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In harm's way: The impact of workplace aggression in Australian clinical medical practice

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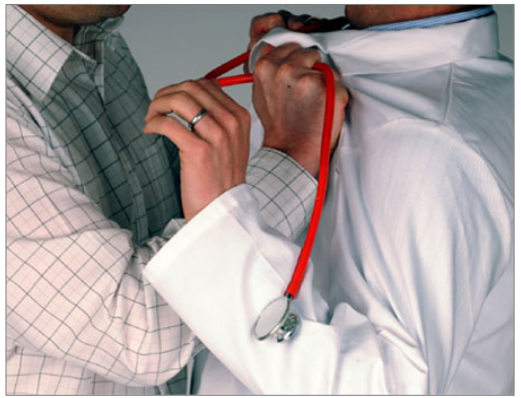
breakthrough

Acknowledgements

- **PhD research supervisors, Monash University**
  - Associate Professor Catherine Joyce
  - Emeritus Professor John Humphreys
- **CRE in Medical Workforce Dynamics**
  - Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey
  - Participating Australian medical practitioners

Background

- **Limited significant research:**
  - Prevalence
  - Predictors
  - Impact
- **Most studies have focused on:**
  - Prevalence of patient aggression
  - General practice
- **Little evidence on prevention and minimisation**



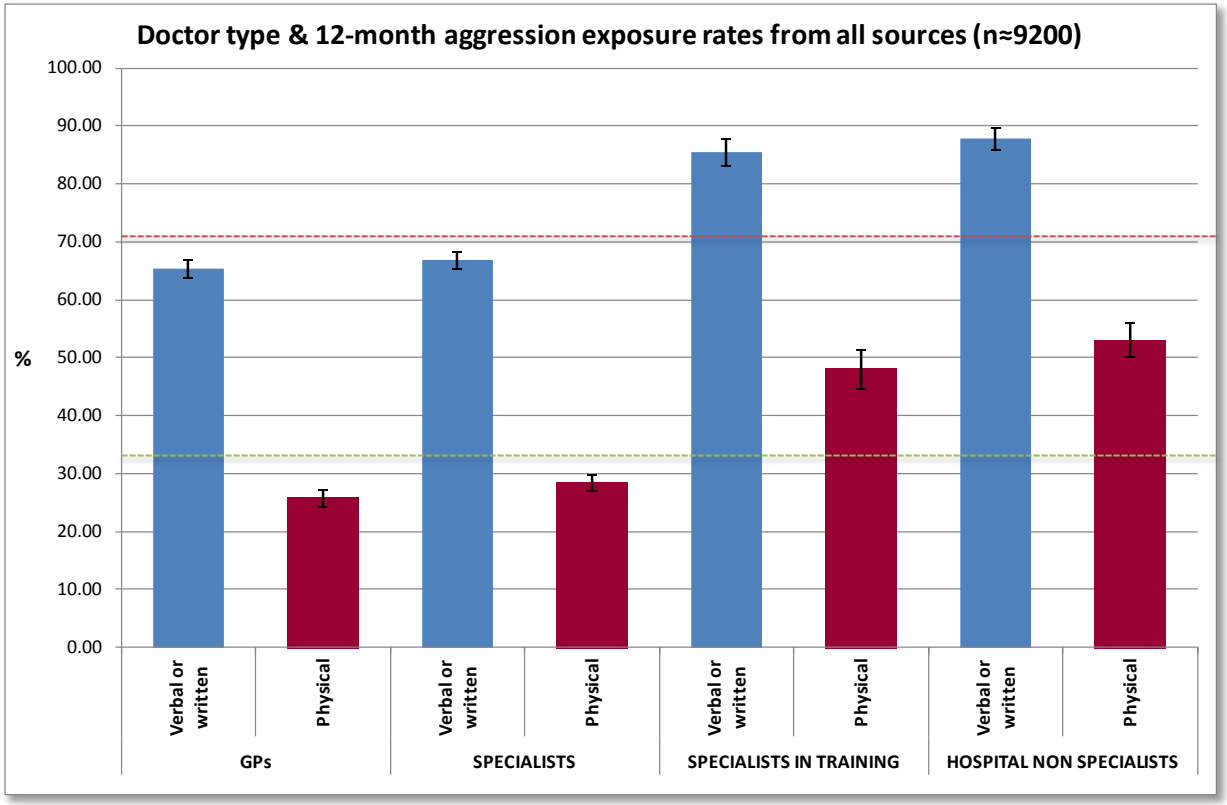
Workplace aggression study

- **Wave 3 of MABEL survey, 2010-2011 (n=9449)**
  - Prevalence of workplace aggression
  - Point-prevalence of aggression prevention and minimisation strategies
  - Key risk and protective factors for exposure
  - Associations with job satisfaction, satisfaction with life and self-rated health
  - Associations with workforce participation intentions

