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Magin, P., Adams, J., Ireland, M., Heaney, S., & Darab, S. (2005). After hours care: a qualitative study of GPs' perceptions of risk of violence and effect on service provision. *Australian Family Physician*, 34(1/2), 91–92. <https://researchportal.scu.edu.au/esploro/outputs/journalArticle/After-hours-care-a-qualitative-study/991012821187402368>

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# After hours care

## *A qualitative study of GPs' perceptions of risk of violence and effect on service provision*



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### BACKGROUND

Workplace violence in general practice has been found to be an important problem in the United Kingdom. No research has been undertaken in this area in Australian urban practice.

### METHOD

Four focus groups involved 18 urban general practitioners and over 9 hours of taped responses were transcribed. The transcripts were coded and subjected to thematic analysis.

### RESULTS

General practitioners expressed a wide range of risks relating to the provision of after hours care. This makes them apprehensive about participating in it. Those who had experienced violence, or perceived its risk, had limited their participation in after hours care; sometimes completely.

### DISCUSSION

Structures may be needed to support provision of after hours general practice services.

Workplace violence can be defined as not only physical injury to the general practitioner but also verbal abuse, threatening behaviour, sexual harassment, violence directed toward general practice staff, and damage to property. It has been increasingly recognised as a problem in general practice. Quantitative studies have established its high prevalence in the United Kingdom.<sup>1-3</sup> It is a problem for Australian rural GPs too.<sup>4,5</sup> However, we found no published research on its prevalence in Australian urban general practice.

### Method

We conducted four focus group interviews with 18 GPs over 9.5 hours. We used purposive sampling to include GPs from a range of urban areas and with a range of characteristics: men and women (running two mixed sex focus group discussions, and one all male GP and one all female GP focus group), established doctors, and those relatively new to general practice, and GPs practising within different socioeconomic patient catchments. We also sampled GPs from Rural Remote and Metropolitan Areas (RRMA) classifications 1 and 2 (capital city urban and regional city urban respectively).<sup>6</sup>

Focus groups followed a theme devel-

oped from both previous literature and the study aim, although the discussions were informant led as much as possible. Focus group discussions were recorded and transcribed. Thematic saturation was achieved relatively early, so only four groups were necessary. Each transcript was coded and differences in perspectives were fed back into the analysis to check codes and themes and develop an overall interpretation of the data.<sup>7</sup> This triangulation was undertaken to improve inter-rater reliability (inconsistent, disconfirming or refuting information).<sup>8</sup> Rigour of the analysis was also strengthened by searching for negative cases in code and theme development.<sup>9</sup>

The study was approved by the Human Research Ethics Committee, University of Newcastle.

### Results

Subjects were aged 36-63 years and had spent 4-35 years in general practice. All had participated in after hours care, and all but one still did. Socioeconomic status of practice populations ranged from low to medium-high by GPs' self assessment.

General practitioners consistently considered after hours work to be inherently more

dangerous than in hours work (*Table 1*). They attributed this to a number of factors: after hours arrangements that overuse house calls (perceived to be more dangerous), isolation of the GP (from decreased surgery staffing levels after hours), more after hours patients unknown to the GP, and more violent patients in evidence out of hours.

They thought after hours care provided at small practices (and house calls) was a greater risk for violence than at large corporate ones, where the capacity of the clinics to deal with violence was seen to be superior.

There were a variety of strategies to reduce house call after hours risk: documentation of destination, provision for ‘call in’ with a third party (often a spouse), only doing after hours calls to well known patients, avoiding calls in dangerous (ie. low socioeconomic) areas, refusing calls to suspected drug seeking patients, a companion (especially for women practitioners, often a spouse), and financial disincentive to patients. More common was complete or partial withdrawal from the provi-

sion of after hours care, or substitution with GP after hours cooperatives co-located with hospital accident and emergency departments.

Discussion

There were limitations of this study; it was small and exploratory. However, participating GPs represented a broad range with a spectrum of ages, years in practice, socioeconomic urban practices, and provided a rich set of coherent themes. These themes showed after hours care is seen as inherently dangerous to personal safety; a factor in decreased after hours service provision in urban general practice.

Unlike the United Kingdom, where the National Health Service’s ‘zero tolerance’ campaign has signalled an institutional recognition of occupational violence for health workers,<sup>10</sup> Australia is without such a coherent and coordinated response. Also, unlike other vocational groups at high risk of occupational violence (eg. nurses and emergency ward staff), GPs work in relative

isolation areas. Recognition of this on the wellbeing of GPs and on their provision of after hours care is important and often neglected in the debate on the effect of after hours cooperative clinics on accident and emergency workload and waiting times.<sup>11</sup>

Implications of this study for general practice

- What we already know
- Occupational violence in general practice is a problem in the UK and in rural Australia.
- What this study adds
- Urban Australian GPs also perceive violence as a problem to the provision of after hours care.
  - Risk of violence restricts after hours care.

Conflict of interest: none declared.

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Table 1. Subjects’ quotations

GPs’ perception of risk

But... aggression I’ve experienced has been from people after hours who would normally see other doctors

I think I’d agree that most of the aggressive situations I’ve experienced of people in the context of, say doing some deputising after hours work

Well, certainly doing home visits after hours, at night [is dangerous]...

Those sorts of people tend to come late at night if they want something illicit

GPs’ measures to reduce risk

And even then if it’s in the middle of the night, my husband will come with me. He won’t let me go and he won’t come inside the house but he’ll just say if you’re not out in 5 minutes, I’m coming in

That is to always let somebody know where I’m going, who with, and when I expect to be back... it’s a very important strategy

I thought that I’d discontinue doing that particular job [after hours work] because it just became, too much of a stress, I guess just thinking about possible scenarios

Well, I guess my response to being in a couple of fairly ‘hairly’ situations was just to say well, I’m not going to do this anymore and withdraw

GPs’ selective withdrawal from after hours care

I worked in a housing commission area and there were a lot of very frightening places that I went to visit, even in the day time. I wasn’t going there in the night...

If it is a local person, I occasionally go out after hours or ask them to come to the surgery... I would never go to a house that I didn’t know

One method that the practice used there to try and reduce after hours calls was by putting the fees up... they just cut their numbers down immensely