
PERSONAL SAFETY AND PRIVACY FOR DOCTORS

2005

Preamble

The AMA recognises that violence against doctors is a growing concern. This Position Statement is provided in an effort to reduce the vulnerability of medical practitioners to physical harm in all locations or settings in which they practise or may be exposed to personal danger arising from their professional work as doctors. It is recognised that there will be wide variation in the level of risk, the practicality of protective measures for prevention of threats to personal safety and the availability of emergency help when such threats do arise.

The statement is framed within a risk management approach, focussing on risk identification, risk assessment, risk control and evaluation of the effectiveness of risk management strategies. It is intended to guide the violence management efforts of hospitals, practice managers and individual doctors – these parties should also keep up to date with current literature on the subject.

Scope

Standard workplaces for doctors include public and private hospitals, other health and aged care facilities and private practices. Many doctors work shifts and many provide after hours services and home visits to patients in the community. Some doctors attend accident scenes and other locations requiring travel by vehicle, boat or aircraft. There is obviously a wide range of workplaces.

Some of these workplaces, such as major hospitals, are able to provide formal protective measures in terms of both prevention of and responses to violence against doctors and other staff. Others, such as small hospitals and private practices, cannot provide the same sorts of formal protective measures, but they should apply the principles set out in this statement in regard to the personal safety and security of doctors. In these smaller workplaces the risk of violence may be lower, but the impact of it is likely to be higher when it occurs because of the lack of immediate response and assistance from security staff or police. This also applies where doctors are working on their own, particularly outside static workplaces, for example on home visits or emergency callouts.

In addition, there are times when the process of consultation and treatment of medical conditions can involve the transmission of deeply sensitive information regarding both the patient and other individuals. Such information generally remains private between the parties, but in some circumstances statutory obligations will require the doctor to convey appropriate information to the relevant authority. This can include information regarding infectious diseases, fitness to drive motor vehicles, etc. The repercussions of these obligatory disclosures can be profound for the patient and, where there is emotional or psychological instability, for others. Doctors involved in these work situations may find themselves faced with threats to their personal safety even while at home or otherwise going about their private business. Thus occupational safety strategies for doctors may need to address risks outside the workplace.

Managing Risk

Every State and Territory has occupational health and safety (OH&S) legislation that places on employers a general duty of care to provide and maintain a safe and healthy workplace. The legislation also assigns to each employee a duty to take reasonable care for their own health and safety, as well as for the health and safety of others who may be affected by that employee's acts or omissions at the workplace.

Violence risk management needs to take into consideration the work environment as a whole. To be successful it requires the commitment of management through sufficient investment of time, money and personnel. This includes commitment to regular audits of the organisation's vulnerability to violence to inform risk management planning.

Consultation with staff is essential for violence risk management planning to be effective. A risk management methodology can be used in conjunction with the detailed knowledge of staff in the local work environment to develop tailored solutions to violence problems. It may be appropriate to assemble a working group of staff to develop a violence risk management plan.

1. Risk Identification

- 1.1 The identification of risks in relation to violence should take into account information from workplace inspections and security assessments, incident and accident reports/investigations, Workers Compensation records, complaints, and other information obtained from staff and users of healthcare facilities.
- 1.2 A system should be in place for reporting violent incidents and staff should be encouraged to report all violent or aggressive incidents that have endangered, or have had the potential to endanger, a staff member's safety.

2. Risk Assessment

- 2.1 Assessments of identified risks should be undertaken to arrive at ratings of both the likelihood of each risk occurring and its impact. These ratings should be used to ascertain the level of each risk so that the relative priority of actions to deal with these risks can be determined.

3. Risk Control

The resourcing and timing of steps to control (eliminate or minimise) risks should reflect the level of each risk as identified through risk assessment. Risk control should include, but not be limited to, the following:

Policy on Violence

- 3.1 The organisation should develop a zero tolerance policy regarding the management of violence and ensure that staff understand it.

Complaints Mechanism

- 3.2 A complaints mechanism should be available for staff and users of healthcare facilities in order to encourage problems to be addressed in a non-violent manner.

Physical Environment

- 3.3 Surroundings should be made as comfortable as possible for users of health care facilities to help lower distress amongst those with health concerns.
- 3.4 There should be sufficient lighting inside and in the immediate vicinity of the hospital to provide a safe and secure working environment.
- 3.5 External doors should be locked at night with only the main entrances, which should be under staff surveillance, left open for public access.
- 3.6 Staff should have access to secure lockers in which valuables can be stored while working.
- 3.7 Sufficient car parking spaces should be available to provide for all doctors rostered on at any particular time or likely to be called in, including specific doctors' parking for on call/after hours work. These spaces should be within close proximity of the area of the building in which the doctor is working, sufficiently well lit to provide secure access at night, and reserved for staff use only.
- 3.8 Staff only areas (including staff office areas, staff common rooms, and other restricted areas) should be accessible only via restrictive access devices such as card keys with photo identification.
- 3.9 Video surveillance in appropriate areas should be considered and, where implemented, signs should be prominently posted advising of its presence to maximise its deterrence value.

