Zero Tolerance of Violent Patients: A Partnership Approach to Evaluating the Impact in General Practice

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Patient aggression and violence is a serious issue for those who work in the NHS, making it an unappealing place to work and an added burden on an organisation that already has substantial recruitment and retention problems (Department of Health 1999). Hostility directed towards staff is an important occupational health concern, particularly when one in 10 doctors, including GPs, have been physically attached, stabbed, kicked, punched, bitten and spat at in the past 12 months (Brindley 2008). Nursing exposure to workplace aggression is also high (Farrell and Cubit 2004). The incidence of aggression to nurses may be under-reported as perpetrators who are rude and antagonistic to nurses, can be less confrontational when seen by doctors (Jenkins et al 1998). The heightened awareness of risks to the safety of healthcare workers in practice has led the UK’s government to tackle this by adopting an attitude of ‘zero tolerance’ towards patients. This is despite the fact that there is limited evidence to suggest that a zero approach in health care is in reality successful (Whittington 2002). The NHS Executive supports the European Commission’s definition of violence as being “any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health” (cited Edgar & Kershaw, 2007, p.9). Hence in adhering to the Zero tolerance policy, any of these circumstances mitigate the exclusion of the ‘violent’ perpetrator from accessing health care services.

The campaign of zero tolerance is intended to reinforce the intolerable nature of violence against staff working within the NHS and is aimed at reassuring them that hostility and intimidation is no longer to be accepted or normalised as being intrinsic to their role (Elston 2002). Work-related aggression is now viewed by clinical staff as unacceptable and liable to be met with restrictions of some sort against the offender.

The feasibility of applying a zero tolerance policy in GP practice is, however, potentially challenging, as there can be conflict between the professional obligation to care for the patient and the need to preserve the dignity and respect of the GP or possible service users (Behr 2005). Decisions to excluded patients from accessing medical attention and healthcare services can be seen as unethical. There are also blurred distinctions between what is considered ‘deviant’ behaviour that warrants exclusion and behaviour that is thought to be manifesting as a result of a medical condition and therefore requiring treatment and care. Perhaps one of the main reasons for a reluctance to apply blanket exclusion policies relates to the fact that few doctors
perceive the incidence of violence or abuse against them as racially or politically motivated. Rather they report other reasons for the incidence of violence, mainly focusing around drug related, psychiatric and mental health issues. More specifically they point to violent and abusive behaviours resulting from patient frustrations with long waiting times, dissatisfaction with diagnosis and or planned treatment. There are also worries that uncompromising attitudes towards zero tolerance could lead to an abuse of a patients’ right to show appropriate anger and frustration with a poor service (Whittington 2002). Notwithstanding these concerns ultimately it is not acceptable for health professionals to be fearful for their own safety at work. Verbal and physical assaults on staff inflict physical and emotional injury, but also undermine morale, create a climate of fear, and subvert the quality of care. Nonetheless, given that resource allocation and marginalisation are perceived as being identifiable and modifiable factors contributing to violence in our health care systems, and that undoubtedly there will always be an element of risk in working in such settings, there is an urgent need to acknowledge and safely manage potential violence in general practice and community settings. Expectations are that primary care will devise solutions to redress the balance between exclusion and the need for treatment for these patients.

Earlier this year researchers from CHSCI started work to describe how a zero tolerance initiative in Enki impacts on primary care. Initial findings reported below highlight that within Enki medical practice there exists a unique patient practitioner partnership that works on the principles of inclusion and rehabilitation rather than exclusion and stigmatisation.

The Centre for Health and Social care Improvement (CHSCI) within the School of Health at The University of Wolverhampton has forged links with a general practice in the Heart of Birmingham (Enki Medical Practice) to examine the policy of zero tolerance and its delivery in primary care. The School’s collaboration with Enki Medical practice is part of a wider commitment to develop translational research in general practice.

Because of the salience of general practice to the delivery of a patient centred NHS, the value of a research partnership located within general practice is self-evident. But until recently the opportunities for multidisciplinary and interdisciplinary research partnerships have been limited. The research agenda in general practice has traditionally been driven by disciplinary interests and located in medical academic institutions far removed from the realities of the clinical practice setting. However, the need to realistically evaluate health care provision, using multiple approaches, highlights the need to expand the paradigm of general practice and research. Problem focussed research rather than discipline based research is a key feature of this development.

ENKI currently holds the Heart of Birmingham PCT contract to provide Primary Healthcare to those who come under the remit of the Zero Tolerance Scheme in Primary Care for the patients of Birmingham and Solihull. As such the practice has the clinical expertise and specialised facilities for the management of these patients. In addition, ENKI holds valuable data pertaining to patterns of behaviour of those patients previously excluded from their own general practices. The CHSCI specialises in research pertaining to the needs of marginalised and excluded groups. The collaboration of ENKI with the CHSCI, therefore, provides a unique opportunity to better understand the needs of this marginalised patient group.