Definition

- **Verbal or written abuse, threats, intimidation or harassment**
  - Such as ridicule, abusive email, racism, bullying, contemptuous treatment and non-physical threats or intimidation
- **Physical threats, intimidation, harassment or violence**
  - Such as a raised hand or object, unwanted touching, damage to property and sexual or other physical assault

Prevalence by doctor type



70.6% verbal or written

32.3% physical

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Other findings

- **Prevention and minimisation actions**
  - Differences across doctor types and age-related
  - Lower rates for some of the easier strategies
- **Key protective and risk factors**
  - Protective: Age, internal control orientation and optimised patient waiting conditions
  - Risk: Hours worked, unpredictable work hours, poor support network, unrealistic patient expectations, patients have complex health and social problems

Impact

- **Internal and external aggression**
- **Logistic regression modelling, controlling for:**
  - Doctor type, gender, age, international medical graduate status, mastery (control orientation), rurality, main practice sector (eg public, private)
  - Annual leave taken, usual hours worked, difficulty taking time off, poor support network of other doctors
  - Majority of patients have unrealistic expectations, have complex health and social problems

Well-being

Outcome	Predictor	Odds Ratio (95% CI)
Intrinsic job satisfaction		
(very satisfied vs. not very satisfied)	Internal aggression	0.59 (0.53 - 0.66)
	External aggression	0.75 (0.67 - 0.84)
Satisfaction with life in general		
(very satisfied vs. not very satisfied)	Internal aggression	0.67 (0.60 - 0.76)
	External aggression	0.87 (0.78 - 0.98)
Self-rated health		
(excellent vs. not excellent)	Internal aggression	0.86 (0.77 - 0.96)
	External aggression	0.83 (0.74 - 0.92)

Adjusting for doctor type, gender, age, mastery, international medical graduate status, rurality, annual leave taken, hours worked, work location, support variables, patient expectations & complexity

Workforce participation intentions

Outcome	Predictor	Odds Ratio (95% CI)
Reduce clinical workload in next 5 years		
(likely / very likely vs. neutral / unlikely / very unlikely)	Internal aggression	1.12 (1.00 - 1.25)
	External aggression	1.13 (1.01 - 1.27)
Leave patient care within 5 years		
(unlikely / neutral / likely / very likely vs. very unlikely)	Internal aggression	1.20 (1.07 - 1.34)
	External aggression	1.16 (1.04 - 1.30)
Leave medicine entirely within 5 years		
(unlikely / neutral / likely / very likely vs. very unlikely)	Internal aggression	1.20 (1.06 - 1.35)
	External aggression	1.06 (0.95 - 1.19)

Adjusting for doctor type, gender, age, mastery, international medical graduate status, rurality, annual leave taken, hours worked, work location, support variables, patient expectations & complexity

Conclusions

- **Workplace aggression inherent in clinical practice**
  - Younger and hospital-based clinicians at higher risk
- **Prevention and minimisation efforts**
  - Variable, more likely reactive than proactive
- **Negative impacts**
  - Job satisfaction, satisfaction with life, self-rated health
  - External aggression with clinical workload decisions
  - Internal aggression with patient care & career decisions

Potential outcomes of exposure

- Threats to the safety and quality of care
- Threats to organisational performance
- Reduced access to clinical care

Overall implications

- **Risk of exposure can be reduced:**
  - Currently undermanaged (proactive vs. reactive)
  - Need to consider clinician knowledge and skills, personal profile factors, work conditions and resources
- **Enhance legislation and policy:**
  - Strengthen work health and safety legislation
  - Strengthen enforcement
  - Skills development
  - Incentives and accountability for minimising risk
- **Research to enhance the evidence base**

Publications – workplace aggression

Hills, D. (2008). Relationships between aggression management training, perceived self-efficacy and rural general hospital nurses' experiences of patient aggression. *Contemporary Nurse*, 31(1), 20-31.

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Hills, DJ, Joyce, CM & Humphreys, JS (2013). Workplace aggression prevention and minimisation in Australian clinical medical practice settings – a national study. *Australian Health Review*, *37*(5), 607-613. doi: 10.1071/AH13149.

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Thank you

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