3	9.0
Practice location		
Metro	10.6	14.9
Non metro	11.3	12.0

Impact of aggression

Some GPs indicated that patient aggression had affected their wellbeing and professional capacity (Figure 41). GPs were most likely to indicate that aggression had negatively affected their emotional wellbeing (27%), but were less likely to agree that aggression had affected their capacity to provide services (11%), or their physical wellbeing (7%).



Survey Q13. Would you agree or disagree with the following statements?
n=781 General Practitioner respondents

Figure 41: Impact of aggression

Male GPs were more frequently identified negative impacts of patient aggression than female GPs (Table 17). Furthermore, full-time GPs more frequently identified negative impacts than part-time GPs.

Table 17: Impact of aggression in the previous 12 months on GPs

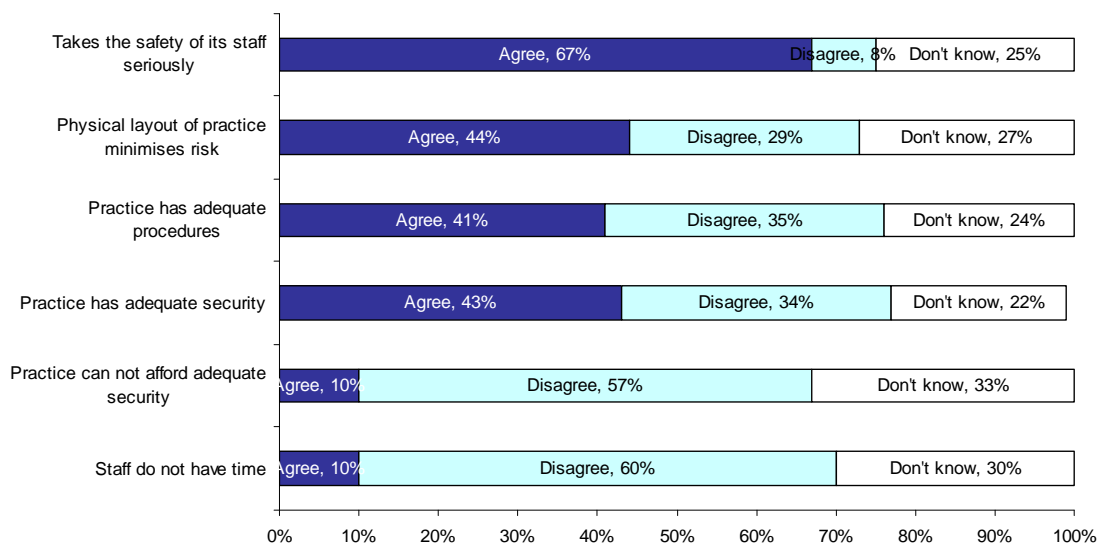
	Affected emotional wellbeing (%)	Affected ability to provide services (%)	Affected physical wellbeing (%)
Gender			
Male	26.8	12.4	7.0
Female	26.0	9.4	6.1
Age			
Less than 50 years	31.6	12.0	7.8
50 years or more	21.9	10.2	5.7
Full or part time			
Full time	29.6	12.1	7.8
Part time	20.6	8.7	4.3
Practice location			
Metro	26.8	12.0	6.9
Non metro	26.1	9.8	6.4

Practice environment

GPs were asked about a range of structural and organisational measures at their practice that may affect the incidence of aggression (Figure 42). GPs were most likely to agree that:

- The practice takes the safety of its staff seriously – 67% agreed, although nearly one in ten (8%) disagreed;
- The physical layout of the practice helped to minimise the risk of harm from aggression; four in ten (44%) agreed, and three in ten (29%) disagreed;

- The practice has adequate procedures to address patient aggression; four in ten (41%) agreed, and more than three in ten (35%) disagreed, and
- The practice has adequate security to minimise harm from patient aggression; four in ten (43%) agreed, and more than three in ten (34%) disagreed.



Survey Q13. Would you agree or disagree with the following statements?
n=781 General Practitioner respondents

Figure 42: Practice environment

Financial and time constraints were not reported as issues preventing most GPs from minimising harm from aggression. Six in ten *disagreed* that their practice could not afford to provide adequate security (57%) and that staff do not have time to implement measures to minimise risk of harm from patient aggression (60%).

There were few differences between the attitudes of GPs from different demographics, with no clear pattern emerging.

Other

In total, GPs provided 197 comments about other impacts as a result of patient aggression. Where GPs provided additional information about the impacts of violence, the most common themes to emerge were:

- General increase in anxiety, stress or fear (28 comments);
- Limit home visits (15 comments);
- Reduce or stopped after hours work (14 comments);
- Denial of services for specific patients (11 comments);
- Wishing to retire or change professions (9 comments);
- Disrupted or reduced concentration with other patients (8 comments);
- Negative impact on staffs' family (7 comments);
- Staff are less willing to help patients in general (4 comments), and
- Less tolerance for all patient misbehaviour, distrust of public (4 comments).

Paper-based General Practice Survey Results

A total of 1109 surveys were sent to practice managers in 19 Divisions nationally (see Chapter 2). Twenty-eight surveys were undeliverable and two surveys were returned blank. Therefore, a total of 214 surveys were received from practice managers resulting in a response rate of 19.8% (214/1079).

General practice demographics

Table 18 provides a summary of general practice demographics. These demographic variables are used as the basis for comparative findings throughout the report.

Table 18: General practice demographics

Average number of staff	Mean (range, SD)
General Practitioners	3.9 (range 1-45, SD 4.5)
Practice Nurses	1.7 (range 0-18, SD 2.1)
Allied Health professionals	0.9 (range 0-14, SD 1.7)
Practice Managers	0.8 (range 0-6, SD 0.6)
Receptionists	3.3 (range 0-16, SD 2.6)
State	%
NSW	21
Vic	15
Qld	13
SA	16
WA	6
NT	2
ACT	11
Tas	15
Practice location	%
Metro	50
Non-metro	49
Practice composition	%
Sole general practitioner	31
Group practice	41
Corporate practice	15
Other	13
Services provided	%
	(more than one category could be selected)
Home visits during hours	68
Home visits after hours	67
After hours consultations weekdays	34
After hours consultations weekends	34
None of the above	12

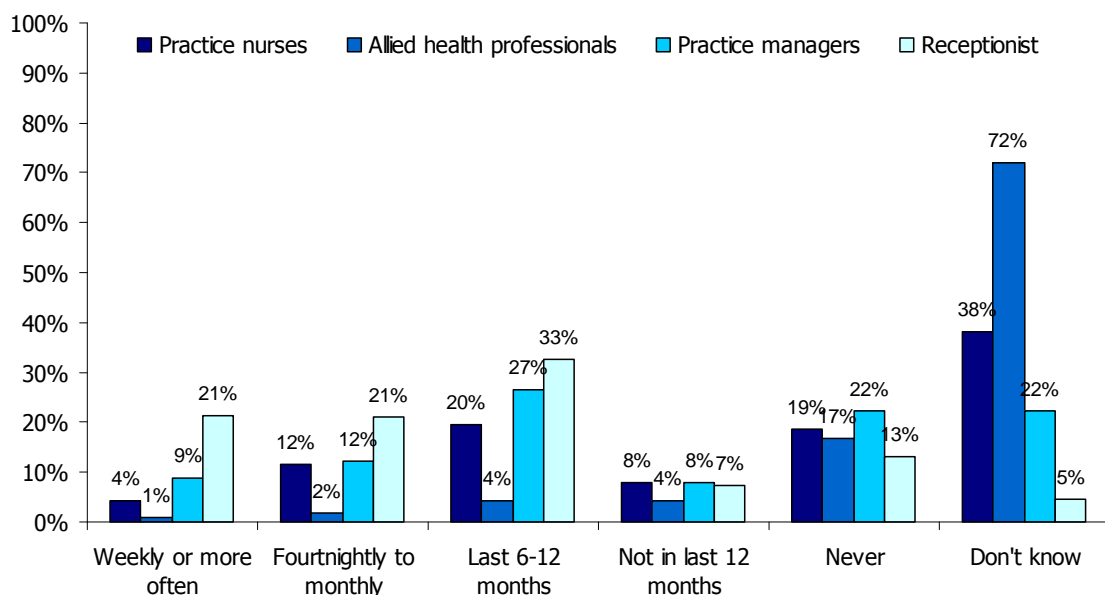
Incidence of verbal aggression

Receptionists experienced more verbal abuse than the other staff working at general practices (Figure 43). Practice managers reported that staff experienced verbal abuse:

- Weekly or more often (4% practice nurses, 1% allied health professionals, 9% practice managers, and 21% receptionists);
- Fortnightly to monthly (12% practice nurses, 2% allied health professionals, 12% practice managers, and 21% receptionists), and
- In the last six to twelve months (20% practice nurses, 4% allied health professionals, 27% practice managers, and 33% receptionists).

Between 4% and 8% of practice staff had experienced verbal abuse, but not in the last 12 months. A minority of practice nurses (19%), allied health professionals (17%), practice managers (22%) and receptionists (13%) had never experienced verbal abuse.

Notably, practice managers were relatively unaware of the experience of allied health professionals (72% don't know). This finding is repeated across the different forms of aggression, and implies that results for allied health professionals should be interpreted with caution.



Survey Q7. In the last 12 months, how many times have staff at this practice been subject to verbal abuse or threats by a patient or someone associated with a patient?
 n= 137 Practices with practice nurses n=75 Practices with allied health professionals
 n=163 Practices with practice managers n= 205 Practices with receptionists

Figure 43: Verbal abuse

Practice staff working in practices with more than one GP reported higher percentages of verbal aggression than those working in solo GP practices (Table 19).

Table 19: Percentage of verbal aggression during last 12 months

	Practice nurses	Practice managers	Allied health	Receptionists
Total n (%)				
	76 (35.3)	102 (47.4)	15 (7.0)	161 (74.9)
Practice location (%)				
Metro	26.2	37.4	8.4	72.9
Non metro	45.3	57.5	5.7	76.4
Size of practice (%)				
Solo GP	13.6	28.8	3.0	53.0
More than one GP	45.6	55.8	8.8	84.4

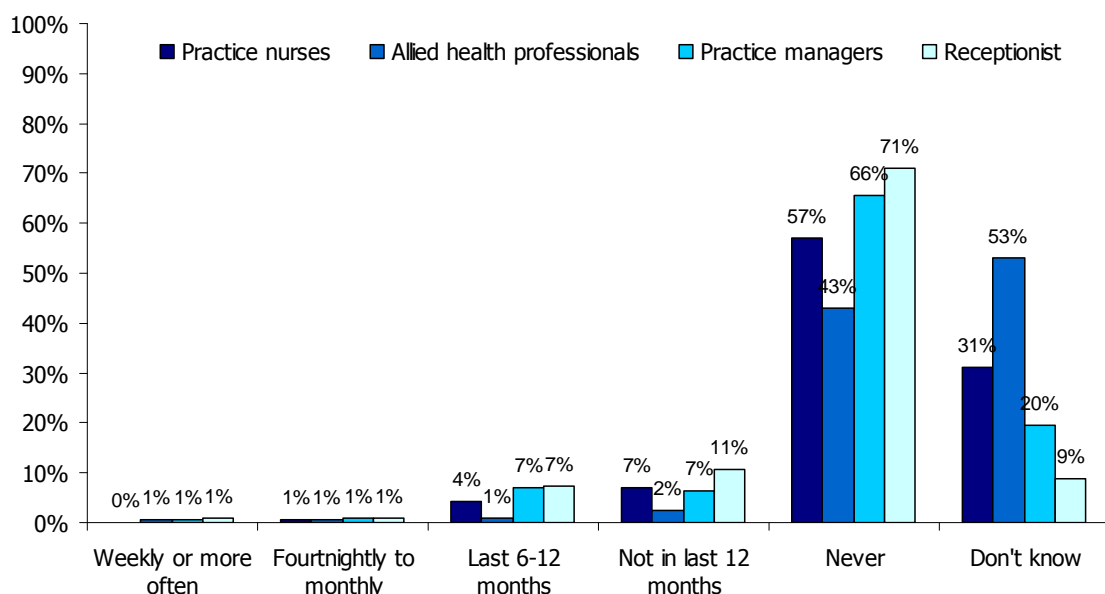
Incidence of physical aggression

Property damage or theft

Few general practice staff experienced property damage or theft (Figure 44). Specifically, practice managers reported that property theft or damage was experienced:

- Very infrequently at the weekly or monthly level (0%-1%);
- Six monthly/yearly (4% practice nurses, 1% allied health professionals, 7% practice managers, and 73% receptionists), and
- At some stage, but not in the last 12 months (7% practice nurses, 2% allied health professionals, 7% practice managers, and 11% receptionists).

Practice managers reported that the majority of practice nurses (57%), practice managers (66%) and receptionists (71%) had never experienced property theft or damage. Half of practice managers (53%) reported that they did not know how often allied health professionals experienced property damage.



Survey Q10. In the last 12 months, how many times have staff at this practice been subject to property damage or theft by a patient or someone associated with a patient?
 n= 137 Practices with practice nurses n=75 Practices with allied health professionals
 n=163 Practices with practice managers n=205 Practices with receptionists

Figure 44: Property damage or theft

A greater percentage of practice nurses experienced property damage or theft who worked in practices in non metropolitan areas and in practices with more than one GP compared to their counterparts (Table 20).

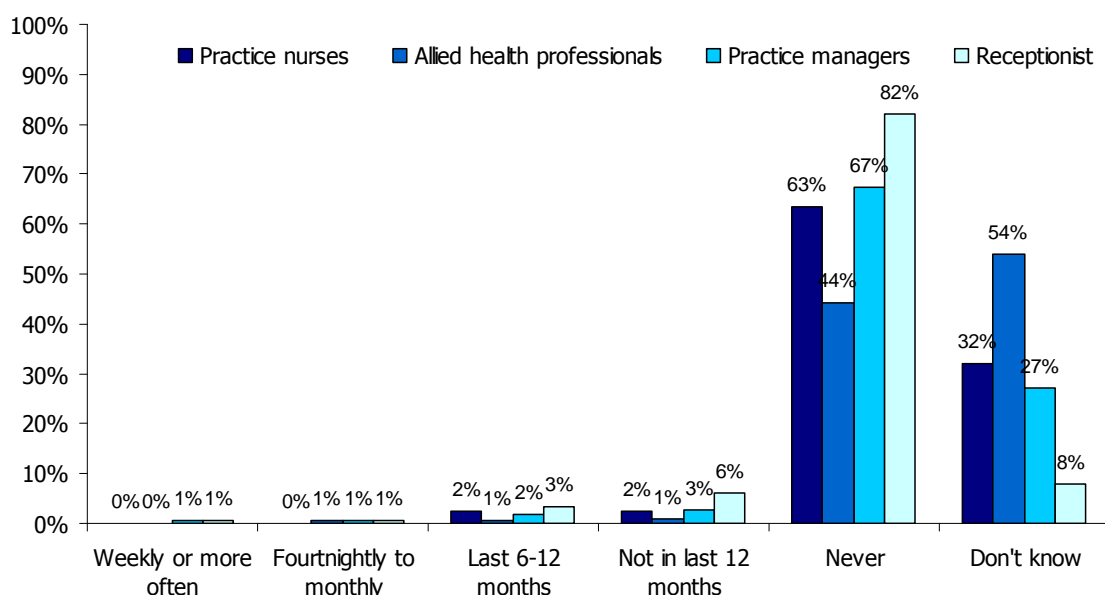
Table 20: Percentage of property damage or theft during last 12 months

	Practice nurses	Practice managers	Allied health	Receptionists
Total n (%)				
	10 (4.7)	18 (8.4)	4 (1.9)	20 (9.3)
Practice location (%)				
Metro	2.8	9.3	1.9	10.3
Non metro	6.6	6.6	1.9	7.5
Size of practice (%)				
Solo GP	1.5	9.1	1.5	7.6
More than one GP	6.1	7.5	1.4	9.5

Stalking

Very few general practice staff experienced stalking (Figure 45). Specifically, practice managers reported that:

- A very small proportion (0 – 2%) of practice staff had experienced stalking on a weekly to monthly basis;
- A very small proportion (1 – 3%) of practice staff had experienced stalking in the last six to twelve months, and
- Very few had experienced stalking, though not in the last 12 months: 2% of practice nurses, 1% of allied health professionals, 3% of practice managers, and 6% of receptionists.