Personal Protection

- 3.10 Duress alarms should be provided where practicable for doctors exposed to higher-risk situations, including doctors working in mental health treatment areas, emergency departments and in settings where there is little organisational backup or delays in getting emergency help, such as after hours surgeries. Duress alarms should also be provided in Resident Medical Officer quarters and in hospital corridors assessed as dangerous.
- 3.11 Where doctors are required to walk significant distances to their cars or walk to their cars at night, an escort should be available upon request to facilitate a safe passage.

Protecting Personal Privacy

- 3.12 Employers must ensure that the personal privacy of doctors is protected, particularly sensitive details such as private address and contact numbers. This is particularly important in situations where the nature of doctors' work places them at risk of harassment and violence from unstable or maladjusted patients.
- 3.13 The AMA's position in relation to the personal privacy of doctors is as follows:
1. It is a fundamental right for the occupational health and safety of medical practitioners providing services to patients, in any setting, for the personal private details of doctors, including residential address, to remain strictly confidential.
 2. OH&S principles, as they relate to medical practitioners, require strict observance of the doctor's need for personal privacy. Further, under no circumstances should a doctor's contact address provided to an employer or Medical Board be made publicly available or be included in publicly accessible databases by medical practitioner registration boards or similar authorities unless the doctor has expressly consented to have the information made available.
 3. Any disclosure of a doctor's private personal information, including private residential address, by an individual, agency or authority, from either the public or private sector, is a clear breach of OH&S principles as they relate to medical practitioners.

Education and Training

- 3.14 Doctors, other healthcare staff, patients and their visitors should be provided with information regarding behaviour expected of them in a health care setting.
- 3.15 Staff should be provided with a copy of the organisation's policy on violence and understand what action they should take to address concerns that may arise.
- 3.16 Staff should be given appropriate training to assist with the management of violence. Preventative approaches should be covered as part of such training, including the skill of projecting a pleasant manner to help prevent feelings of resentment and alienation on the part of users.
- 3.17 Staff should be provided with information regarding the identification and assessment of risks in relation to violence in their work environment, as well as control measures to address the risks.

Home Visits

- 3.18 Guidelines should be in place to protect doctors undertaking home visits. These may include, for example, providing security escorts upon request, keeping timetables recording details of doctors' client visits, reporting in at the end of each visit, following predetermined procedures if doctors become uncontactable or do not check in when expected, and ensuring that they carry a duress alarm and/or mobile phone (GPS-linked if necessary) during visits.

Additional Security Measures

- 3.19 Additional security measures should be taken to protect doctors working late hours (for instance, in after hours surgeries), in settings where they are on their own or where emergency help is not quickly available and in places where drugs are stored or being distributed. An example in relation to the latter would be to reposition drugs cabinets so that they are within view of as many staff as possible during the course of their work to deter violent incidents.

Post-incident Management

- 3.20 Post-incident management activities should include post-incident support (such as first aid, medical attention, and incident debriefing), incident reporting, and incident investigation activities which include recommendations to help prevent future recurrence.

4. Monitoring and Evaluation

- 4.1 Continuous monitoring and evaluation of outcomes needs to be undertaken to assess the effectiveness of the risk management strategies that have been implemented. The outcomes of such evaluation should be reflected in updates to violence risk management plans.

Resources

Some useful sources for more information include:

- ACT WorkCover (2000), *Guidance on Workplace Violence* (available through www.workcover.act.gov.au).
- Delaney J (2001), *Prevention and Management of Workplace Aggression: Guidelines and Case Studies from the NSW Health Industry*, Central Sydney Area Health Service, Sydney (available through www.workcover.nsw.gov.au).
- Job Watch and WorkSafe Victoria (2003), *Workplace Violence and Bullying: Your Rights, What to Do, and Where to Go for Help* (available through www.workcover.vic.gov.au).
- Mayhew C (2000), *Preventing Client-Initiated Violence – A Practical Handbook*, Research and Public Policy Series, no. 30, Australian Institute of Criminology, Canberra (available through www.aic.gov.au).
- Mayhew C and Chappell D (2001), *Prevention of Occupational Violence in the Health Workplace, Working Paper Series no. 140*, UNSW, Sydney (available through www.health.nsw.gov.au).
- NSW Department of Health (2003), *Zero Tolerance Policy and Framework Guidelines*, NSW Government (available through www.health.nsw.gov.au).
- NT WorkSafe (2000), *Work Environment – Violence in the Workplace* (available through www.worksafe.nt.gov.au).
- QLD: The Queensland Workplace Health and Safety Board is developing a *Workplace Violence Advisory Standard* which is expected to be issued during 2004.
- WorkCover Authority of NSW (2002), *Violence in the Workplace: Guide 2002*, WorkCover NSW, Sydney (available through www.workcover.nsw.gov.au).
- WorkCover Corporation of South Australia (2002), *Guidelines for Reducing the Risk of Violence at Work* (available through www.workcover.com).
- WorkCover Tasmania (2003), *Violence at the Workplace* (available through www.workcover.tas.gov.au).
- WorkSafe Western Australia (1999), *Code of Practice: Workplace Violence* (available through www.safetyline.wa.gov.au).