From the editor

Violence and abuse

Would you elect to work for a public service in which the chance of being physically assaulted by your clients in any one month was nearly 70%? And to which public service staff do we allude? Prison warders? Security guards? Front-line police officers? Forensic psychiatric nurses? In fact, these figures come from Lepping *et al*'s survey of acute medical wards in three district general hospitals in North Wales. The authors investigated the experiences of staff working on gastroenterology and elderly-care wards.[1]

To the hospital physician, I think these figures will come as a substantial shock. Over 4 weeks 83% of staff reported being verbally abused and 68% physically abused. There are the admitted caveats of a questionnaire survey with incomplete response rates and reporting bias. Nonetheless, particularly among bedside carers – nurses and healthcare support workers – the response rates were clearly adequate to reveal an intolerable, though accepted, situation. At first sight the figures are surprisingly different from the NHS staff survey, with a report of physical violence to 15% of staff over 12 months and 30% experiencing some form of harassment. But that survey covers many whose immediate contact with patients is limited. However, international data show that the high levels they report are within the expected range.[2] Furthermore, contrary to expectations, the incidence figures they report are no lower than in psychiatric wards in the UK.

Clearly abuse of all kinds is a problem and its prevalence in UK hospitals must be diminished. Interestingly the corporate responses to the problem, such as aggression management and de-escalation training, did not, as reflected in this survey at least, appear to protect staff. There was some indication that longer-serving staff might be at less risk – possibly reflecting the fruits of experience, but alternatively that the more vulnerable removed themselves to other areas of work. If staff education and training does not defuse the risk, what other actions can be taken?

There are some limited areas where there may be a strictly medical approach. Gastroenterology wards were chosen in this survey because they have been recognised as providing a higher risk environment for patient and visitor violence, and the effect of alcohol and alcohol withdrawal may well explain that. Meticulous attention to appropriate medication to control withdrawal states would provide some small degree of mitigation. Similarly in the elderly-care wards, confusion and medication change and the effects of infection may all provide medical paradigms for reducing risk. But one can speculate that it is in fact the much more general non-medical triggers to abuse that initiate these outbursts – frustration, fear, waiting, lack of information and, in some cases of violence by visitors, feelings of guilt. Environmental factors – poor lighting, overcrowding between beds, lack of personal space and noise – may all contribute. While scarcely panaceas, the latter factors offer multiple small opportunities for improving the environment in medical wards.

Who should drive these improvements? Events of the last 2 years demonstrate that the answer 'management of course' is inadequate. This must be 'everybody's' problem, as it impacts on the well-being of front-line staff looking after patients at the bedside – even if only a tiny proportion of patients and visitors are the source of the abuse. As already mentioned, the highest rate of violence and abuse was reported against those workers in constant attendance on the wards – the nursing staff and healthcare support workers. Doctors may be relatively protected, and indeed the fact that doctors are less bothered in this way may be inferred from the very low survey response rate among this group (only eight doctors among all those who must have visited the six acute wards over 4 weeks responded). However, the pressure for clinical leadership, the development of the concept of citizenship as discussed by the RCP's registrar[3] and in the Future Hospital Commission[4] all indicate that hospital doctors should actively explore what is happening in their own wards and what can be done in concert with others to mitigate the problem.

References

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