Survey Q13. In the last 12 months, how many times have staff at this practice been subject to stalking by a patient or someone associated with a patient?
 n=137 Practices with practice nurses n=75 Practices with allied health professionals
 n=163 Practices with practice managers n=205 Practices with receptionists

Figure 45: Stalking

No clear pattern emerged regarding whether some practice staff members experienced stalking more frequently than others (Table 21).

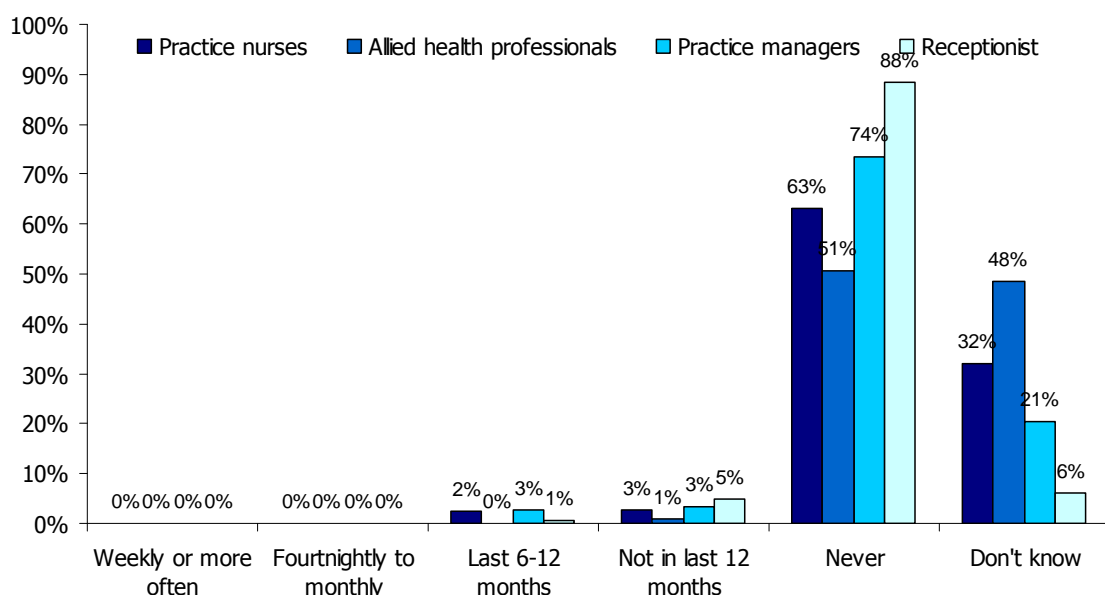
Table 21: Percentage of stalking during last 12 months

	Practice nurses	Practice managers	Allied health	Receptionists
Total n (%)				
	5 (2.3)	6 (2.8)	2 (0.9)	9 (4.2)
Practice location (%)				
Metro	0	2.8	0	2.8
Non metro	4.7	1.9	1.9	4.7
Size of practice (%)				
Solo GP	0	1.5	0	1.5
More than one GP	1.1	3.4	0	4.6
Corporate practice	3.1	0	0	3.1

Physical assault

The majority of practice staff had never experienced physical assault (Figure 46). Specifically, practice managers reported that:

- No practice staff experienced physical assault weekly or more often;
- No practice staff experienced physical assault on a fortnightly to monthly basis;
- Very few practice staff members experienced physical assault on a six to twelve monthly basis (0 – 3%);
- Very few had experienced assault, but not in the last year: 3% of practice nurses, 1% of allied health professionals, 3% of practice managers, and 5% of receptionists.



Survey Q16. In the last 12 months, how many times have staff at this practice been subject to physical assault by a patient or someone associated with a patient?
 n=137 Practices with practice nurses n= 75 Practices with allied health professional
 n=163 Practices with practice managers n = 205 Practices with receptionists

Figure 46: Physical assault

No clear pattern emerged regarding whether some practice staff members experienced stalking more frequently than others (Table 22).

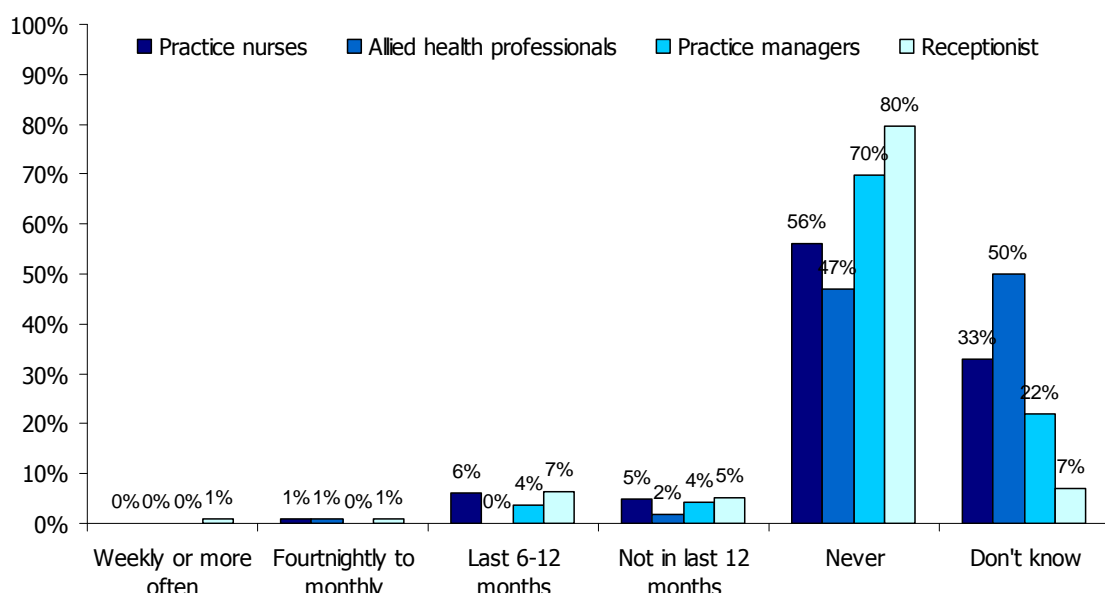
Table 22: Percentage of physical assault during last 12 months

	Practice nurses	Practice managers	Allied health	Receptionists
Total n (%)				
	2 (2.3)	6 (2.8)	1 (0.5)	1 (0.5)
Practice location (%)				
Metro	0.9	0.9	0	0
Non metro	3.8	3.8	0	0
Size of practice (%)				
Solo GP	1.5	3.0	0	1.5
More than one GP	2.7	2.7	0	0

Sexual harassment

Very few practice managers reported that practice staff had experienced sexual harassment (Figure 47). Specifically:

- One per cent of practice managers reported that sexual harassment was experienced by receptionists on a weekly or more frequent basis;
- One per cent practice managers reported that sexual harassment was experienced by practice nurses, practice managers and receptionists on a fortnightly to monthly basis;
- Few practice managers reported that that sexual harassment was experienced by practice nurses, practice managers and receptionists once in the last six to 12 months, and
- Few practice managers reported that that sexual harassment was experienced by practice staff at some time but not in the previous 12 months.



Survey Q19. In the last 12 months, how many times have staff at this practice been subject to sexual harassment by a patient or someone associated with a patient?
 n=137 Practices with practice nurses n= 75 Practices with allied health professional
 n=163 Practices with practice managers n = 205 Practices with receptionists

Figure 47: Sexual harassment

Practice managers reported that practice nurses and receptionists who worked in non metropolitan practices experienced more frequent sexual harassment than their counterparts (Table 23). The same was reported for practice nurses and receptionists who worked in larger practices.

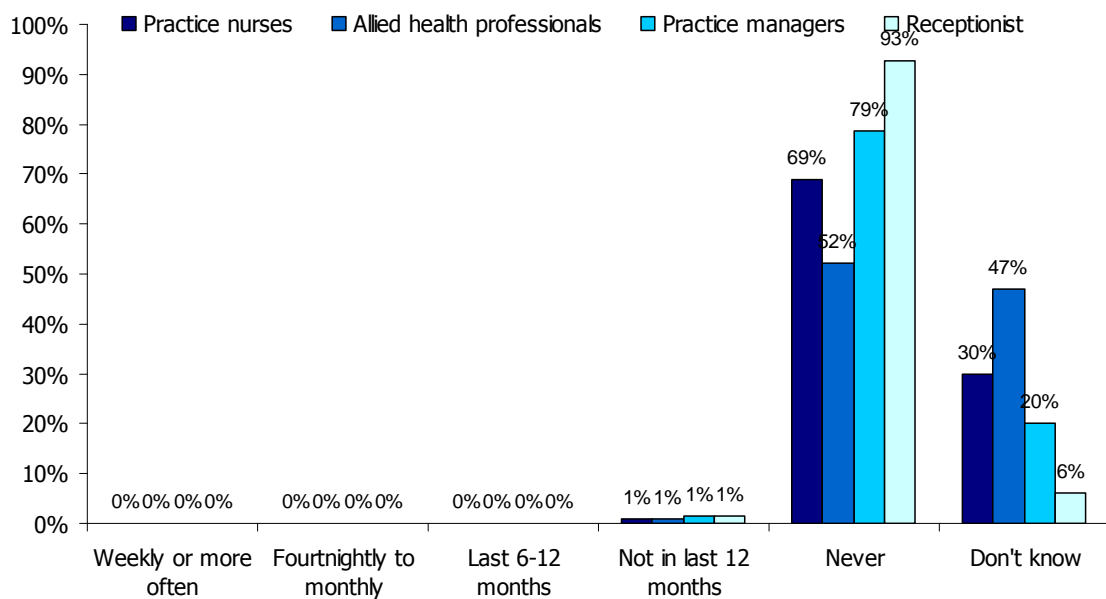
Table 23: Percentage of sexual harassment during last 12 months

	Practice nurses	Practice managers	Allied health	Receptionists
Total n (%)				
	13 (6.0)	8 (3.7)	1 (0.5)	18 (8.4)
Practice location (%)				
Metro	1.9	3.7	0	6.5
Non metro	10.4	3.8	0.9	10.4
Size of practice (%)				
Solo GP	3.0	1.5	0	4.5
More than one GP	7.5	4.8	0.7	10.2

Sexual assault

Practice managers reported that the majority of practice staff never experienced sexual assault (Figure 48). Specifically:

- No practice managers reported that sexual assault had been experienced by practice staff in the last 12 months; and
- One per cent of practice managers reported each type of staff had experienced sexual assault, but not in the past 12 months.



Survey Q22. In the last 12 months, how many times have staff at this practice been subject to sexual assault by a patient or someone associated with a patient?
 n=137 Practices with practice nurses n= 75 Practices with allied health professional
 n=163 Practices with practice managers n = 205 Practices with receptionists

Figure 48: Sexual assault

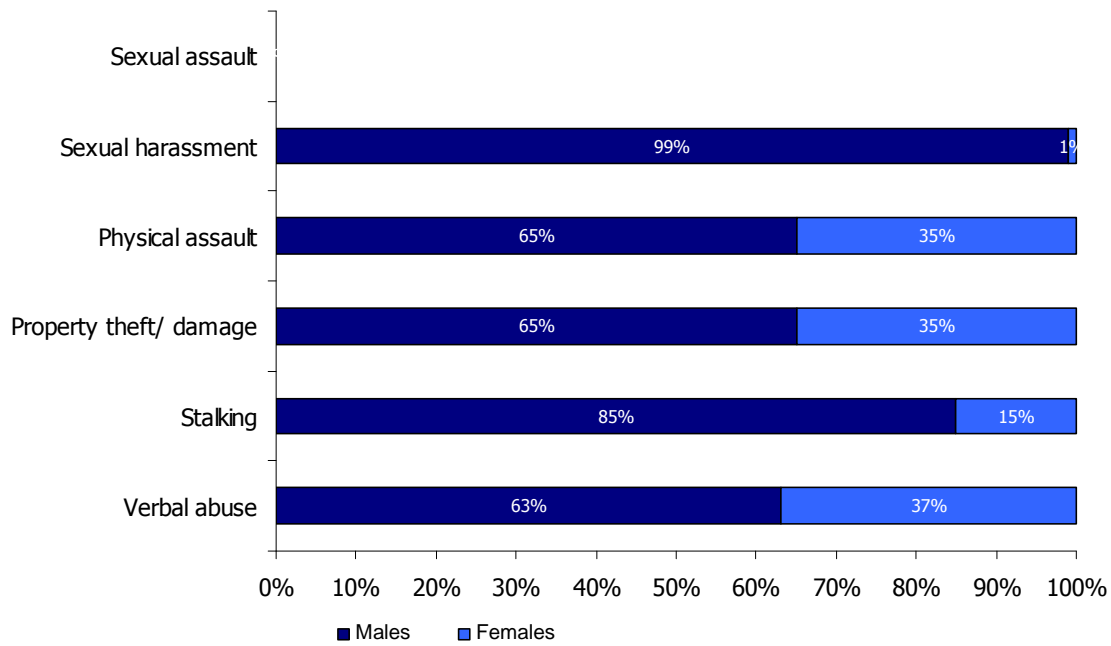
Patient initiated aggression by demographic

Practice managers were asked what proportion of aggression was perpetrated by males vs. females; and patients vs. people accompanying patients.

Males and females

Overall, males were perceived to be more likely to behave aggressively than were females (Figure 49). For each type of aggression, the majority of incidents were reported to have been perpetrated by males, specifically:

- 99% of sexual harassment;
- 65% of physical assault;
- 65% of property theft or damage;
- 85% of stalking, and
- 63% of verbal abuse.



Multi survey questions

Overall, how much of this <aggression type> threats comes from males, how much from females?

Reported aggression in the last 12 months

Verbal: n = 174

Property theft or damage: n = 39

Stalking: n = 16

Physical: n = 13

Sexual harassment: n = 29

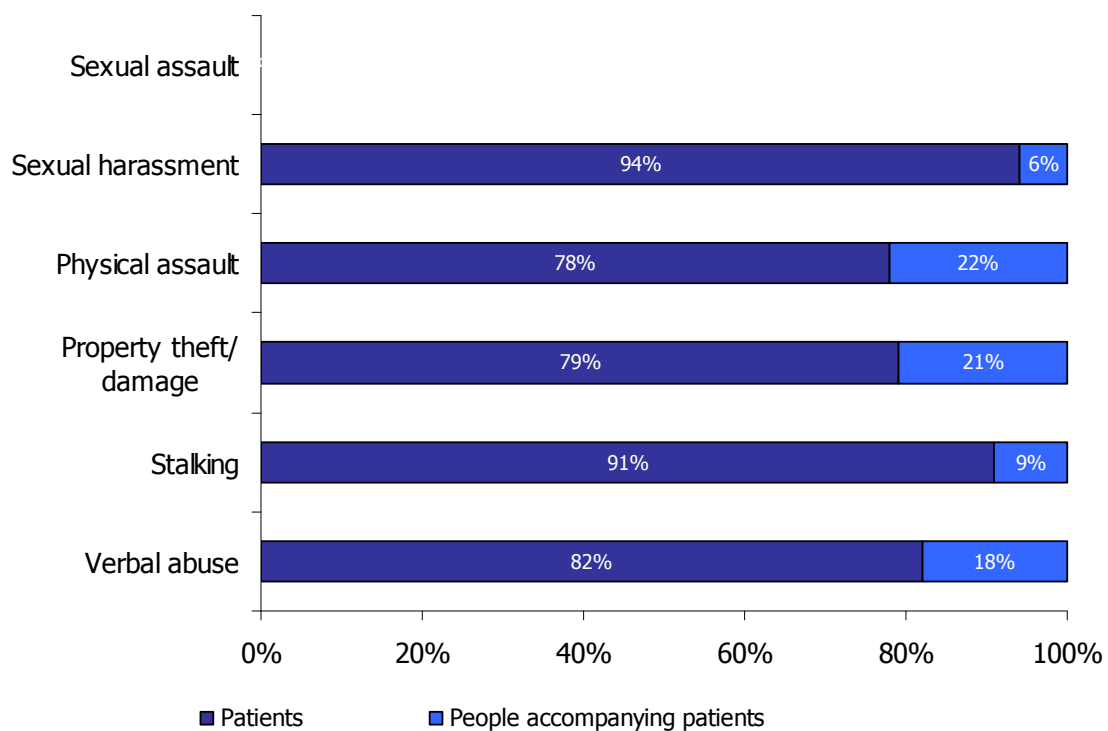
Sexual assault: n = 0

Figure 49: Male vs. female patient aggression

Patients and people accompanying patients

Overall, patients were perceived to be more likely to initiate aggression than were people accompanying patients (Figure 50). For each type of aggression, patients were responsible for the majority of incidents, specifically:

- 94% of sexual harassment;
- 91% of stalking;
- 82% of verbal abuse;
- 79% of property theft or damage, and
- 78% of physical assault.