The literature suggest that aggression and violence in patients is frequently stimulated by conditions such as crowded waiting rooms, limited space for privacy, increased levels of noise and bustle (Cowen et al 2003). Researchers found that Enki works to combat this by having a private roomed facility for treating zero tolerance patients that is part of the main building, but away from the normal surgery premises. Researchers also found the zero tolerance zone to be a discrete but secure purpose built area that is designed to be effectual and unobtrusive rather than conspicuous or blatant. They found, for example, nothing in the outward appearance of this secure unit that might make other patients uneasy about having a security environment nearby. Nonetheless security was of paramount importance, not only for mainstream patients but also for the staff who work there, and security guards were visible on the premises at all times.
Whilst describing the processes and systems of the unit, researchers found that while this service appeared separate in space from the rest of the practice, it was nonetheless integrated in time so that appointments could be booked at any time, and telephone calls could be placed any time that the practice was open. This level of integration appeared to be important both logistically and psychologically and clearly added to the perception of inclusion.

Overall the unit layout and management systems were designed and used to provide patients with a stable environment, to receive continuing health care, and to address their underlying causes of aggressive behaviour, as well as encourage them to use general practice services in a responsible, appropriate and safe way in the future.

A zero tolerance policy carries with it the disadvantage of compounding problems by attributing blame to patients (National Health Service Executive 1999), the care patients receive should therefore ultimately aim at improving practitioner/patient relationships and facilitate constructive ways of working together. If aggression is to be handled effectively then it is important that the fundamental aim of service provision such as this promotes therapeutic relationships (Duxbury 2002). Researchers found that Zero tolerance patients were not treated however, any differently from the rest of the practice and while staff were prepared to see patients at separate specific times if they wished, most patients were happy to fit in with the normal clinic times.

Despite the investment made in tailoring the environment and the service to meet the needs of a disenfranchised group of patients, examination of clinic appointments or attendance indicated that the patients on the scheme did not engage with the practice as much as expected, as shown (table 1) by a comparison of zero tolerance appointments with mainstream patients:

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>ZT Number</th>
<th>% Usage</th>
<th>Comparison to mainstream practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone (including triage)</td>
<td>60</td>
<td>133</td>
<td>241</td>
</tr>
<tr>
<td>HCA (including smoking cessation)</td>
<td>22</td>
<td>49</td>
<td>58</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>35</td>
<td>35</td>
<td>91</td>
</tr>
<tr>
<td>Advanced Nurse Practitioner</td>
<td>46</td>
<td>102</td>
<td>171</td>
</tr>
<tr>
<td>GP</td>
<td>62</td>
<td>138</td>
<td>22</td>
</tr>
<tr>
<td>Midwife</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>227</td>
<td>504</td>
<td>587</td>
</tr>
</tbody>
</table>

It can be seen that there was an overall general under using of the service in comparison to mainstream General Practice (504:587). The apparent reluctance of patients to attend the practice in relation to mainstream users may be attributed amongst other things, to both the generally younger nature of the population and the decreased ease of access in terms of the average distance of the premises from the patients.

This contrasts with evidence that suggests Zero Tolerance registered patients utilise a greater proportion of services than the average service user. For example, zero tolerance patients tend to require greater telephone support, and practitioner consultation time, (240:193).
The findings also indicate that zero tolerance patients have seven times greater contact with their GP in comparison to mainstream patients but demonstrate less frequent use with other practitioners. It may be that under using of nurses services may be accounted for in part, by the triage activities of the advanced practitioners rather than patient preference.

In terms of rehabilitative function findings so far suggest a low level of re-referral back into the zero tolerance scheme. It appears that there have been three re-referrals in the whole lifetime of the project out of 122 referred back into mainstream. Interestingly two of those re-referrals were expressly engineered by the patients who particularly liked the GP and felt that he was the best one they could find to deal with their addiction problems (one drug and one alcohol).

The approaches adopted by Enki appear to provide a much-needed solution to meeting the health needs of previously excluded patients. Further work however, needs to be undertaken to examine what patients themselves feel about the service and to find out why they are more likely to be reluctant to attend the practice than their counterparts. Studies examining the nature of the patient consultation may also reveal important information regarding the process of rehabilitation and why Enki appears to be so successful in preventing reoffending.

Research is ongoing to address these issues as well as plans to develop research collaborations and training initiatives with other general practices.

References


