The risks of clinical practice

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The hospital workplace is changing dramatically, moulded in part by the need to protect medical staff from the increasing physical and mental risks of medical practice today. This article examines the risks and look to the future.

Surely the recent past has seen the extremes of the spectrum of violence in clinical practice offered side by side in the tabloid press? A GP in Kent is stabbed in the back by his patient in a seemingly unprovoked attack while the murderous details of the Shipman case send shock waves of disbelief through the general public and the medical community alike. Where will it end?

It appears that these extremes are uncommon, but rising levels of violence in our society would make it seem inevitable that clinical practice will be affected increasingly by violence in the future. The spectrum of violence also contains non-physical acts (those of aggression which implies a certain element of intent), verbal abuse and the threat of violence.

Many observers maintain that, as a society force-fed images of violence through every avenue available to the media, we have become desensitized to it. Urban deprivation and the ever-widening chasm of social inequality serve to fuel the fires of violence and aggression which are reported with increasing frequency. The desensitization that occurs makes it seem that aggressive behaviour is becoming an acceptable, and, in some situations, even useful form of social interaction.

VIOLENCE IN CLINICAL PRACTICE

Violence and aggression may arise for a variety of different reasons, but there is a significant connection between violent behaviour, traumatic experience and substance abuse (Dunnegan, 1997). Emerging evidence from the study of Vietnam veterans that aggression is a distinct and prevalent entity in post-traumatic stress disorder further supports this link (Yehuda, 1999).

For the more elderly patient, violence and aggression are often a consequence of dementia and once the arguably difficult distinction between aggression and agitation has been made, management strategies for the long-term care of these individuals can be put in place. The risk to the clinician is usually far less from the elderly demented patient than from the agitated psychotic younger patient.

The concept of dangerousness will be more familiar to those in psychiatric practice. The psychiatrist is often, as part of his or her daily routine, required to make a formal assessment of whether a patient is dangerous or not, so that the best interests of the patient and others may be protected.

Also, the psychiatrist is often asked to assess offenders under consideration of release and as professionals they are invariably the target of criticism when individuals reoffend. The assessment of dangerousness is an unquantified science and there are few predictors of violence that are of proven value. The best criterion in assessing the risk of violence from any individual appears to be whether or not they have been violent in the past (Scott, 1999).

The accident and emergency department is a common site for violence and aggression in the hospital setting and it is an issue which has received much attention in the recent past. Figures released by the Health Services Advisory Committee (HSAC) in 1997 (HSAC, 1997) led the Secretary for Health to describe nursing as being the most dangerous profession in the UK. The accident and emergency environment is a highly stressful one where clinicians may be exposed, on a 24-hour basis and with a low level of security on site, to attacks from patients affected by alcohol, drugs or mental illness. The

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local police on standby are now an ever-present part of accident and emergency life and most main hospitals have now substituted the uniformed security guard for the helpful porter.

For most medical practitioners outside the fields of forensic psychiatry or accident and emergency, the impact of violence in their clinical lives is at a lesser level. The aggressive patient with no readily identifiable reason for this behaviour, such as mental illness or substance misuse, is often labelled as the 'difficult patient' or the 'complainer'. In this situation, it is clearly of interest to understand the common causes of this aggression against the doctor, who is simply attempting to benefit the patient.

As humans, it is said that we often display that which we are most fearful of. The school bully, while displaying violence, is fundamentally fearful of it and it is of some additional concern that a recent article (Kattiala-Heine et al, 1999) has highlighted the excessive morbidity and mortality suffered by bullies in later life.

Similarly, the attending practitioner must realize that much of the aggression displayed by patients (or their relatives) might be a consequence of fear — fear of the effects of their disease, for their future or of their impending treatment. This aggression serves as a mask to hide the true identity of the patient's emotions from the doctor.

The perception by patients that they are no longer in control of their own future is a common reason for fear. The doctor, by dint of his/her position and what he/she is trying to achieve as he/she treats the patient's disease, may inadvertently take control away from the patient who may find himself or herself in a novel and frightening position. Fear such as this is 'freefloating' and imbued with panic. It is but a short step for this to be manifest as aggression against the doctor who, quite reasonably, may be offended or hurt by the behaviour of the patient he/she is trying to help.

Currently undergraduate medical training offers little in the way of education in counselling skills, interpersonal relationships or psychology, and so the doctor often finds him/herself poorly prepared to avoid the pitfalls of generating or failing to recognize fear in his or her patient and is poorly equipped to deal with the aftermath.

The doctor–patient relationship is one of privilege on both sides. A fundamental component of the relationship is trust, enshrined since the Hippocratic oath in the aphorism 'first do no harm'. The patient is privileged to be able to see a doctor, while the doctor is privileged that the patient is asking for help and that he or she is in a position to provide help. When the patient commits a violent or aggressive act towards the doctor — or vice versa — it stands to reason that the conventional doctor–patient relationship has been disrupted.