Multi survey questions Overall, how much of this verbal abuse comes from a patient, and how much from people associated with patients?
 Reported aggression in the last 12 months
 Verbal: n = 174 Property theft or damage: n = 39 Stalking: n = 16
 Physical: n = 13 Sexual harassment: n = 29 Sexual assault: n = 0

Figure 50: Patient vs. Person accompanying Patient Perpetrated Aggression

Trends and periods of particular risk

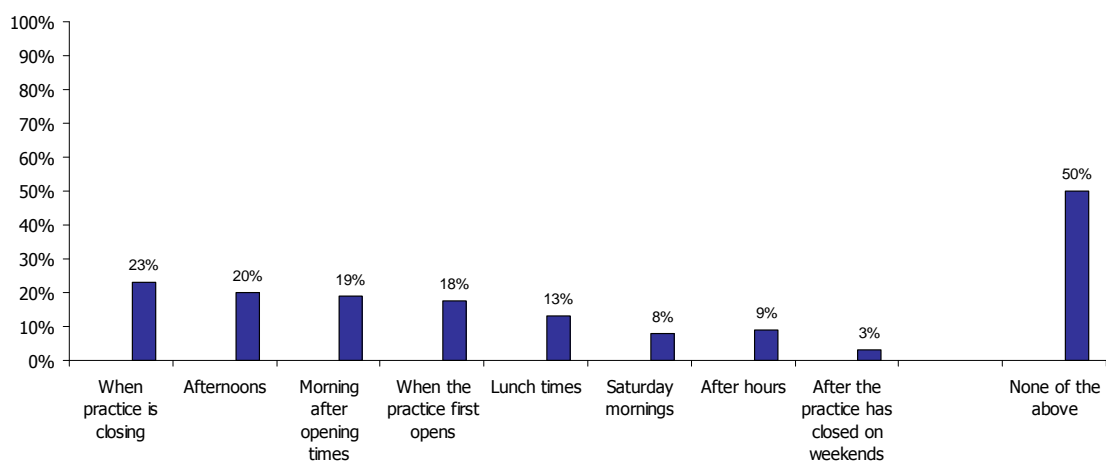
Practice manager’s perceptions of times of particular risk were assessed.

Times of particular risk

Practice managers were most likely to identify the times immediately after practice opening and closing as periods of particular risk (Figure 51). Specifically, practice managers reported the following daily times of particular risk of patient initiated aggression:

- When the practice is closing (23%);
- Afternoons (20%);
- Mornings after opening time (19%);
- When the practice first opens (18%);
- Lunch times (13%);
- After hours when the practice has closed (9%);
- Saturday mornings (8%), and
- After the practice has closed on weekends (3%).

Half the practice managers reported that none of these specific times represented elevated risk.



Survey Q26. Are there any times of the day or week when staff are at particular risk of aggressive patient behaviour?
 Figures do not sum 100% because multiple choice was accepted for this question.
 n = 215 practices

Figure 51: Times of particular risk

The five most common times of perceived risk were further divided to examine practice location and the size of the practice (Table 24).

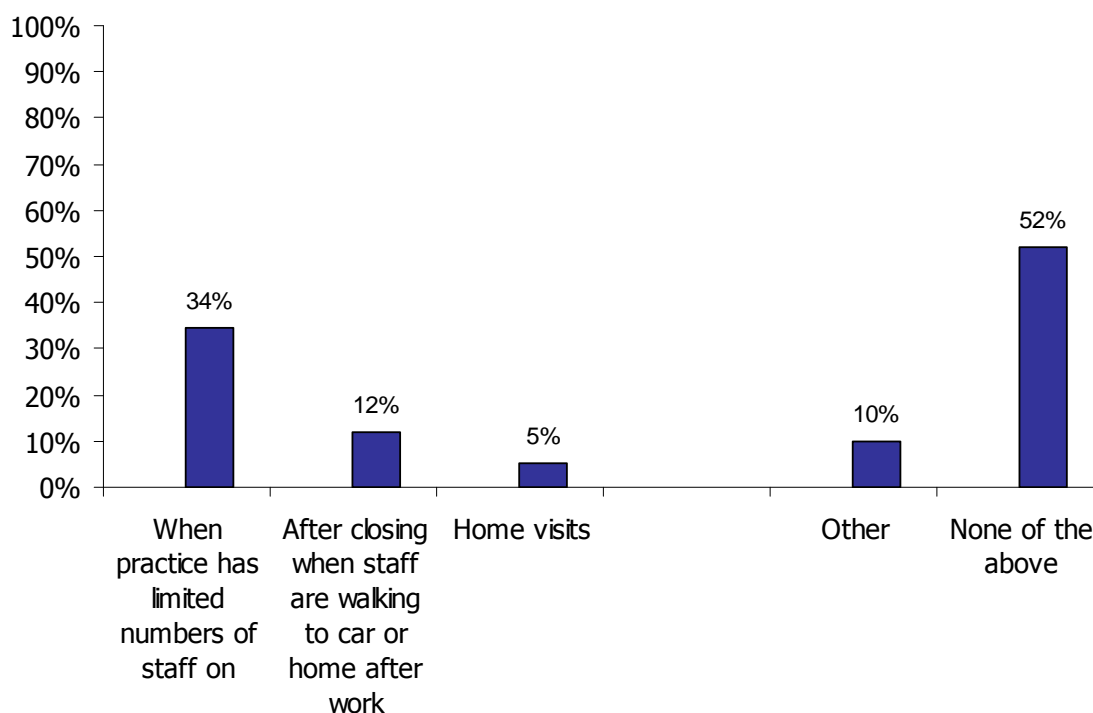
Table 24: Times of perceived risk

	When practice is closing	Afternoons	Mornings after opening	When practice first opens	Lunch times
Practice location (%)					
Metro	29.0	20.6	16.8	15.9	14.0
Non metro	17.0	18.9	20.8	19.8	10.4
Size of practice (%)					
Solo GP	19.7	21.1	3.0	16.7	15.2
More than one GP	25.2	23.1	25.2	18.4	10.9

Practice managers were also asked about other times of day when staff were at particular risk of aggression (Figure 52). These times were reported to be:

- When the practice has limited number of staff on (34% the highest indicated period of risk);
- After the practice had closed and staff were walking to their car (12%), and
- During home visits (5%).

More than half (52%) practice managers indicated that none of these periods represented a time of particular risk.



Survey Q27. Are there any other times when staff are at particular risk of aggressive patient behaviour?
n = 215 practices

Figure 52: Other times of particular risk

Practice managers employed at practices with more than one GP more frequently perceived that staff were at risk of aggressive patient behaviour when there were limited numbers of staff on (Table 25).

Table 25: Other times of perceived risk

	Limited staff on	Staff walking to car
Practice location (%)		
Metro	32.7	11.2
Non metro	35.8	11.3
Size of practice (%)		
Solo GP	16.7	9.1
More than one GP	41.5	12.2

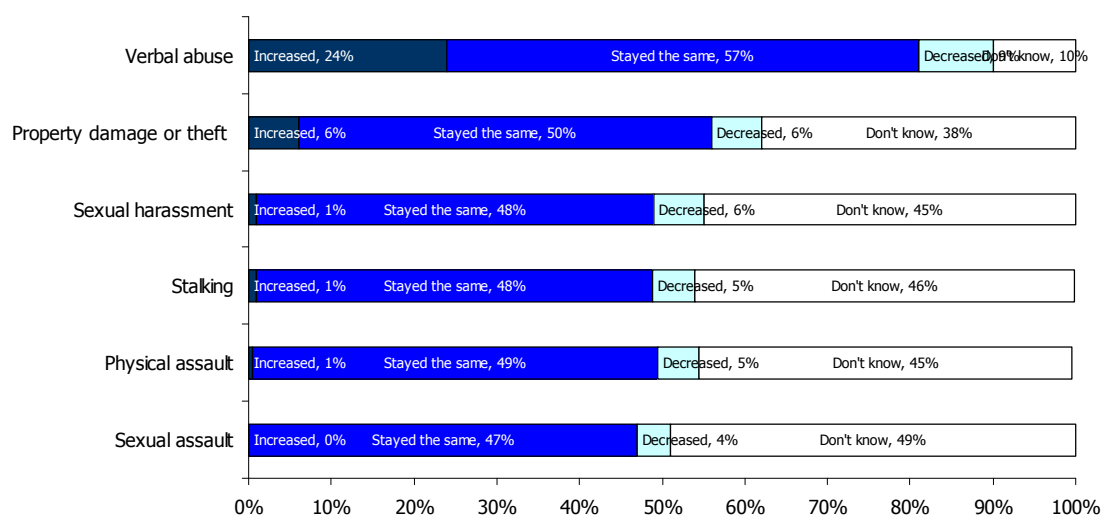
Other times of risk

Practice managers identified some other times of elevated risk of patient initiated aggression. Where times of increased risk were identified, the most commonly reported periods were:

- When the GPs are running late (6 comments);
- When patients can not get appointments (4 comments);
- When the practice is short-staffed (3 comments);
- When a patient is denied medicines or drugs (2 comments);
- When a patient is denied services (1 comment);
- Limited or no witness (1 comment), and
- Younger staff on duty (1 comment).

Perceived change in the incidence of aggression

Practice managers were asked whether they thought the incidence of aggression had changed in the last 12 months (Figure 53). With the exception of verbal aggression, few practice managers perceived a change in levels of patient aggression.



Survey Q28. In the last 12 months, has aggressive patient behaviour increased, decreased or stayed the same at this practice?
n = 215 practices

Figure 53: Change in the incidence of aggression

Specifically, for each form of aggression:

- More than two in ten (24%) practice managers perceived verbal aggression to have increased (57% perceived no change, 9% decreased);
- Less than one in ten (6%) perceived property theft or damage to have increased (50% no change, 6% decreased);
- One in one hundred (1%) perceived sexual harassment to have increased (48% no change, 6% decreased);
- One in one hundred (1%) perceived stalking to have increased (48% no change, 5% decreased);
- One in one hundred (1%) perceived physical assault to have increased (49% no change, 5% decreased), and
- None perceived sexual assault to have increased (47% no change, 4% decreased).

More practice managers working in metropolitan practice and practices with more than one GP perceived verbal aggression to have increased compared to their counterparts (Table 26).

Table 26: Changes in types of aggression

	Verbal aggression		Property damage or theft		Stalking	
	Increased	Decreased	Increased	Decreased	Increased	Decreased
Practice location (%)						
Metro	25.2	9.3	5.6	6.5	0.9	5.6
Non metro	21.7	8.5	5.7	6.6	0	4.7
Size of practice (%)						
Solo GP	16.7	4.5	3.0	4.5	1.5	3.0
More than one GP	27.2	10.9	6.8	7.5	0.7	6.1

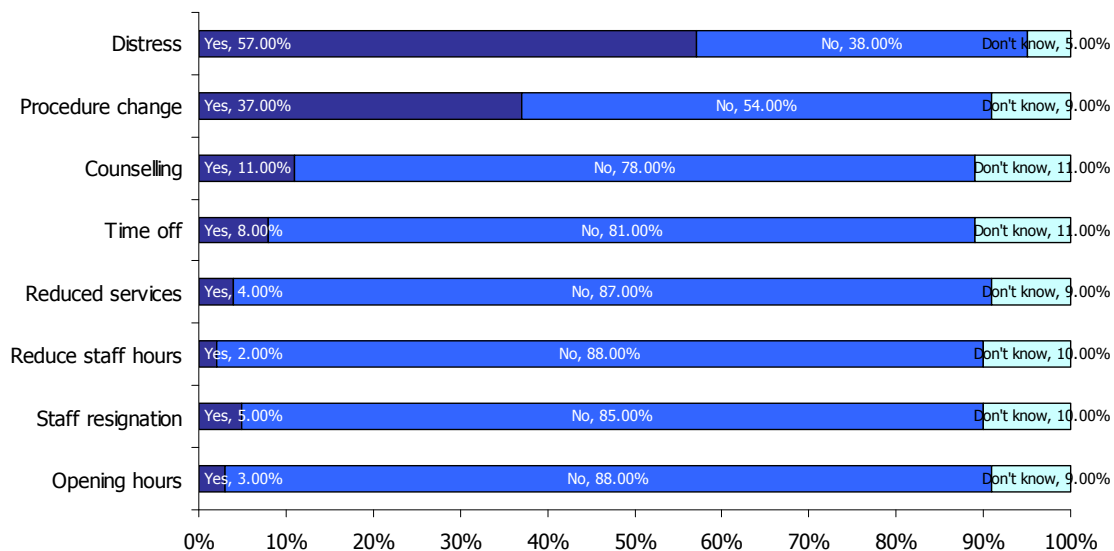
Impact of aggression

Practice managers' perceptions of the impact of patient initiated aggression on staff were assessed.

Impact of verbal aggression

The most common form of negative impact of verbal aggression was staff distress, as perceived by practice managers (Figure 54). Specific impacts of aggression in the last 12 months were reported to be:

- Staff distress (57% of practice managers replied 'yes' when asked if patient aggression had led to this impact);
- A change in the practice's procedures (37%);
- The need for staff counselling (11%);
- The need for staff to have time off (8%);
- The need to reduce health services at the practice (4%);
- The need for staff to reduce their hours (2%);
- Staff turn-over or staff resignation (5%), and
- The need to reduce the practice's opening hours (3%).



Survey Q28. In the last 12 months, has verbal aggression by patients or people associated with patients resulted in ...
n = 215 practices

Figure 54: Impact of verbal aggression

Practice size appeared to be the key driver behind risk of negative impact of verbal aggression on staff (Table 27):

Table 27: Impact of verbal aggression on staff

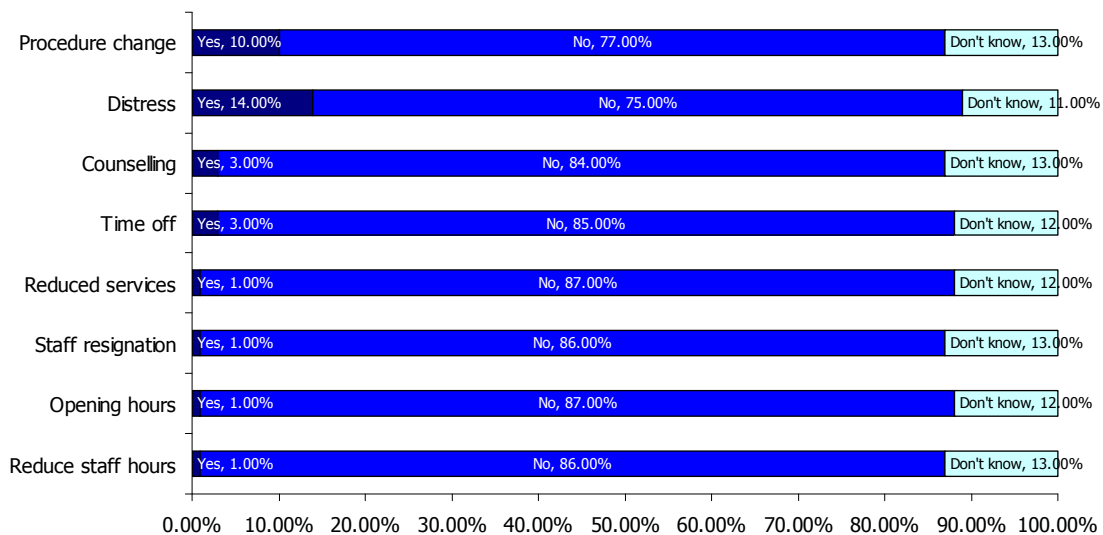
	Distress	Change policies & procedures	Change opening hours	Reduce services	Staff resignation
Size of practice (%)					
Solo GP	33.3	24.2	3.0	3.0	0
More than one GP	66.7	37.9	2.3	2.3	5.7
Corporate practice	62.5	43.8	6.3	9.4	9.4

Impact of physical aggression

The most commonly reported impact of physical aggression was staff distress (Figure 55). Specific impacts of aggression in the last 12 months were reported to be:

- Staff distress (14% of practice managers replied 'yes' when asked if patient aggression had led to this impact);
- A change in the practice's procedures (10%);
- The need for staff counselling (3%);
- The need for staff to have time off (3%);
- The need to reduce health services at the practice (1%);
- Staff turn-over or staff resignation (1%);
- The need to reduce the practice's opening hours (1%), and
- The need for staff to reduce their hours (1%).

