Letter to the Editor

Rise in violence in general practice settings during the COVID-19 pandemic: implications for prevention

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Introduction

Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physical or verbal, whether physical harm is sustained or whether the intention is clear. Between 2013 and 2014, there were 68 683 assaults reported against National Health Service (NHS) staff in England, of which 25% involved primary care staff (1). A majority of GPs report experiencing violence at some point over the course of their careers (2–5). These incidents have the potential to impact on the safe working of primary care staff and GPs, as well as affecting the care that patients receive. However, a significant proportion of violence in health care settings goes unreported (6). Violence against doctors has become an increasingly concerning international phenomenon with the COVID-19 pandemic (7,8) and this includes doctors in primary care settings (9). The International Committee of the Red Cross recorded over 600 incidents of threats and violence towards health care workers between February and July 2020 and this is acknowledged to be an underestimate (7). A large study from China reported that over 2800 doctors, nearly one in five surveyed, had experienced verbal or physical violence during the pandemic (10). There is a paucity of data on absolute rates of violence in different practice settings but reports from the international medical community are cause for growing concern. Attacks on health care workers during the pandemic have included, for example, throwing of faeces and sending of funeral wreaths to doctors in Latin America, a denial of funeral rites to a deceased doctor in India, the stabbing of a doctor in India, an attack on a health care worker by a mob in Russia, an attack with bleach in the Philippines as well as gun-related violence towards doctors in parts of Pakistan (11–14). There remains a relative paucity of research in the area of interventions aimed at reducing such violence.

Causes of violence in primary care

A 2003 systematic review of violence in primary care reported that the majority of such incidents were linked to disinhibition caused by alcohol or drug use, long waiting times or mental illness. This study found that most incidents were clinic-based and that GPs working in areas of deprivation were affected more often (15). A relatively recent systematic review of 44 studies found that major risk factors included long waiting times, discrepancy between patients’ expectations and services, substance abuse by the patient and psychiatric conditions (16). However, concerns from humanitarian organizations highlight misinformation in respect of COVID-19 and adverse care outcomes leading to an increase in violence against medical practitioners in countries such as Bangladesh, India, Pakistan, Syria and Sudan (7). In UK primary care settings, a perception of reduced face-to-face consultation availability has been cited as a reason for frustration and abusive behaviour (9).

Primary prevention

In general, primary prevention is best conceptualized using systemic and patient-specific approaches. On a systemic level, the display of zero-tolerance policies such as the NHS zero-tolerance posters might have a deterrent effect, although the efficacy of this has not been established (17). Specialized primary care centres for patients with a history of violence may play a role (18). The use of security guards for high-risk patients and in particular for domiciliary visits has been suggested (18). Many practices, however, do not have these facilities which make primary prevention more challenging. Additionally, predicting violence is difficult, and formal violence risk assessment instruments have relatively poor positive predictive value in populations with low base rates (19).
Violence prevention in respect of the pandemic is more complex. The International Committee of the Red Cross and the World Health Organization have produced a checklist for managers of health care services that focusses on local risk assessment and accountability towards those receiving care (7). Some countries such as India, have passed stringent laws against health care violence during the pandemic (7) and others such as Sudan, are developing a specific police response (7). It is too early to evaluate the effectiveness of these deterrent measures.

Secondary prevention

Secondary prevention aims at escaping or de-escalating an evolving violent situation. In an acute situation where violence is imminent, it might be necessary for the practitioner to exit the consultation to seek help (20). Having an unobstructed exit route on the practitioner’s side of the room is critical to these circumstances. The ability to summon help and chance intervention by colleagues are regarded by practitioners as important, especially out of hours (21). It is therefore useful to have protocols for such incidents in the clinic, with appropriate training for each member of the practice and support staff. In the consultation, a range of techniques such as allowing the patient space to vent, preventing an increase in arousal by using empathy, and maintaining a calm tone of voice has been described as surprisingly effective and ought to not be underestimated (20).

Tertiary prevention

A qualitative study in two London settings (22) reported a lack of protocols for dealing with violent incidents. Practice receptionists were found to be most at risk, due to exclusion from team meetings and lack of peer support and advice. The authors found that ‘negative management tactics, such as patient appeasement or exclusion, were the norm’. Recommendations from this study included the development of practice protocols. Tertiary prevention (after the incident) includes accurate recording of the incident in the patient's clinical notes and clinical alerts. Having an incident debrief with practice staff, including, sometimes an independent experienced colleague, can help establish learning points in respect of how an incident was managed. Decisions about the ongoing care of the patient by a different practitioner within the same clinic or at a different clinic might need to be taken based on the seriousness of the violent episode (23). In the UK, there have also been calls for a systematic response from Clinical Commissioning Groups to respond to the increased reports of pandemic-related violence with a consistent approach and for increasing the availability of occupational health measures for the doctors involved (9).

Recommendations for research

The literature is clear—violence and aggression in primary care are common and this is a worldwide phenomenon (2–6). Violence against doctors has been an increasing international concern in light of the COVID-19 pandemic and retrospective survey data are needed to accurately quantify the extent of this in general practice and other settings (7–14). Much of the current guidance in the area is opinion-based. Observational studies and pragmatic trials looking at measures such as zero-tolerance policies, specific policing responses and legislation across different jurisdictions would help evaluate the effects of these approaches. These are critical research priorities. The evaluation of patient-specific measures in violence prevention, such as specialist clinics for high-risk patients including for instance real-time closed-circuit camera monitoring or surveillance, is more challenging as it involves confidentiality concerns, shifting of risk and, thereby, creating ethical considerations for any prospective trial of such interventions. Indeed, such enhanced surveillance may deter violence, fail to influence such behaviour or be limited to mitigating severity of injuries arising. However, irrespective of the latter concerns, it seems reasonable to argue that in situations where potential for violence is an acknowledged risk, evaluation of such protective measures may be warranted.

Declaration

Conflict of interest: the authors declare no conflicts of interest.

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