When the patient is mentally ill, demented or has a drug-dependent illness, the expression of violence is a manifestation of his or her illness and therefore the practitioner at the receiving end should continue in his/her care, which should be unaffected by his/her personal views of the patient.

When there is no medical explanation for violent behaviour, the medical profession, supported by the General Medical Council, has taken an increasingly robust stand, where the doctor's right to practice his/her profession without fear of attack is upheld. Such patients may be taken off a GPs list and be required to register with another practice.

ADDICTION IN CLINICAL PRACTICE

As drug misuse in society increases, doctors are increasingly faced with the consequences. Inebriated or 'high' patients in the accident and emergency departments are a part of everyday life for the junior doctor. Common new clinical syndromes have emerged. The 'Saturday night fever' (hyperthermia in association with ecstasy usage) is now well recognized. Surgical teams will be familiar with injection site abscesses and thromboembolic complications of intravenous drug misuse. Casualty staff need to be familiar with the administration of naloxone and the resuscitation of the unconscious and narcosed patient. There is a significant workload and resource implication to metropolitan surgical units providing care to inner city drug abusers (Keshtgar et al, 1998).

It has been said light-heartedly that a patient was drinking too much if he drank more than his doctor. In the past, social drinking was often the precursor of alcoholism, whereas it is now recognized that more doctors turn to drink to escape from the pressures of the job. The easy availability of drugs in medical practice has exposed the clinician to the equally disastrous risk of drug addiction.

As the policing bodies of the world accept that the war against drugs on the street is all but lost, with levels of supply, demand and usage constantly escalating; the availability of medical drugs, particularly opiates, has allowed a constant source for the addicted doctor. Anaesthetists and GPs have perhaps the most immediate access among all clinicians to opiates.

The menace of addiction, however, comes in many forms and regular reports of doctors addicted to narcotics filter through the press to the public. In summer 1999, a south London GP was pictured smoking crack cocaine on the front page of a daily paper. In Spain, an anaesthetist addicted to heroin was discovered to have infected many of his patients with the hepatitis B virus as he administered the remaining contents from the syringe he had used himself into the anaesthetized patients. One of the aspects in the recent murder trial of Dr Shipman to cause great outrage was the fact that he had, years previously, been convicted of pethidine misuse.

INFECTION IN CLINICAL PRACTICE

For clinicians involved in exposure-prone procedures, in particular those involved in surgery, anaesthesia, interventional radiology and accident and emergency, acquired infection from needlestick injury remains a constant concern. Historically, the commonest acquired infection has been hepatitis B but this risk has been all but eliminated with the obligatory requirement for several years now that all clinicians, including medical students in training, should submit proof of hepatitis B immunization with an adequate antibody titre.

Isolated examples continue to be reported of clinicians, usually in the fields of surgery or gynaecology, who have falsified documentation on their hepatitis B status. The response of the General Medical Council in striking off practitioners guilty of falsification of their hepatitis B status reflects the seriousness with which the profession regards this risk of clinical practice.

The possible transmission of human immunodeficiency virus (HIV) and hepatitis C, for which immunization is not currently available, remains a concern for clinicians involved with invasive procedures. The relatively low infectivity and seroconversion rates for HIV have gone some way to reassuring clinicians working with this group of patients. Nevertheless, the risk of seroconversion following a hollow needlestick injury with blood from a patient infected with HIV is in the region of 1 in 300. Prophylactic antiretroviral therapy should reduce this risk, but even with prompt commencement, prophylaxis will not prevent seroconversion in all cases (Duff et al, 1999).

Psychological trauma from needlestick injury has also been reported. A recent case attracted wide publicity when a junior doctor received compensation of almost half a million pounds, although there was no transmission of infection, because of the phobic mental state which followed her needlestick injury and which allegedly ruined her career.

CONCLUSIONS

As society becomes evermore complex and social mores change at an increasing rate, the risks of clinical practice — both to the doctor and the patient — will inevitably increase. The need for education in the various sociopathological issues relating to risk is mandatory both for today's doctor and for the medical student who will become tomorrow's doctor. In addition, psychological support and counselling for those clinicians in the front-line specialties need to be developed and refined if we are to ensure that the risks of clinical practice do not exert too heavy a toll on the profession. HM

Conflict of interest: none.

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KEY POINTS

- Medical personnel face increasing levels of violence in the workplace, increasing exposure to serious infections and serve a population in which drug and alcohol addiction have become commonplace.
- Psychological support and counselling should be available for those affected by traumatic events.
- There is an increasing requirement for security in all hospital in order to protect medical staff.