Overall, far fewer impacts were reported for physical aggression compared with verbal aggression.



Survey Q29. In the last 12 months, has physical aggression by patients or people associated with patients resulted in ...
n = 215 practices

Figure 55: Impact of physical aggression

Other

Some comments were made about other impacts of patient aggression. Where additional or other impacts were identified, most commonly reported were:

- General increase in anxiety, stress or fear (7 comments);
- Denial of services for specific patients (3 comments);
- Staff are more guarded or less confident (2 comments);
- Staff are less willing to help patients in general (2 comments);
- Diminished capacity or productivity of staff (1 comment);
- The need for further training of staff (1 comment);
- Number of staff changed their jobs (1 comment), and
- Distrust of public (1 comment).

Summary of paper-based survey findings

Data from 782 GP respondents and from 214 practice staff respondents has been analysed to present the following key findings of the paper-based survey:

Verbal aggression

- Almost all (88%) GPs had experienced some form of verbal aggression from patients and 58% had experienced verbal aggression in the last year
- Receptionists experienced more verbal aggression (75%) than practice nurses (36%) and practice managers (48%) in the last year

Physical aggression

Property damage or theft

- Of all types of physical aggression, GPs mostly experienced property damage or theft (16% had experienced this in the previous 12 months, 37% experienced it at some time over their career)
- Practice managers reported that the majority of practice nurses (57%), practice managers (66%) and receptionists (71%) had never experienced property theft or damage

Stalking

- Few GPs had experienced stalking, with 4% experiencing this once or more in the previous 12 months and 11% experiencing it sometime over their career
- Female GPs experienced greater frequencies of stalking compared to male
- The majority of practice nurses, practice managers and receptionists had never been stalked

Physical assault

- Few GPs had experienced physical assault, with 6% experiencing this in the previous 12 months and 16% experiencing it sometime over their career
- The majority of practice staff had never experienced physical assault

Sexual harassment

- Almost 20% of GPs have experienced sexual harassment at some time in their career, with 7% reporting being sexually harassed in the previous 12 months
- The majority of practice managers reported that practice nurses, practice managers and receptionists had never experienced sexual harassment

Sexual assault

- No GPs reported being sexually assaulted in the previous 12 months, however 2% had been sexually assault at some time in their career
- Practice managers reported that the majority of practice staff never experienced sexual assault

Trends in patient aggression

Perceived times of higher risk

- GPs perceived the times when they were most at risk from patient aggression were when the practice was closing for the day (25%), when staff were at the practice after-hours (19%), and when limited numbers of staff were present at the practice (25%)
- Practice managers perceived the times when they were most at risk from patient aggression were when the practice is closing for the day (23%), in the afternoons (20%), and when limited numbers of staff were present at the practice (34%)

Changes in the incidence of patient aggression

- Sixty-five per cent of GPs disagreed that patient aggression had increased over the last 12 months
- The majority of practice managers perceived no changes in the levels of patient aggression over the last 12 months
- Twenty-seven per cent of GPs felt that patient aggression had negatively affected their emotional wellbeing
- 57% of practice managers felt that patient aggression had caused staff distress

Chapter 8 Discussion and Conclusions

This is the first national study examining patient initiated violence against general practice staff to be conducted in Australia. Although previous studies on patient initiated violence in general practice have been undertaken in Australia these have not gathered national data. There are also significant limitations with their findings due to the differences in definitions used to enquire about types of patient aggression and violence. Furthermore, these studies have focused on GPs and the empirical data about the experience of other general practice staff are limited.¹⁷

Past studies suggest that patient initiated aggression and violence is not unique to general practice staff but affects most health care professionals and other employees working in healthcare services internationally.⁸⁰⁻⁸² The literature also suggests that verbal abuse is the most commonly perpetrated form of aggression directed towards healthcare workers, and younger staff are more likely to experience patient initiated aggression and violence.¹⁶

This current study sought to gather national data so as to provide more robust evidence. The aims of the study were therefore to;

1. develop a national evidence base for the prevalence and incidence of violence against GPs and general practice staff in Australia; and
2. assess the impact of violence on GPs and general practice staffs' ability to provide quality primary care services.

The study used a mixed methods approach and the methodology comprised of, a comprehensive international literature review, consultation with stakeholder organisations, qualitative research with general practice staff across eastern Australia and interviews with GPs from across Australia, and national online and paper based surveys. The study also had a Reference Group comprised of health practitioners, representatives of key general practice organisations, academics and staff from the Department of Health and Ageing.

Stakeholder Consultations

During the first stage of the study representatives of key stakeholder groups were interviewed to assess their experience of patient initiated aggression and their organisation's response to it. Australian primary health care is represented by a range of organisations, some of them related directly to general practice whilst others have a broader constituency. The Department of Health and Ageing and the study team jointly agreed a list of fourteen organisations to be approached for input. Findings from these interviews suggested that in relation to patient initiated aggression and violence, professional organisations were neither proactive in advocating harm minimisation strategies, nor were they responsive in terms of post-incident support. In some instances, it was beyond the current charter of the organisation to provide support, and rural and remote organisations were logistically hindered in the support they were able to provide.

There was some sense that professional organisations were not keeping abreast of changes in society and of member needs in the area of patient initiated aggression in Australian general practice. Respondents acknowledged the need for GP education and training. They also commented that Industry accreditation requirements reportedly overlook this issue. Five of the stakeholder organisations mentioned Division of General Practice activity, particularly in the area of education and training, to deal with aggressive patients, however, several mentioned the same two projects.

Qualitative Study

Following these consultations a series of focus groups and in-depth interviews were conducted to explore general practice staff experiences of patient initiated aggression and violence. This part of the study did not seek precise details of the incidence or prevalence of patient initiated aggression but aimed to understand staff subjective experience and to inform the development of the survey for the quantitative phase of the study.

A significant finding of the qualitative study was that neither GPs nor general practice staff related to the term 'patient initiated violence'. As a result the term 'patient initiated aggression' was used in the survey. Another important finding was that frontline general practice staff, including receptionists and practice managers, were much more likely than GPs to be the target of patient aggression. In fact, verbal aggression was reported as being a daily occurrence while incidents of physical violence were rare. Interestingly when physical aggression had occurred GPs were more likely to have been the targets.

The focus groups and interviews also found that some practice staff, including GPs, had *never* experienced aggressive patient behaviour so believed that precautionary measures to protect staff against such behaviours were unnecessary. Others had experienced patient aggression and/or violence, and believed that all aggression, including verbal aggression, was unacceptable. These practice staff reported a variety of harm minimisation measures that were in various stages of implementation across practices. Staff also reported a range of barriers that hampered optimum measures, but generally, they believed that some action had been taken to maximise their safety in the workplace. Barriers included the enormous cost of renovating old practice buildings, the cost of purchasing alarms or security devices, and 'head-in-the-sand' attitudes of some practice owners. Nevertheless, all participants agreed that frontline staff were the principal recipients of patient aggression. In addition, participants agreed that drug-affected and drug-seeking patients were the most common perpetrators of aggressive incidents.

Triggers to patient initiated aggression included procedural issues such as long waiting times to see a doctor, unavailability of the doctor of choice, and refusal of specific patient-requested medication or treatment. Other triggers of aggression included issues of payment and refusal of bulk-billing. Some times of the day, the physical location of the practice and having young or inexperienced staff were also reported as risk factors for aggressive patient behaviour. There was also a suggestion that cultural difficulties with overseas trained doctors and gender bias encountered by some female GPs could trigger aggressive incidents.

Overall, participants agreed that patient initiated aggression was a problem in general practice, and many staff welcomed education, training, and other measures to maximise their safety, to maintain maximum possible service delivery and to ensure safety for other patients attending their practice. The strategies that were adopted to minimise the risk of harm from aggressive patients included interpersonal strategies where training and selective hiring of staff were seen as effective; procedural strategies focussing on policies to deal with aggressive patients; and structural strategies where modifications were made to the practice building, for example locks, alarms and constructing barriers.

National surveys

Online Survey Results

The data from the qualitative phase of the study informed the development of both the GP survey and the survey for practice managers to complete on behalf of other general practice staff. The survey was delivered online across Australia utilising the Divisions of General Practice network communication tools. Supporting this was a media publicity campaign and some paid advertisements. The response to the online survey was very poor and a second phase of quantitative data collection was undertaken

using paper based surveys. Nineteen Divisions of General Practice across Australia were targeted for the paper based survey, representing all RRMA classifications.

GP Online Survey

The online survey results for GPs (n=178) found that 95% of GPs had ever experienced some form of verbal aggression from patients and 70% had experienced such aggression in the past year. Male GPs and those working full time were more likely to have experienced this form of aggression with 78% of male GPs experiencing verbal aggression over the past 12 months compared with 63% of female GPs. Younger GPs were more likely to have experienced verbal aggression with 80% (<50 years) reporting such aggression compared with 64% of older GPs (>50 years). Again, full time GPs experienced more verbal aggression over the past year, 77% compared with 62% of part time GPs. Almost all GPs (95%) reported being verbally abused at some time in their career.

Physical aggression was not as common with only 8% of GPs reporting physical assault over the past year, 8% reported sexual harassment, 6% reported stalking. However, 29% reported damage to property. There were no reports of sexual assault over the past 12 months. Forty two per cent of GPs reported that they had *never* experienced damage or theft of property and 27% had experienced this at some time in their career but not in the last 12 months. Again over three quarters of GPs had *never* been stalked by patients, nearly 70% had *never* experienced physical assault by a patient, three quarters had *never* been sexually harassed and 94% had *never* experienced sexual assault. Full time GPs and male GPs were more likely to have experienced physical assault at some time in their career.

GPs identified that they felt at increased risk of aggression at some times of the day. In particular 40% reported an increased risk when the practice was closing and 31% when staff were at the practice after hours. Metropolitan GPs were more likely to identify closing time as a risky period (55%) compared with non metropolitan GPs (29%). GPs also identified other periods of high risk with 30% identifying that having limited staff at the practice posed a risk, 25% said that when staff were leaving the practice for the day was risky and 19% said that home visits posed a risk.

The majority of GPs did not identify an increase in patient aggression over time but 25% did think that patient aggression had become worse in their practice over the past 12 months. Male GPs were more likely to think that aggression had become worse over the past 12 months (31% compared with 17% of female GPs). Similarly full time GPs were more likely to think that aggression had become worse in the last 12 months (30% compared with 16% of part time GPs).

Some GPs reported that patient aggression had affected their wellbeing and professional capacity. The most impact was on emotional wellbeing (38%) with a lesser impact on their capacity to provide services (23%) or their physical wellbeing. GPs were likely to agree that their practice took the emotional wellbeing of staff seriously (80%) and half of GPs agreed that the physical layout of the practice helped minimise the risk of harm. However, the views of GPs on practice procedures to address patient aggression were mixed with 48% agreeing that their practice had adequate procedures and 42% disagreeing with this. Similarly, 48% of GPs thought their practice had adequate security to minimise harm from aggressive patients and 44% thought security was inadequate. Older GPs were more likely to agree that their practice had adequate procedures than younger GPs (57% and 38% respectively).

Practice Manager Online Survey

Practice managers (n=247) were asked to report on the incidence and prevalence of patient incidence aggression on behalf of non GP staff (allied health professionals, practice nurses, receptionists and practice managers). The results showed that receptionists were the most likely staff to experience verbal abuse. Thus, practice managers reported that 39% of receptionists experienced verbal abuse weekly or more often, 14% of practice managers experienced this abuse, 7% of practice nurses and 3% of allied health professionals. When asked about occurrences of verbal abuse over the past six to

twelve months, practice managers reported that 37% of practice nurses, 36% of practice managers, 23% of receptionists and 17% of allied health professionals had been verbally abused by a patient.

Practice size and location seem to influence the incidence of verbal aggression with receptionists from larger practices being more likely to experience verbal aggression over the past 12 months than their counterparts from smaller practices (93% and 82% respectively). Similarly practice managers from metropolitan practices were more likely than those from non-metropolitan practices to have experienced verbal aggression in the last 12 months (78% and 66% respectively).

Practices managers reported that 10% of practices had experienced property damage or theft over the past 12 months and 20% reported ever having experienced property damage or theft. Reported rates of property damage or theft across all GP staff groups was low with 22% of practice nurses, 18% allied health professionals, 21% practice managers and 23% receptionists having experienced property damage or theft at some point but not in the last 12 months. Interestingly, the experience of allied health professionals was little known by practice managers with over a quarter of practice managers reporting that they did not know how often this group experienced property damage or theft.

About one tenth of staff had ever experienced stalking and one in twenty had experienced it in the past 12 months. No clear pattern emerged about which practice staff were more likely to experience stalking. Over 80% of practice nurses, 80% of practice managers, 79% of receptionists and 69% of allied health professionals had *never* experienced physical assault by a patient, patients' relatives or friends. However, receptionists at larger practices seemed to be at higher risk of experiencing physical assault at some time compared with receptionists from smaller practices.

The experience of sexual harassment was also low with practice managers reporting that 20% of receptionists, 16% of practice nurses, 10% of practice managers and 3% of allied health professionals had experienced sexual harassment over the past 12 months. Again, practice managers seemed relatively unaware of the experiences of sexual harassment of allied health professionals with 33% reporting that they did not know what those experiences were. Over 90% of practice nurses, practice managers and receptionists had *never* experienced sexual assault and 78% of allied health professionals were reported as not having this experience.

Male patients were perceived as being more likely than female patients to be aggressive for all categories of aggression. Also, patients rather than their relatives or friends were seen most likely to be aggressive towards practice staff. Practice managers identified certain times of the day as being times of particular risk for patient initiated aggression. These were mornings after opening times (28%), when the practice was closing (27%), when the practice first opened (21%), afternoons (21%). However, over 40% of practice managers reported that there were no particular times when the risk of patient aggression was greater. With the exception of verbal aggression, practice managers did not perceive a change in levels of patient aggression over the past 12 months. Forty per cent of practice managers thought that the incidence of verbal aggression had increased.

The most common impact of patient aggression was staff distress. Thus, for example, 63% of practice managers said that patient aggression had caused staff distress and 58% said that patient aggression had resulted in a change to practice procedures. The key driver of the impact of patient aggression seemed to be practice size with staff at larger practices experiencing more distress than those at smaller practices (71% and 54% respectively). Larger practices were more likely to have changed their policies as a result of verbal aggression compared with smaller practices (64% and 51% respectively). The most commonly reported impact of aggression was the need to change practice procedures. Little impact of physical aggression was noted compared with verbal aggression.

Summary of Online Survey Results

Almost all GPs and practice staff had experienced verbal aggression at some stage in their career. Seventy two per cent of GPs had experienced verbal aggression in the past year but frontline practice

staff experienced verbal aggression from patients far more frequently than GPs. GPs were more likely to experience physical aggression with damage to, or theft of property, being the most frequently occurring expression of physical aggression. Practice managers reported that property damage or theft occurred infrequently. Between 40 and 50% of practice staff had ever experienced physical assault. Practice managers reported that between 10 and 40% of staff had ever experienced sexual harassment and 10% had ever experienced sexual assault.

GPs identified a number of times of the day when they thought they were at increased risk of aggression. These were when the practice was closing for the day (40%) and when staff were at the practice after hours (31%). The riskiest periods identified by practice managers were those when the practice had limited staff on duty (36%) and the times immediately after opening and closing (28% and 27% respectively).

GPs most commonly reported that aggression had negatively affected their emotional wellbeing (38%), but were less likely to report that the aggression had affected their capacity to provide services (23%), or their physical wellbeing (14%). Practice managers most commonly reported that the aggression had caused staff distress (63%) and/or the need for the practice to change policies and procedures (58%).

Most GPs did not believe that patient aggression had increased in recent years and only 25% felt that patient aggression had become worse at their practice in the last 12 months. With the exception of verbal aggression (40% reported an increase) few practice managers perceived a change in levels of patient aggression.

Overall, male GPs working full time were more likely to experience aggression than part time GPs and males were more likely to experience physical aggression than females. Staff at larger practices were at greater risk of both aggression and the negative impact of that aggression than staff at smaller practices.

Paper Based Survey Results

A total of 3090 paper surveys were sent to GPs in 19 divisions across Australia. Twenty one were undeliverable, 6 were returned blank and a total of 782 surveys were returned (response rate of 25.5%). A total of 1109 paper surveys were sent to practice managers in the same Divisions. Twenty eight surveys were undeliverable and two surveys were returned blank. Two hundred and fourteen surveys were returned completed (response rate of 19.8%).

GP Paper Based Surveys

Almost all GPs (88%) had experienced verbal aggression from patients and 58% had experienced such aggression in the past year. Male GPs, younger GPs, full time GPs and non metropolitan GPs experienced more frequent verbal aggression in the past 12 months than their counterparts.

The incidence of physical aggression reported by GPs was highest for damage to, or theft of, property. Thirty seven percent had ever experienced this form of aggression with 16% experiencing it in the past year. Sixteen per cent had ever experienced physical assault with 6% experiencing it in the past year and 19% had ever been sexually harassed with 7% experiencing this in the past year. Only 2% reported ever being sexually assaulted, 11 % ever being stalked.

Property damage or theft had *never* been experienced by 60% of GPs. Whereas 16% of GPs reported that this had occurred at least once or more frequently in the past 12 months. Male GPs, those working full time and metropolitan GPs experienced more frequent property theft or damage compared with their counterparts.

Most GPs had *never* been stalked (83%) by a patient, 8% had ever been stalked and 2% had been stalked in the past 12 months. There was little difference between age, gender, part-time or full time

workers and practice location with regard to the percentage of GPs who had been stalked in the previous 12 months but a greater percentage of female GPs had ever been stalked.

Over 80% of GPs had *never* experienced physical assault by a patient, 10% had experienced physical assault during their career but not in the past 12 months and 4% had experienced physical assault in the past year. A greater percentage of male GPs and older GPs (>50 years) experienced physical assault ever compared with their counterparts.

Over three quarters of GPs had *never* experienced sexual harassment, 12% had ever experienced sexual harassment but not in the past 12 months. Seven per cent had experienced sexual harassment in the past 12 months. More female GPs and younger GPs reported experiencing sexual harassment compared with their counterparts in the previous 12 months and ever. Sexual assault was the least common form of aggression reported by GPs with almost all (94%) reporting that they had *never* experienced sexual assault perpetrated by a patient.

The most commonly reported time when GPs felt at greatest risk of patient aggression was when the practice was closing for the day (25%) and after hours (19%). Almost 60% of GPs indicated that there were no times of particular risk for practice staff. Metropolitan GPs (30%) were more likely to identify closing time as a risky period compared with non metropolitan GPs (20%). Similar to the risks identified at closing time, metropolitan GPs (30%) were more likely to identify the period after closing as staff walked to their cars as risky compared with regional and rural based GPs (20%).

Sixty five per cent of GPs did not think that patient aggression had become worse over the past 12 months and 11% of GPs felt that it had. Male GPs were more likely to agree that patient aggression had become worse in the past 12 months.

Some GPs felt that patient aggression had affected their wellbeing and professional capacity. In particular, GPs were most likely to agree that their emotional wellbeing had been affected (27%). Fewer GPs (11%) were likely to agree that aggression had affected their capacity to provide services or impacted on their physical wellbeing (7%). Male GPs were more likely to report negative impacts of patient aggression than female GPs and those working full time identified negative impacts more than those working part time.

In terms of practice environment, 67% of GPs felt that their practice took the safety of staff seriously although 8% disagreed with this statement. Also 44% agreed that the physical layout of the practice helped minimise the risk of harm from aggression, but 29% disagreed with this statement. In addition, 41% of GPs said the practice had adequate procedures in place to address patient aggression, whereas 35% disagreed. Forty three per cent of GPs thought that the practice had adequate security to minimise harm from patient aggression but 34% felt that this was not the case.

Almost 60% of GPs disagreed that their practice could not afford to provide adequate security and that staff do not have time to implement measures to minimise risk of harm from patients (60%).

Practice Manager Paper Based Survey

The results from this survey confirmed that verbal abuse is the most frequent form of patient initiated aggression and that receptionists experience more of this form of abuse than other staff working in general practice. Twenty one per cent of receptionists experience verbal abuse weekly or more often compared with 9% of practice managers, 4% of practice nurses and 1% of allied health professionals. A minority of practice managers (22%), practice nurses (19%), allied health professionals (17%) and receptionists (13%) had *never* experienced verbal abuse. Again, practice managers were relatively unaware of the experiences of allied health professionals (72% do not know). These findings are repeated across all forms of aggression suggesting that the findings for allied health professionals should be interpreted with caution.

Practice staff working in practices with more than one GP reported higher percentages of verbal abuse than those working in solo GP practices. Receptionists, practice managers and practice nurses working in non metropolitan areas experienced more verbal abuse than their counterparts in metropolitan areas.

Few staff experienced property damage or theft with practice managers reporting that 71% of receptionists, 66% of practice managers and 57% of practice nurses had *never* experienced property theft or damage. Over half of practice managers said they did not know how often allied health professionals had experienced property theft or damage.

Very few practice staff experienced stalking with no clear pattern emerging regarding whether some staff experienced stalking more than others. Again over half practice managers did not know what the experiences of allied health staff were regarding stalking.

The majority of practice staff had *never* experienced physical assault, none experienced it weekly or more often and 5% or fewer staff had ever experienced physical assault.

There were very few reports of sexual harassment with 80% of receptionists, 70% practice managers, 56% of practice nurses and 47% of allied health professionals *never* having experienced this form of abuse from patients. Similarly very few staff had experienced sexual assault and none had experienced this in the past six to twelve months.

For all forms of aggression, males were perceived as more likely to be aggressive than females. Specifically males were thought to be responsible for 99% of sexual harassment, 85% of stalking, 65% of physical assault and property damage or theft and 63% of verbal abuse. Patients were more likely to be the aggressors than someone who accompanied them for all aggressive acts.

Practice managers identified the times immediately after the practice opened and when the practice was closing as periods of particular risk of patient aggression. However half of the practice managers reported that there were no particular times of elevated risk. The five most common times of perceived risk were further divided to examine practice location and the size of the practice. Practice managers from metropolitan practices reported higher risk when the practice was closing compared to those from non metropolitan practices (29% and 17% respectively). Other than lunch time, practices with more than one GP were more likely to have times of perceived risk across all times identified in the survey. Also, staff in practices with more than one GP were at more risk of patient aggression when there were limited staff on duty.

When asked about the changing incidence of patient initiated aggression over the past 12 months, 24% of practice managers reported an increase in verbal aggression, 57% saw no change and 9% reported a decrease. Half of practice managers reported no change in the incidence of property damage or theft, only 6% thought this had increased and 6% thought it had decreased. Just under half of the practice managers felt that there had been no change in the incidence of sexual harassment, sexual assault, stalking and physical assault and just under half did not know if sexual harassment, sexual assault, stalking or physical assault had increased or decreased. Almost four in ten practice managers did not know if the incidence of property damage or theft had increased or decreased. More practice managers working in metropolitan practices and practices with more than one GP perceived verbal aggression to have increased compared to their respective counterparts.

The most common negative impact of verbal aggression was staff distress with 57% reporting that verbal aggression caused distress, 37% reported that it had resulted in a change of practice procedures. Very few reported that there had been a reduced service as a result of verbal aggression (4%), 11% reported that staff needed counselling, 8% reported that staff needed to have time off work and 5% thought verbal aggression impacted on rates of staff turnover. Again, the most common impact of physical aggression was staff distress (14%) and a change in practice procedures (10%).

Summary of Paper Based Survey Results

Data from 782 GP respondents found verbal aggression to be the most common form of patient initiated aggression experienced by GPs over the past year (58%) and ever (88%). Additionally, 214 practice staff respondents indicated that receptionists experienced more verbal aggression than practice managers and practice nurse over the past year (75%, 48%, and 36% respectively). Property damage or theft had been experienced by 16% of GPs over the past 12 months and 37% during their career. The majority of receptionists, practice managers and practice nurses had *never* experienced property theft or damage (71%, 66% and 57% respectively). Few GPs experienced stalking and the majority of other practice staff had *never* been stalked. Few GPs had experienced physical assault during the past 12 months or ever (6% and 16% respectively) and the majority of practice staff had *never* experienced physical assault. One fifth of GPs had been sexually harassed at some time in their career and 7% had been sexually harassed during the past 12 months. The majority of practice staff had *never* been sexually harassed. No GPs reported that they were sexually assaulted during the past 12 months and only 2% reported that they had been sexually assaulted at some time during their career. The majority of practice staff had *never* been sexually assaulted by a patient.

Two thirds of GPs disagreed that patient aggression had increased over the past 12 months and the majority of practice staff perceived no change in the levels of patient aggression over the past 12 months. Similar numbers of GPs and practice managers (25% and 23% respectively) felt that a time of high risk of patient aggression was when the practice was closing for the day and when limited staff were on duty (25% and 34% respectively). Over one quarter of GPs reported that patient aggression had affected their emotional wellbeing and 57% of practice managers felt that patient aggression had caused staff distress.

Comparison of online and paper based survey results

The online and paper based survey results were compared for GPs and for other practice staff. Table 28 demonstrates that GPs who responded to the survey online had experienced greater frequencies of all types of aggression over 12 months and ever compared with GPs who completed the paper based survey. Table 29 indicates that practice managers who reported patient aggression on behalf of general practice staff in the online survey reported double the frequency of property damage or theft and sexual harassment experienced by practice managers, practice nurses and receptionists compared to those who completed the paper based survey. The most similar findings between the online survey and the paper based survey were the practice managers' reports of the frequency that receptionists experience verbal abuse ever, which was 82%.

Table 28: Comparison of online and paper based survey results for GPs

	Online GP responses		Paper based GP responses	
	12 months	Ever	12 months	Ever
Verbal aggression				
Verbal abuse	72	95	58	88
Physical aggression				
Stalking	6	17	3	11
Property damage or theft	29	56	16	37
Physical abuse	8	31	6	16
Sexual aggression				
Sexual harassment	8	26	7	19
Sexual assault	0	6	0	2

Table 29: Comparison of online and paper based survey results for general practice staff over 12 months or ever

	Practice managers (%)				Receptionists (%)				Practice nurses (%)				Allied health professionals (%)				
	Online		Paper based		Online		Paper based		Online		Paper based		Online		Paper based		
	12	Ever	12	Ever	12	Ever	12	Ever	12	Ever	12	Ever	12	Ever	12	Ever	
Verbal aggression																	
Verbal abuse	70	81	48	56	87	82	75	82	62	78	36	44	27	38	7	11	
Physical aggression																	
Property damage or theft	13	34	9	16	17	40	9	20	9	31	5	12	6	24	2	5	
Stalking	4	13	4	7	6	18	5	11	1	9	2	4	4	13	2	3	
Physical assault	2	16	3	6	4	18	1	6	2	14	2	5	3	12	0	1	
Sexual aggression																	
Sexual harassment	13	26	4	8	28	41	9	14	21	35	7	12	4	15	1	3	
Sexual assault	0	6	0	1	0	6	0	1	0	5	0	1	1	8	0	1	

Conclusions

This first national survey of patient initiated aggression in Australian general practice has clearly identified that verbal aggression is the most commonly occurring form of aggressive patient behaviour and that front line general practice staff, such as receptionists, are by far the most likely to experience this form of aggression. General practice organisations, in the main, do very little to address this issue. The qualitative study found that GPs and general practice staff did not respond to the term 'patient initiated violence' but to the term 'patient initiated aggression'. Again, the qualitative study found that frontline staff were the principle recipients of patient aggression. Here, triggers to patient aggression were said to be long waiting times, the unavailability of the doctor of choice, refusal to prescribe patient-requested medication or treatment and issues related to payment and refusal of bulk billing. Barriers to minimise the risk of harm to staff included the cost of renovating older buildings, the cost of purchasing alarm systems or security devices and the unwillingness of practice owners to acknowledge patient aggression as an issue. Staff welcomed education, training and other measures to maximise their safety, maintain optimal service delivery and ensure the safety of other patients attending the practice.

The online and paper based surveys confirmed that front line staff were at greatest risk of patient initiated aggression and that verbal aggression was very common with receptionists experiencing high levels of such aggression. Verbal aggression was also the most common form of aggression experienced by GPs. These findings are consistent with other regional quantitative studies undertaken in Australia which have investigated patient initiated violence perpetrated towards GPs. These studies found that the most common form of violence experienced by GPs was verbal aggression.^{2, 15, 16, 18} The only study to include other practice staff involved qualitative interviews with receptionists working in general practice and similarly reported that receptionists also predominantly experience verbal aggression.¹⁷ Therefore, the findings from the national surveys are consistent with those of pre-existing Australian studies.

References

1. World Health Assembly. Prevention of violence: a public health priority. Geneva 1996.
2. Tolhurst H, Baker L, Murray G, Bell P, Sutton A, Dean S. Rural general practitioner experience of work-related violence in Australia. *Australian Journal of Rural Health* 2003; 11(5):231-6.
3. Rowe L, Morris-Donovan B, Watts I. General practice - a safe place: tips and tools. South Melbourne: The Royal Australian College of General Practitioners, 2009.
4. Primary Health Care Research and Information Service (PHCRIS). Key Division of General Practice characteristics 2007-2008.
5. Department of Health and Ageing. General Practitioner Demographics. Canberra: Commonwealth of Australia; 2008 [cited 2009 20th July]; Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-statistics-gpdemo.htm>.
6. Australian General Practice Network. National Practice Nurse Workforce Survey Report. Canberra, Australia, 2007.
7. Framework guidelines for addressing workplace violence in the health sector. Geneva: International Labour Office, International Council of Nurses, World Health Organisation, Public Services International, 2002.
8. International Council of Nurses. Violence: A World-wide epidemic. [cited 2009 30th June]; Available from: http://www.icn.ch/matters_violence.htm.
9. Mayhew C, Chappell D. Workplace Violence in the Health Sector - A Case Study in Australia. *Journal of Occupational Health & Safety* 2003; 19(6).
10. Australian Nursing Federation Policy. Zero tolerance of violence and aggression in the workplace. Melbourne: Australian Nursing Federation, 2008.
11. International Council of Nurses. Guidelines on coping with violence in the workplace. Geneva: International Council of Nurses, 2007.
12. National Health and Medical Research Council. When it's right in front of you. Assisting health care workers to manage the effects of violence in rural and remote Australia. Canberra: Commonwealth of Australia, 2002.
13. New South Wales Department of Health. Zero tolerance for violence in health system. Sydney: NSW Government; 2004 [cited 2009 4th March]; Available from: http://www.health.nsw.gov.au/news/2004/20040304_00.html.
14. McKinnon K. Attacks on GPs a symptom of society's ills. *The West Australian*. 2009 17/06/2009.
15. Alexander C, Fraser J. Occupational violence in an Australian healthcare setting: implications for managers. *Journal of Healthcare Management* 2004; 49(6):377-90.
16. Koritsas S, Coles J, Boyle M, Stanley J. Prevalence and predictors of occupational violence and aggression towards GPs: a cross-sectional study. *British Journal of General Practice* 2007; 57(545):967-70.

-
17. Magin P, Joyce T, Adams J, Goode S, Cotter G. Receptionists' experiences of occupational violence in general practice: a qualitative study. *British Journal of General Practice* 2009; 59(565):578-83.
 18. Magin PJ, Adams J, Sibbritt DW, Joy E, Ireland MC. Experiences of occupational violence in Australian urban general practice: A cross-sectional study of GPs. *Medical Journal of Australia* 2005; 183(7):352-6.
 19. Magin PJ, Adams J, Ireland M, Heaney S, Darab S. After hours care: a qualitative study of GPs' perceptions of risk of violence and effect on service provision. *Australian Family Physician* 2005; 34(1/2):91-2.
 20. Tolhurst H, Talbot J, Baker L, Bell P, Murray G, Sutton A, et al. Rural general practitioner apprehension about work related violence in Australia. *Australian Journal of Rural Health* 2003; 11(5):237-41.
 21. Gale C, Arroll B, Coverdale J. Aggressive acts by patients against general practitioners in New Zealand: One-year prevalence. *New Zealand Medical Journal* 2006; 119(1237):1-7.
 22. Magin P, Adams J, Joy E, Ireland M, Heaney S, Darab S. Violence in general practice: perceptions of cause and implications for safety. *Canadian Family Physician* 2008; 54(9):1278-84.
 23. Magin P, Adams J, Joy E, Ireland M, Heaney S, Darab S. General practitioners' assessment of risk of violence in their practice: Results from a qualitative study. *Journal of Evaluation in Clinical Practice* 2008; 14(3):385-90.
 24. Magin PJ, Adams J, Sibbritt DW, Joy E, Ireland MC. Effects of occupational violence on Australian general practitioners' provision of home visits and after-hours care: A cross-sectional study. *Journal of Evaluation in Clinical Practice* 2008; 14(2):336-42.
 25. Magin P, Adams J, Ireland M, Joy E, Heaney S, Darab S. The response of general practitioners to the threat of violence in their practices: results from a qualitative study. *Family Practice* 2006; 23(3):273-8.
 26. Bayman PA, Hussain T. Receptionists' perceptions of violence in general practice. *Occupational Medicine* 2007; 57(7):492-8.
 27. Chambers F, Kelly M. Violence at work: The experience of general practice receptionists. *Irish Medical Journal* 2006; 99(6):169-71.
 28. Dixon CAJ, Tompkins CNE, Allgar VL, Wright NMJ. Abusive behaviour experienced by primary care receptionists: A cross-sectional survey. *Family Practice* 2004; 21(2):137-9.
 29. Elston MA, Gabe J, Denney D, Lee R, O'Beirne M. Violence against doctors: A medical(ised) problem? The case of National Health Service general practitioners. *Sociology of Health and Illness* 2002; 24(5):575-98.
 30. Health Policy and Economic Research Unit. Violence at work: the experience of UK doctors. London: British Medical Association, 2003.
 31. Hobbs FD. Violence in general practice: a survey of general practitioners' views. *British Medical Journal* 1991; 302(6772):329-32.
 32. Myerson S. Violence to General Practitioners and fear of violence. *Family Practice* 1991; 8(2):145-7.

-
33. Ness GJ, House A, Ness AR. Aggression and violent behaviour in general practice: population based survey in the north of England. *British Medical Journal* 2000; 320(7247):1447-8.
 34. Health Policy and Economic Research Unit. Violence at work: the experience of GPs in Northern Ireland. London: British Medical Association, 2003.
 35. D'Urso P, Hobbs R. Aggression and the general practitioner. *British Medical Journal* 1989; 298(6666):97-8.
 36. Gabe J, Ann Elston M. 'We don't have to take this': Zero tolerance of violence against health care workers in a time of insecurity. *Social Policy and Administration* 2008; 42(6):691-709.
 37. Ashworth M, Armstrong D. Sources and implications of dissatisfaction among new GPs in the inner-city. *Family Practice* 1999; 16(1):18-22.
 38. Hobbs FD. Fear of aggression at work among general practitioners who have suffered a previous episode of aggression. *British Journal of General Practice* 1994; 44(386):390-4.
 39. Phillips S, Schneider MS. Sexual Harassment of Female Doctors by Patients. *New England Journal of Medicine* 1993; 329(26):1936-9.
 40. Meidema B, Easley J, Fortin P, Hamilton R, Tatemichi S. Disrespect, harassment, and abuse: All in a day's work for family physicians. *Canadian Family Physician* 2009; 55(3):279-85.
 41. Sampson JM, Achololnu Jr WW. Reducing patient aggression and hostility in primary care with urine drug testing [4]. *Southern Medical Journal* 2004; 97(9):916-7.
 42. Aydin B, Kartal M, Midik O, Buyukakkus A. Violence Against General Practitioners in Turkey. *Journal of Interpersonal Violence* 2009; 24(12):1980-95.
 43. Ayranci U, Yenilmez C, Balci Y, Kaptanoglu C. Identification of violence in Turkish health care settings. *Journal of Interpersonal Violence* 2006; 21(2):276-96.
 44. Carmi-Iluz T. Verbal and physical violence towards hospital- and community-based physicians in the Negev: an observational study. *BMC Health Services Research* 2005; 5:54.
 45. Gascón S, Martínez-Jarreta B, González-Andrade JF, Santed MA, Casalod Y, Rueda MA. Aggression towards health care workers in Spain: a multi-facility study to evaluate the distribution of growing violence among professionals, health facilities and departments. *International Journal of Occupational and Environmental Health* 2009; 15(1):29-35.
 46. Arnetz JE, Arnetz BB. Violence towards health care staff and possible effects on the quality of patient care. *Social Science & Medicine* 2001; 52(3):417-27.
 47. Findorff MJ, McGovern PM, Wall M, Gerberich SG, Alexander B. Risk factors for work related violence in a health care organization. *Injury Prevention* 2004; 10(5):296-302.
 48. Gerberich SG, Church TR, McGovern PM, Hansen HE, Nachreiner NM, Geisser MS, et al. An epidemiological study of the magnitude and consequences of work related violence: the Minnesota Nurses' Study. *Occupational & Environmental Medicine* 2004; 61(6):495-503.
 49. Hegney D, Eley R, Plank A, Buikstra E, Parker V. Workplace violence in Queensland, Australia: The results of a comparative study. *International Journal of Nursing Practice* 2006; 12(4):220-31.
 50. Jackson M, Ashley D. Physical and psychological violence in Jamaica's health sector. *Revista Panamericana de Salud Publica/Pan American Journal of Public Health* 2005; 18(2):114-21.

-
51. Mackin JG. Violence against trainee paediatricians. *Archives of Disease in Childhood* 2001; 84(2):106-8.
 52. Vanderslott J. A study of violence towards staff by patients in an NHS Trust Hospital. *Journal of Psychiatric and Mental Health Nursing* 1998; 5(4):291-8.
 53. Atawneh FA, Zahid MA, Al-Sahlawi KS, Shahid AA, Al-Farrah MH. Violence against nurses in hospitals: prevalence and effects. *British Journal of Nursing* 2003; 12(2):102-7.
 54. Jenkins MG, Rocke LG, McNicholl BP, Hughes DM. Violence and verbal abuse against staff in accident and emergency departments: a survey of consultants in the UK and the Republic of Ireland. *Journal of Accident & Emergency Medicine* 1998; 15(4):262-5.
 55. Wyatt JP, Watt M. Violence towards junior doctors in accident and emergency departments. *Journal of Accident & Emergency Medicine* 1995; 12(1):40-2.
 56. James A, Madeley R, Dove A. Violence and aggression in the emergency department. *Emergency Medicine Journal* 2006; 23(6):431-4.
 57. Hislop E, Melby V. The lived experience of violence in accident and emergency. *Accident and Emergency Nursing* 2003; 11(1):5-11.
 58. Boyle M, Koritsas S, Coles J, Stanley J. A Pilot Study of Workplace Violence towards Paramedics. *Emergency Medicine Journal* 2007; 24(11):760-3.
 59. Mechem CC, Dickinson ET, Shofer FS, Jaslow D. Injuries from assaults on paramedics and firefighters in an urban emergency medical services system. *Prehospital Emergency Care* 2002; 6(4):396-401.
 60. Pozzi C. Exposure of prehospital providers to violence and abuse. *Journal of Emergency Nursing* 1998; 24(4):320-3.
 61. Sprigg CA, Armitage CJ, Hollis K. Verbal abuse in the National Health Service: impressions of the prevalence, perceived reasons for and relationships with staff psychological well-being. *Emergency Medicine Journal* 2007; 24(4):281-2.
 62. Suserud BO, Blomquist M, Johansson I. Experiences of threats and violence in the Swedish ambulance service. *Accident and Emergency Nursing* 2002; 10(3):127-35.
 63. Mahoney B. The extent, nature, and response to victimization of emergency nurses in Pennsylvania. *Journal of Emergency Nursing* 1991; 17:282-94.
 64. Black D, Guthrie E. Doctors' safety: who cares? *British Medical Journal* 1990; 300(6737):1471.
 65. Langmead J. Safety of doctors at work: Lessons learnt from personal experience. *British Journal of General Practice* 2008; 58(551):439.
 66. Gough P, Goss RM, Jordan S. Violence in the workplace The nurse's experience Commentary: Could guidelines reduce number of incidents? Commentary: Carers deserve care too Commentary: Roles and identities. 2001; 323(7325):1362-4.
 67. Manca DP. Woman physician stalked: Personal reflection and suggested approach. *Canadian Family Physician* 2005; 51(DEC.):1640-5.
 68. Arthur T, Bain EI. Workplace violence and chemical exposure: a 73-year-old CVA patient assaults nurses with a fire extinguisher. *Journal of Emergency Nursing* 2002; 28(6):484-8.

-
69. McIntosh E. GP Stabbing sparks new safety fears. *Medical Observer*. 2009 10th April;Sect. 1 (col. GP).
 70. East M. GP attack sparks call for action. *Australian Doctor* 2009; 22 June.
 71. Loosemore S. Stephen Loosemore's letter. *Australian Doctor* 2009; 22 June.
 72. Ferguson H. The danger out there. *Australian Doctor* 2005; 13 January.
 73. Arsonists attack Mosman Park Medical Centre. Perth: ABC News; 2009 [cited 2009 9th July]; Available from: <http://www.abc.net.au/news/stories/2009/01/07/2460486.htm>.
 74. Richards J. Management of Workplace Violence Victims. Geneva: International Labour Office, International Council of Nurses, World Health Organization, Public Services International, 2003.
 75. International Council of Nurses. Abuse and violence against nursing personnel. Geneva: International Council of Nurses; 2006 [cited 2009 30th June]; Available from: <http://www.icn.ch/psviolence00.htm>.
 76. Laver S. Client initiated aggression prevention and management - a rural-metro partnership project. GP&PHC Research Conference; May: Primary Health Care Research Institute Services; 2007.
 77. WorkSafe Victoria. A handbook for workplaces: Prevention and management of aggression in health services. first ed. Melbourne: Victorian WorkCover Authority; 2008.
 78. Dandenong Casey General Practice Association. Safety and security kit for general practice. Melbourne, Australia, 2008 September.
 79. Wright NM, Dixon CA, Tompkins CN. Managing violence in primary care: an evidence-based approach. *British Journal of General Practice* 2003; 53(492):557-62.
 80. Di Martino V. Workplace Violence in the Health Sector: Country case studies: Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand, and an Additional Australian Study: International Labor Organization, International Council of Nurses, World Health Organization, Public Services International, 2002.
 81. Mayhew C, Chappell D. The occupational violence experiences of 400 Australian health workers: An exploratory study. *Journal of Occupational Health & Safety* 2003; 19(6):3-43.
 82. Rippon TJ. Aggression and violence in health care professions. *Journal of Advanced Nursing* 2000; 31(2):452-60.

List of appendices

Appendix A	List of Divisions of General practice targeted for paper-based survey
Appendix B	Distribution of focus groups and interview sessions across Australia
Appendix C	Consultation guide
Appendix D	Survey Instrument – General practitioner
Appendix E	Survey Instrument – Practice staff
Appendix F	Summary of marketing strategy
Appendix G	List of stakeholder organisations
Appendix H	Stakeholder consultation – thematic framework for interview
Appendix I	Locations for qualitative research with general practice staff

Appendix A: List of Divisions of General practice targeted for paper-based survey

State	RRMA	Div ID	Division Name
ACT	1	901	ACT Division of General Practice
NSW	1	201	Central Sydney General Practice Network
NSW	3	230	Dubbo Plains Division of General Practice
NSW	3 to 7	228	Riverina Division of General Practice and Primary Health
NT		801	General Practice Network NT
QLD	1	401	South East Alliance of GP (Brisbane) GPLinks Wide Bay Division of General Practice
QLD	4 to 7	420	Association Inc
QLD	6 & 7	416	North & West Qld Primary Health Care
SA	1	501	Adelaide Western General Practice Network
SA	5	508	Mid North Division of Rural Medicine
SA	4 to 7	511	Eyre Peninsula Division of General Practice
TAS	1	701	General Practice South
TAS		702	General Practice North
VIC	1	301	Melbourne General Practice Network
VIC	5	330	West Victoria Division of General Practice
VIC		328	East Gippsland Division of General Practice
WA	1	601	Perth Primary Care Network
WA		612	Mid West Division of General Practice
WA	6	614	Pilbara Division of General Practice

Appendix B: Distribution of focus groups and interview sessions across Australia

Division	State	Region	Intervention
Liverpool Sydney South West Division 210	NSW	Metro	1, 3, 4
Riverina and Primary Health Division 228	NSW	Regional/ Rural	1, 2, 3 (x2)
Central Australia, Alice Springs	NT	Regional/ Rural	2 (x2), 3, 4 (x2)
Top End, Darwin	NT	Regional/ Rural	1, 3, 4
Townsville Division 412	QLD	Regional	1, 3 (x2)
Ipswich and West Moreton Division 408	QLD	Metro/ Regional	1, 2, 3, 4
South City Melbourne Division 304	VIC	Metro	1, 2, 3, 4
Ballarat and District Division 325	VIC	Regional/ Rural	1, 3, 4
Perth Division 601	WA	Metro	4
Adelaide, Divisions 501-504, not specified	SA	Metro	4
Hobart Division 701	Tas	Metro	4

Type of intervention:

- 1 = traditional focus group (n=7)
- 2 = mini-focus group (n=5)
- 3 = in-depth interview, in person (n=10)
- 4 = in-depth interview, per telephone (n=10)

Appendix C: Consultation guide

TOPIC	POINTS TO COVER	DURATION
<p>INTRODUCTION</p> <p>Nature of the discussions. Confidentiality, privacy, recording, non-identifiable.</p>	<ul style="list-style-type: none"> • Campbell Research and APHCRI commissioned by Department of Health and Ageing to conduct research into the prevalence and incidence of violence against staff working in Australian General Practices • APHCRI is a research Institute at the Australian National University • Campbell Research is a private company based in Melbourne specialising in social research for government and business. • Project background: <ul style="list-style-type: none"> ○ The project involves focus groups and discussions with general practice staff across Australia. ○ We will also be doing an online survey of general practice staff later this year. ○ The survey will ask about the incidence and prevalence of violence against general practice staff • Definition of violence: <ul style="list-style-type: none"> ○ For the purposes of this project, the term violence refers to acts such as verbal abuse, property damage or theft, stalking, physical abuse, sexual harassment or sexual abuse by a patient, patients' family members or friends towards any staff member working in your practice. • The format of today's / this evening's / this morning's group discussion is open and conversational. There are no right or wrong answers. However, we do ask that: <ul style="list-style-type: none"> ○ You don't all talk at once, as it means we might not catch something important, or something that someone else in the group might want to comment on. ○ Everyone joins in and offers their opinion, everyone's view is important. ○ It would be best if you don't talk among yourselves but address yourselves to the group – otherwise it can be disruptive for the group and people can miss what others have to say. 	<p>5-10 min</p>

TOPIC	POINTS TO COVER	DURATION
	<ul style="list-style-type: none"> • The information and opinions you provide today will only be used for research purposes associated with this project. • Reporting will present the overall aggregated findings from the research. No individual will be identified. • If you agree, I would like to record this discussion. This is only to help us write our report. The recording is not provided to anyone and will only be accessed by those people working on the research project. The recordings will be transcribed and any identifying information about you will be removed. The de-identified transcripts and recordings will be stored separately and securely at APHCRI in accordance with ethics requirements. (NB respondents will have been advised of recording at the time of recruitment). <p>Distress Protocol</p> <ul style="list-style-type: none"> • This project has Ethics approval from the Australian National University and I will now ask you to look at, and sign, your consent to being part of this project. • Some of the topics for discussion may be sensitive, and if you feel uneasy you do not need to talk or answer any questions if you do not want to. • You may also leave the discussion at any point should you wish. • Should you feel distressed after participating and would like support, we have a number of avenues available which are all listed in the participant information sheet: <ul style="list-style-type: none"> ○ Ms Ros Lording, Campbell Consulting, who is a social worker ○ Dr Rhian Parker ,APHCRI, who is trained in violence and abuse counselling ○ GP Support Program, RACGP, available to RACGP members who are registered medical practitioners ○ Lifeline 13 11 14 • If you would like more information about this project, please contact the chief investigator for this project, Rhian Parker whose information is available in the information sheet. • If you have concerns about the conduct of this project, you can contact the Research Office at ANU. Their 	

TOPIC	POINTS TO COVER	DURATION
	<p>contact details are also available in the information sheet.</p> <ul style="list-style-type: none"> • Did you have any questions at this stage? 	
BACKGROUND	<ul style="list-style-type: none"> • Participants in a focus group will be asked to briefly introduce themselves, and share where they practice and the broad demographic profile of their patients. • Interview participants will be asked by the interviewer where they practice and the broad demographic profile of their patients. 	10 mins
EXPERIENCES of violence in the general practice	<p>I would like to start off tonight by asking you to share with the group any examples of patient aggression of violence towards staff at your practice.</p> <p>Reminder about the definition of violence:</p> <ul style="list-style-type: none"> • Acts such as verbal abuse, property damage or theft, stalking, physical abuse, sexual harassment or sexual abuse by a patient, patients' family members or friends towards any staff member working in your practice. <p>Explore themes such as:</p> <ul style="list-style-type: none"> • Causes of violence • Triggers for violent incidences • Context within which violence occurs • Consequences of violent incidences • Short-term management of violent incidences • Low-level compared to high-level violence: <ul style="list-style-type: none"> ○ Do staff overlook certain types of patient aggression? (eg patients being rude and/or raising their voice, patients swearing at staff if they can't get an appointment) • Trends of violence: <ul style="list-style-type: none"> ○ Do participants consider that frequency or type of violence is changing? If so, why? 	20 mins
IMPACT of violence in the general practice	<p>Explore the impact of the violent experiences raised by participants, cover off:</p> <ul style="list-style-type: none"> • Impact upon staff who have directly experienced 	15 mins

TOPIC	POINTS TO COVER	DURATION
	<p>violence in their workplace</p> <ul style="list-style-type: none"> • Impact upon staff who have indirectly experienced violence in their workplace • Impact on other patients in the vicinity, e.g. those waiting to see the GP • Ways in which violence has affected how staff provide care and service 	
<p>PROCESSES involved in identification and reporting of violence</p>	<p>Explore the processes that participants, or their practices, use to identify a potentially aggressive or violent patient, how they diffuse potential situations, and how/ whether they report violent acts in their general practice.</p> <p>Explore themes such as:</p> <ul style="list-style-type: none"> • Risk assessment and associated problems • Staffs' sense of readiness to respond • Ethical issues of not providing medical care to someone in need; or of sending a violent patient to a colleague • Interface with Occupational Health and Safety systems and requirements • The role of the OH & S officer • The role of the practice manager • The role of General Practitioner 	15 mins
<p>STRATEGIES developed/ implemented</p>	<p>Explore strategies that participants have put in place, or actions that have been taken in an attempt to:</p> <ul style="list-style-type: none"> • To prevent violence in general practice • To minimise violence in general practice • To manage violence in general practice • Staff education and training 	10 mins
<p>SUCSESSES</p>	<p>Explore the outcomes from these strategies or actions</p> <ul style="list-style-type: none"> • Have these strategies or actions identified in previous discussion been successful or effective in helping to prevent/ minimise/ manage violence • What has helped or hindered adopting these identified 	10 mins

TOPIC	POINTS TO COVER	DURATION
	strategies/ actions in to your practice?	
CONCLUSION	Thank participants again for their time, and remind them of the relevant contact details should they wish to contact the research team, access support after participating or contact the ethics committee representative. \	5 mins
END		

Appendix D: Survey instrument – General practitioner

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE Aggressive Patient Behaviour in Australian General Practice

General Practitioner survey

Principal Investigator: A/Prof Rhian Parker
Research team: Dr Dagmar Ceramidas
Dr Laura Forrest

rhian.parker@anu.edu.au

The Department of Health and Ageing has commissioned the Australian Primary Health Care Research Institute (APHCRI) to conduct this study investigating aggressive patient behaviour in Australian general practice.

This study will help gain a better understanding of the extent to which aggressive patient behaviour is an issue for those working in Australian general practices, and will:

- Measure the incidence of aggressive behaviour in general practice
- Assess the attitudes of practice staff towards aggression.

This survey is asking about your own personal experience.

This survey should take approximately **5-10 minutes**.

Please provide a response by **12th March 2010**.

Should you feel upset or disturbed due to recalling aggressive behaviour, you can contact:

- GP support program, RACGP, 1300 366 789 <http://www.racgp.org.au/gpsupport>
- Lifeline 13 11 14 <http://www.lifeline.org.au>
- Assoc Prof Rhian Parker, (02) 6125 7838 rhian.parker@anu.edu.au

Participation in this research is voluntary and your consent is implied through completion of the survey. All information gathered in the process of this survey will be treated in the strictest of confidence. You will remain anonymous.

The data from this survey will be kept and stored securely by the Primary Investigator for this project, Assoc Prof Rhian Parker from APHCRI.

This research has received ethics approval from the Australian National University. If you have any concerns about the way the research was conducted please click here Human.Ethics.Officer@anu.edu.au.

Demographics

Q1. Are you male or female?

- Male
 Female
-

Q2. Please provide your age in years

- Years
-

Q3. How long have you been a general practitioner?

Please enter '1' if you have been a general practitioner for less than one year

- Years
-

Q4. Do you work full time or part time as a general practitioner?

Please tick the box below

- Full time (work 30 hours per week or more)
 Part time or casual (work less than 30 hours per week)
-

Q5. What is the postcode of this practice?

This information will not be used to identify your practice. We only need this information to work out which state you practice in, and whether you practice in a metropolitan or regional area.

Q6. What Division of general practice is your practice located in?

Demographics continued

Q7. Is this practice a:

Please select only one option.

- Sole general – a practice with only one GP
 - Group practice – a ‘traditional’ practice owned by the GPs who work in the practice
 - Corporate practice – a corporate practice that is owned by an individual or organisation other than the GPs who work at the practice
 - Other, please specify: _____
-

Q8. Do you personally provide any of the following services?

Please tick all that apply:

- Home visits during business hours
 - Home visits after business hours
 - After hours consultations in the practice on week days
 - After hours consultations in the practice on weekends
 - None of the above
-

Personal experience of verbal aggression

Q9. In the **last 12 months**, how often have you been exposed to **verbal aggression** from patients, or people associated with patients?

In this survey, verbal aggression includes verbal abuse or threats, for example when a patient or somebody accompanying the patient swears, threatens to harm or uses obscene gestures to offend practice staff.

- Daily
- More than once a week
- Weekly
- Fortnightly
- Monthly
- Once every six months
- Once in the last 12 months
- I have been subject to verbal abuse, but not in the last 12 months
- I have never been subject to verbal abuse
- Don't know

Personal experience of physical aggression

In this survey there are different types of physical aggression. This could be by a patient or a person associated with a patient.

Stalking (any unwanted and intrusive attention including being followed to or from home or place of work)

Physical assault (includes grab, push, hit, kick, use of a weapon with intent of intimidation or causing bodily harm)

Property damage or theft (includes stealing or damaging personal property, or of medical or office supplies)

Sexual harassment

Sexual assault (any forced sexual act, rape or indecent assault)

Q10. In the **last 12 months**, how many times have you personally experienced the following types of **physical aggression** from patients or people associated with patients?

	Daily	More than once a week	Weekly	Fortnightly	Monthly	Once every six months	Once in the last 12 months	Not in the last 12 months	Never	Don't know
Stalking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damage or theft of property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual harassment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q11. In the last 12 months, have you experienced any other forms of patient aggression in your role as a general practitioner?

(Apart from the types of aggression listed in the previous questions) Please describe below.

Trends

Q12. Are there any times of the day or week when you feel at particular risk of aggressive patient behaviour?

Please tick all that apply

- When the practice first opens
 - Mornings after opening time
 - Lunch times
 - Afternoons
 - When the practice is closing
 - After hours
 - Saturday mornings
 - After the practice has closed on weekends
 - None of the above
-

Q13. Are there any other times when you feel at particular risk of aggressive patient behaviour?

- When the practice has limited numbers of staff on
 - During home visits
 - After closing when you are walking to your car, public transport or walking home
 - None of the above
 - Other, please specify: _____
-

Impact of patient aggression

Q14. Would you agree or disagree with the following statements?

	Agree	Disagree	Don't know/ No opinion
Impact			
Patient aggression has affected my physical wellbeing in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient aggression has affected my emotional wellbeing in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient aggression has affected my ability to provide medical services in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perceptions of violence			
Patient aggression has become worse at this practice in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff at this practice are not affected by patient aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice environment			
The physical layout of this practice helps minimise the risk of harm from patient aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This practice has adequate security measures to minimise the risk of harm from patient aggression (e.g. duress alarms, locked areas for staff etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This practice has adequate procedures to minimise the risk of harm from patient aggression (e.g. escape routes, incident reporting, training etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This practice can not afford adequate security measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff at this practice do not have time to implement adequate security measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This practice takes the safety of its staff seriously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q15. Has patient aggression had any other impacts on your wellbeing and capacity to provide medical services?

Please describe below.

The research team at the Australian Primary Health Care Research Institute sincerely thanks you for your time and effort

Appendix E: Survey instrument – Practice staff

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE Aggressive Patient Behaviour in Australian General Practice

General Practice survey (to be completed by one practice representative, i.e. practice manager, practice nurse, receptionist, or allied health staff)

Principal Investigator: A/Prof Rhian Parker
Research team: Dr Dagmar Ceramidas
Dr Laura Forrest

rhian.parker@anu.edu.au

The Department of Health and Ageing has commissioned the Australian Primary Health Care Research Institute (APHCRI) to conduct this study investigating aggressive patient behaviour in Australian general practice.

This study will help gain a better understanding of the extent to which aggressive patient behaviour is an issue for those working in Australian general practices, and will:

- Measure the incidence of aggressive behaviour in general practice
- Assess the attitudes of practice staff towards aggression.

You have been invited to complete this survey as a representative for this practice on behalf of the other staff at this practice

- You will need to complete this survey with input from other staff or by checking an incident register.

This survey should take approximately **15 – 20 minutes**.

Please provide a response by **12th March 2010**.

Should you feel upset or disturbed due to recalling aggressive behaviour, you can contact:

- GP support program, RACGP, 1300 366 789 <http://www.racgp.org.au/gpsupport>
- Lifeline 13 11 14 <http://www.lifeline.org.au>
- Assoc Prof Rhian Parker, (02) 6125 7838 rhian.parker@anu.edu.au

Participation in this research is voluntary and your consent is implied through completion of the survey. All information gathered in the process of this survey will be treated in the strictest of confidence. You will remain anonymous.

The data from this survey will be kept and stored securely by the Primary Investigator for this project, Assoc Prof Rhian Parker from APHCRI.

This research has received ethics approval from the Australian National University. If you have any concerns about the way the research was conducted please click here Human.Ethics.Officer@anu.edu.au.

Practice Demographics

Q16. How many of the following staff work at this practice?

Please indicate number in the box

- General practitioners
- Practice managers
- Practice nurses
- Receptionists
- Allied health professionals
- Other, please specify _____

Q17. And how many are female?

Please indicate number in the box

- General practitioners
- Practice managers
- Practice nurses
- Receptionists
- Allied health professionals
- Other, please specify _____

Q18. And how many work **full time** at this practice (30 hours or more per week)

Please indicate number in the box

- General practitioners
- Practice managers
- Practice nurses
- Receptionists
- Allied health professionals
- Other, please specify _____

Q19. What is the postcode of this practice?

This information will not be used to identify your practice. We only need this information to work out in which state your practice is located, and whether your practice is in a metropolitan or regional area.

Demographics continued

Q20. What Division of general practice is your practice located in?

Q21. Is this practice a:

Please select only one option.

- Sole general practitioner – a practice with only one GP
 - Group practice – a ‘traditional’ practice owned by the GPs who work in the practice
 - Corporate practice – a practice that is owned by an individual or organisation other than the GPs who work at the practice
 - Other, please specify: _____
-

Q22. Does your practice provide any of the following services:

Please tick all that apply:

- Home visits **during** business hours
 - Home visits **after** business hours
 - After hours consultations in the practice on **weekdays**
 - After hours consultations in the practice on **weekends**
 - None of the above
-

Types of aggressive patient behaviour

This section is about types of aggressive patient behaviour directed towards staff at this practice. For this survey, the term 'aggressive patient behaviour' includes:

- **Verbal Aggression**
 - Verbal abuse or threats
- **Physical Aggression**
 - Property damage or theft
 - Stalking
 - Physical assault
 - Sexual harassment
 - Sexual assault

Verbal Aggression

These questions are about verbal aggression by patients or associated with patients.

In this survey, verbal aggression means verbal abuse or threats, for example when a patient or somebody associated with the patient **swears, threatens to harm or uses obscene gestures** to offend practice staff.

Verbal aggression includes threats or abuse over the phone.

Q23. In the last 12 months, how many times have staff at this practice been subject to verbal abuse or threats by a patient or someone associated with a patient?

	Daily	More than once a week	Weekly	Fortnightly	Monthly	Once every six months	Once in the last 12 months	Not in the last 12 months	Never	Don't know
Practice managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptionists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allied health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF ALL ITEMS AT Q23 = NEVER OR DON'T KNOW, GO TO Q26

Q24. Overall, how much of this verbal abuse or threats comes from males, how much from females?

Please estimate the percentage of instances for males and females

Males %

Females %

Total 100%

Q25. Overall, how much of this verbal abuse or threats comes from patients, how much from people associated with patients?

Please estimate the percentage of instances for patients and people associated with patients

Patients %

People associated with patients %

Total 100%

Physical Aggression

This next section is about physical aggression from patients or people associated with patients at this practice.

These questions will ask about instances of the different types of physical aggression over the **last 12 months**.

- Property damage or theft
- Stalking
- Physical assault
- Sexual harassment
- Sexual assault

Property damage or theft

These questions are about damage to, or theft of, property belonging to the practice or to practice staff.

Property damage or theft includes when a patient or somebody associated with a patient:

- Steals or damages personal property of practice staff, including cars
- Steals or damages medical or office equipment, supplies, and office furnishings

Attempted theft or damage of the above items and theft from and damage to practice staff's homes is also included.

Q26. In the last 12 months, how often were staff at this practice subject to property damage or theft by a patient or someone associated with a patient?

	Daily	More than once a week	Weekly	Fortnightly	Monthly	Once every six months	Once in the last 12 months	Not in the last 12 months	Never	Don't know
Practice managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptionists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allied health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF ALL ITEMS AT Q26 = NEVER OR DON'T KNOW, GO TO Q29

Q27. Overall, how much of this property damage or theft was done by males, how much by females?

Please estimate the percentage of instances for males and females

Males %

Females %

Total 100%

Q28. Overall, how much of this property damage or theft was done by patients, how much by people associated with patients?

Please estimate the percentage of instances for patients and people associated with patients

Patients %

People associated with patients %

Total

100%

Stalking

These questions are about stalking of practice staff by a patient or person associated with a patient.

Stalking includes any unwanted and intrusive attention by patients or people associated with patients towards practice staff. For this survey, stalking includes when a patient or person associated with a patient **purposely follows a staff member** to or from their home or place of work.

Q29. In the **last 12 months**, how many times were staff at this practice subject to **stalking** by a patient or someone associated with a patient?

	Daily	More than once a week	Weekly	Fortnightly	Monthly	Once every six months	Once in the last 12 months	Not in the last 12 months	Never	Don't know
Practice managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptionists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allied health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF ALL ITEMS AT Q29 = NEVER OR DON'T KNOW, GO TO Q32

Q30. Overall, how much of this stalking was done by males, how much by females?
Please estimate the percentage of instances for males and females

Males %

Females %

Total 100%

Q31. Overall, how much of this stalking was done by patients, how much by people associated with patients?
Please estimate the percentage of instances for patients and people associated with patients

Patients %

People associated with patients %

Total 100%

Physical assault

These questions are about the physical assault of practice staff by patients or people associated with patients. For this survey, physical assault includes when a patient or person associated with a patient:

- Grabs pushes, hits, kicks or slaps a practice staff member
- The use of a weapon or other object with the intent of intimidation or causing bodily harm to a practice staff member

Q32. In the last 12 months, how many times were staff at this practice subject to physical assault by a patient or someone associated with a patient?

	Daily	More than once a week	Weekly	Fortnightly	Monthly	Once every six months	Once in the last 12 months	Not in the last 12 months	Never	Don't know
Practice managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptionists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allied health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF ALL ITEMS AT Q32 = NEVER OR DON'T KNOW, GO TO Q35

Q33. Overall, what percentage of these physical attacks were by males, what percentage by females?

Please estimate the percentage of instances for males and females

Males %

Females %

Total 100%

Q34. Overall, what percentage of these physical attacks were by patients, what percentage by people associated with patients?

Please estimate the percentage of instances for patients and people associated with patients

Patients %

People associated with patients %

Total 100%

Sexual harassment

These questions are about the sexual harassment of practice staff by patients or people associated with patients. For this survey, sexual harassment includes any time when a patient or someone associated with the patient initiates:

- Sexual propositions or unwelcome sexual attention
- Humiliating or offensive jokes and remarks with sexual overtones
- Suggestive looks or physical gestures
- Requests for inappropriate or invasive physical examinations
- Pressure for dates
- Aggressive brushing, touching, or grabbing **excluding** the genital or breast area

Q35. In the last 12 months, how many times were staff at this practice subject to sexual harassment by a patient or someone associated with a patient?

	Daily	More than once a week	Weekly	Fortnightly	Monthly	Once every six months	Once in the last 12 months	Not in the last 12 months	Never	Don't know
Practice managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptionists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allied health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF ALL ITEMS AT Q35 = NEVER OR DON'T KNOW, GO TO Q38

Q36. Overall, how much of this sexual harassment was from males, how much from females?

Please estimate the percentage of instances for males and females

Males %

Females %

Total 100%

Q37. Overall, how much of this sexual harassment was from patients, how much from people associated with patients?

Please estimate the percentage of instances for patients and people associated with patients

Patients %

People associated with patients %

Total

100%

Sexual assault

These questions are about the sexual assault of practice staff by patients or people associated with patients. For this survey, sexual assault is any forced sexual act, rape or indecent assault

Q38. In the last 12 months, how many times were staff at this practice subject to sexual assault by a patient or someone associated with a patient?

	Daily	More than once a week	Weekly	Fortnightly	Monthly	Once every six months	Once in the last 12 months	Not in the last 12 months	Never	Don't know
Practice managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receptionists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allied health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF ALL ITEMS AT Q38 = NEVER OR DON'T KNOW, GO TO Q42

Q39. Overall, what percentage of this sexual assault was by males, what percentage by females?

Please estimate the percentage of instances for males and females

Males %

Females %

Total 100%

Q40. Overall, what percentage of this sexual assault was by patients, what percentage by people associated with patients?

Please estimate the percentage of instances for patients and people associated with patients

Patients %

People associated with patients %

Total 100%

Q41. In the last 12 months, have staff at this practice experienced any other forms of patient aggression?

(Apart from the types of aggression listed in the previous questions) Please describe below.

Trends

Q42. Are there any times of the day or week when staff are at particular risk of aggressive patient behaviour?

Please tick all that apply

- When the practice first opens
 - Mornings after opening time
 - Lunch times
 - Afternoons
 - When the practice is closing
 - After hours
 - Saturday mornings
 - After the practice has closed on weekends
 - None of the above
-

Q43. Are there any other times when staff are at particular risk of aggressive patient behaviour?

- When the practice has limited numbers of staff on
 - During home visits
 - After closing when you are walking to your car, public transport or walking home
 - None of the above
 - Other, please specify: _____
-

Q44. In the **last 12 months**, has aggressive patient behaviour increased, decreased or stayed the same at **this practice**?

If the type of aggressive behaviour has never occurred at the practice, please tick 'stayed the same'

	Increased	Stayed the same	Decreased	Don't know
Verbal abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Property damage or theft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stalking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual harassment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Impacts of aggressive patient behaviour

Q45. In the **last 12 months**, has **verbal aggression** by patients or people associated with patients resulted in ...

Please provide one response for each item

	Yes	No	Don't know
Staff distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The need for staff to have time off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The need for staff to have counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The need for staff to reduce their hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changed practice opening hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduced services (such as home visits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff resignation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes to procedures/ policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q46. In the **last 12 months**, has **physical aggression** by patients or people associated with patients resulted in ...

Please provide one response for each item

	Yes	No	Don't know
Staff distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The need for staff to have time off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The need for staff to have counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The need for staff to reduce their hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changed practice opening hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduced services (such as home visits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff resignation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes to procedures/ policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q47. Has patient aggression had any other impacts on staff's wellbeing and capacity to provide services?

Please describe below.

The research team at the Australian Primary Health Care Research Institute
sincerely thanks you for your time and effort

Appendix F: Summary of marketing strategy

SBOs

Wednesday 30th September – All were contacted in person, with a follow-up email containing project information

Divisions of GP

Laura & Dagmar phoned all 113 DGPs in Australia 29th September to 5th October, with a follow-up email containing project information, and advise that the survey links would follow.

RACGP Faculty newsletters

21st September - WA

16th October - NSW/ACT released (\$400 +GST)

25th September

9th October

23rd October

} SA / NT released (\$501 +GST)

Press releases and radio interviews

Wednesday 7th October – Murray Mallee General Practice Network (newsletter)

Thursday 8th October - AMA & RACGP Press release – through ANU advertising because of the logo etc

Melanie, contact @ RACGP – approaching Dr Chris Mitchell (president) for a few words to include in the press release

Friday 9th October Pilot links to Sutherland Division, as CR&C not yet trialed online survey with practices

RACGP President (Dr Chris Mitchell) has had telephone interview and will be quoted in press releases

AMA Peter Jeans (AMA) has provided project info to AMA

Monday 12th October – Rhian took press interviews from:

The Sydney Morning Herald

The Australian

Victorian press syndicate

Radio interviews: Radio National

ABC Drive time interview

Canberra region news

RACGP Chris Mitchell has had interviews from SMH and ABC Radio PM Program asking for interviews with Chris. I believe Chris received some calls directly as well.

Press:

1. The Australian:

<http://www.theaustralian.news.com.au/story/0,25197,26198184-12377,00.html>

2. The Daily Telegraph

<http://www.dailytelegraph.com.au/news/breaking-news/impatient-patients-abusing-doctors/story-e6freuz0-1225785791243>

3. The Courier Mail

http://www.news.com.au/couriermail/story/0,20797,26198184-5003402,00.html?from=public_rss

4. Adelaide Now

<http://www.news.com.au/adelaidenow/story/0,22606,26198184-5005962,00.html>

5. The Herald Sun

<http://www.heraldsun.com.au/news/breaking-news/impatient-patients-abusing-doctors/story-e6frf7kf-1225785791243>

6. The Australian Doctor (online)

<http://www.australiandoctor.com.au/articles/e1/0c0649e1.asp>

Division Newsletters:

1. General Practice NSW (newsletter)

http://www.gpnsw.com.au/_data/assets/pdf_file/0014/1175/10-Minute-Update-ISSUE-271.pdf

2. Western Australian General Practice Network (newsletter)

http://www.wagnetwork.com.au/site/index.cfm?PageMode=indiv&module=NEWS&page_id=49567&leca=227

3. GP Access (NSW, newsletter)

http://www.gpaccess.com.au/index.cfm?fuseaction=fuseaction_12&fusesubaction=docs&documentid=15&CFID=7953779&CFTOKEN=75546677

4. GPA Geelong (newsletter)

<http://www.gpageelong.com.au/Our-Services/Research/research.html>

5. ACT Division of General Practice (newsletter)

<http://www.actdgp.asn.au/content/Document/September%202009/vol%20113.pdf>

6. North-West Queensland Primary Health Care (newsletter)

http://www.nwqphc.com.au/page/Publications/E-Newsletter/e-news_25_Sep_2009/

7. Shoalhaven Division of General Practice (newsletter)

http://www.sdgp.com.au/site/content.cfm?page_id=49859¤t_category_code=3554&leca=218

8. South Eastern Sydney Division of General Practice (website)

http://www.sesdgp.com.au/page/News_Events/News_Archive/Aggressive_Patient_Behaviour_in_Australian_General_Practices_National_Survey/

Tuesday 13th October – Rhian took a radio interviews with:

Red Symons, Victorian radio station

A second Victorian radio station

4BC Brisbane

1. The Melbourne Age

<http://www.theage.com.au/national/gps-face-patient-violence-20091012-gu1p.html>

2. The Australian: page 8, General News. Author Adam Cresswell. Circulation 138765, national press. Ref: 58297713.

3. Ballarat Courier, page 11, General News. Circulation 18750, regional press. Ref: 58310403.

4. Canberra Times, page 3, General News. Author Natasha Rudra.. Circulation 34354, capital city press. Ref: 58309077.

-
5. Courier Mail, page 9. General News. Circulation 214468, capital city press. Ref: 58299242.
 6. Daily Advertiser, page 7, General News. Circulation 12851, regional press. Ref: 58309493.
 7. Daily Telegraph, page 11, General News. Circulation 360563, capital city press. Ref: 58299074.
 8. Heidelberg & Diamond Valley Weekly, page 5, General News. Author Benjamin Priess. Circulation 74524, Melbourne suburban press. Ref: 58350680
 9. Herald Sun, page 4, General News. Circulation 518000, capital city daily press. Ref: 58302939.
 10. Hobart Mercury, page 3, General News. Author Damian Brown. Circulation 47123, capital city daily press. Ref: 58309704.
 11. Maitland Mercury, page 5, General News. Circulation 4331, regional press. Ref: 58346214.
 12. Newcastle Herald, page 11, General News. Circulation 49880, regional press. Ref: 58305886.
 13. Northern Weekly, page 6, General news, Author Benjamin Priess. Circulation 42961, suburban press. Ref: 58350914.
 14. West Australian, page 17, General News. Circulation 199707, capital city daily (Perth) press. Ref: 58309634.
 15. Western Advocate, page 7, General News. Circulation 3949, regional press (Bathurst). Ref: 58307477
 16. ABC news, online
<http://www.abc.net.au/news/stories/2009/10/13/2712138.htm>
 17. SBS world news Australia, online
<http://www.sbs.com.au/news/article/1109306/Patients-often-abuse-GPs:-research>

Rhian took a lengthy phone call from a retired GP

Dagmar took a medium length call from a practice manager who reported regularly experiencing violence in the practice.

Wednesday 14th October – press release through to RACGP Friday Facts

Melbourne Times, page 5, General News. Author Benjamin Priess. Circulation 98252, Melbourne suburban press. Ref: 58343112.

Friday 16th October Medical Press release
RACGP Friday Facts, via ANU Marketing

Front page, Medical observer
Info to Jan Chaffey, Practice Managers

Monday 19th October – Laura emailed survey links to all Australian DGPs.

Tuesday 20th October – Dagmar emailed survey information and links to
Gloria McCorkell, Ascot Vale General practice

Christine Cox, Hastings Macleay GP Network

Thursday 29th October – GP Adelaide Division newsletter

<http://www.gppadelaide.org.au/LinkClick.aspx?fileticket=Gb%2fIV7tRScg%3d&tabid=370&mid=1495>

Appendix G: List of Stakeholder organisations

- Australian Association of Practice Managers (AAPM)
- Australian College of Mental Health Nurses (ACMHN)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian General Practice Network (AGPN)
- Australian Medical Association (AMA)
- Australian Nursing Federation (ANF)
- Australian Practice Nurses Association (APNA)
- Council of Remote Area Nursing (CRANA)
- General Practice Registrars Australia (GPRA)
- The Primary Health Care Research Institute Service (PHC RIS)
- Royal Australian College of General Practice (RACGP)
- National Association for Medical Deputising Services (NAMDS)
- Royal College of Nursing, Australia (RCNA)
- Rural Doctors Association of Australia (RDAA)

Appendix H: Stakeholder consultations – thematic framework for interview

A. Introduction

Theme	Prompts
Introductions	
Thank the interviewee	<ul style="list-style-type: none"> • interest in the project • giving up their time to participate in the interview • approximately one hour duration
Seek permission to record and transcribe	<ul style="list-style-type: none"> • recording can be suspended at any time • use of interviewee's information
Rhian's role in the project	<ul style="list-style-type: none"> • CI • Project manager • Etc
Purpose, nature and scope of the study	<ul style="list-style-type: none"> • Background: DoHA's interest in the area • Aims • Methodology • Reporting and dissemination of results
Three-phase structure of interview	<ul style="list-style-type: none"> • Introduction • Exploration of organisation's views, issues, and response mechanisms towards violence against GPs in Australia

Commence recording

Interviewee's questions or comments regarding the project

B. Explorative body of interview (45 minutes)

Theme	Prompts
Nature of [organisation]	
How is [organisation] involved with GPs?	<ul style="list-style-type: none"> direct indirect
If indirect - What is the pathway that links [organisation] to GPs?	How would you hear from GPs, or hear about what's happening at GP level?
If direct - Frequency and type of involvement with GPs?	
Organisation's views on issues relating to violence in general practice generally	
Perception of violence	
Perception of extent of violence	
Perception of escalation of violence	<ul style="list-style-type: none"> intensity frequency
Perception of causes of violence	<ul style="list-style-type: none"> GP training issues GP inexperience (newer graduates) poor GP recognition of potential violence lack of GP training in management of potential violence females GPs

Perception of patterns of violence	younger GPs sole practitioners after hours services geographical location greater numbers of mental health, D & A, or forensic clients lower socio-economic clients
Possible GP ethical issues	how does GP feel about passing the violent client on to a colleague? Violent clients still have medical needs that can't be turned away ethical dilemma of personal safety versus patient need for medical assistance
Possible systems issues	lack of service / community infrastructure to deal with potentially violent clients insufficient Police to offer immediate response general poor physical layout of surgeries
Other perceived causes and /or issues	GP personality GP ill-health global economy

Organisational response to reports of violence against GPs

How does the [organisation] respond to reports of violence	protocol tracking of reports advice / support for GP recipients of violence on-reporting - to Police or under any mandatory reporting requirement press
--	--

Organisational literature

Does [organisation] have any documents that relate to violence in general practice for incorporation into the grey literature for review	reports best practice guidelines policies position documents
--	---

Closure (5 -10 minutes)

Organisational support for Project	informing constituents about the project alerting constituents to forthcoming online survey and qualitative strategies
Is there any other information you wish to add?	
Have you any questions arising from the interview and relating to the project?	

Cease recording

Thank interviewee for time and contribution to the project
Leave business card and invitation for further contact if necessary

Appendix I: Locations for qualitative research with general practice staff

State	Region	Location	Research Method
Victoria	Metropolitan (South city Division)	St Kilda	Focus Group
		Toorak	Affinity Group
		North Caulfield	GP In-depth (F-T-F)
		Elsternwick	GP In-depth (telephone)
	Regional (Ballarat and District Division)	Ballarat	Focus Group
			GP In-depth (F-T-F)
			GP In-depth (telephone)
New South Wales	Metropolitan (Liverpool Division)	Liverpool	Focus Group
			GP In-depth (F-T-F)
			GP In-depth (telephone)
	Regional (Riverina Division)	Wagga Wagga	Affinity Group
			Focus Group
			GP In-depth (F-T-F) (2)
Queensland	Metropolitan (Ipswich and West Moreton Division)	Ipswich	Focus Group
			Affinity Group
			GP In-depth (F-T-F)
			GP In-depth (telephone)
	Regional (Queensland North Division)	Townsville	Focus Group
			GP In-depth (F-T-F) (2)
Northern	Regional	Darwin	Focus Group

State	Region	Location	Research Method
Territory	(General Practice Network NT)		GP In-depth (F-T-F)
			GP In-depth (telephone)
	Remote (General Practice Network NT)	Alice Springs	Affinity Group (2)
			GP In-depth (F-T-F)
			GP In-depth (telephone) (2)
Western Australia	Metropolitan	Perth	GP In-depth (telephone)
South Australia	Metropolitan	Adelaide	GP In-depth (telephone)
Tasmania	Metropolitan	Hobart	GP In-depth (telephone)