

Healthcare professionals' perceptions of alcohol-intoxicated trauma patients: Implications for healthcare delivery at South Rand Hospital Emergency Department

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Keywords: perceptions, healthcare professionals, alcohol, intoxicated, assaulted, emergency department

Abstract

Objectives: The objectives of this study were to explore healthcare professionals' (HCPs) perceptions about patients who had been assaulted, who consult under the influence of alcohol, and to make them aware of their attitudes towards these patients, with a view to improving their care.

Design: An explorative, descriptive study with 15 HCPs purposively selected across professional categories, qualifications, work experience, gender and age. These HCPs participated in four focus group interviews on intoxicated patients who had been assaulted. The interviews were audio-taped and supplemented with field and observational notes. Themes were identified using the cut-and-paste method and grouped into categories. Findings were subjected to mental triangulation, peer review and member check, and were compared with those in the literature.

Settings and subjects: HCPs who treat assault patients within the emergency department (ED) of South Rand Hospital, Rosettenville, comprised the study population. They expressed their perceptions and inner feeling about patients under the influence of alcohol who had been assaulted. Interviews were carried out in the boardroom of the hospital.

Outcome measures: HCPs' awareness of their attitudes towards assaulted patients under the influence of alcohol.

Results: Frustration, anger, a desire to punish intoxicated patients and concern about wastage of hospital resources were some of the stressors experienced by HCPs. Exposure to health hazards and a poor security system were concerns that arose following intimidation, aggression and verbal abuse from alcohol-intoxicated patients who had been assaulted.

Conclusion: HCPs experience negative emotions and develop negative attitudes in response to alcohol-intoxicated patients who have been assaulted.

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S Afr Fam Pract 2013;55(4)398-402

Introduction

Alcohol intoxication is one of the leading causes of morbidity and mortality in South Africa and has been shown to increase the incidence of trauma through its ability to alter behaviour and impair motor performance.¹ From 1999-2001, between 43% and 90% of victims presenting to hospital trauma units in Cape Town, Durban and Port Elizabeth tested positive for alcohol.² Alcohol was used historically in South Africa by mine owners as a means of labour mobilisation and control within the migratory work system during colonial and apartheid rule.³ In addition, it was a means used with which to encourage dependency among the workers and a way of relaxing after a hard day's work.³

Findings from family, twin and animal studies have shown that vulnerability to alcoholism is determined by a complex

interaction of genetic and environmental factors.⁴ At individual level, alcohol misuse is likely to be associated with several factors, including genetics, personality, gender, power needs, a predisposition to taking risks and self-destructiveness.³ Socio-economic factors, such as poverty, urbanisation, delinquency, family background, peer pressure and unemployment, also impact on drinking behaviour.⁵

Harm that occurs with alcohol intoxication includes psychomotor impairment of balance and movement, both of which increase the risk of accidents and injuries. Damage to judgement also results in dangerous risk taking and aggressive behaviour. Problematic alcohol consumption is associated with an increased risk of experiencing violence too. Those reporting more frequent intoxication are more likely to be involved in an alcohol-related assault, either as perpetrators or as victims.⁶

The closure of Johannesburg General Hospital to level 1 and 2 patients in 2008 led to patients being redirected to other hospitals, including South Rand Hospital in Rosettenville. Consequently, South Rand Hospital witnessed an upsurge in the number of admitted patients, especially in acute trauma cases. Most of these trauma patients are intoxicated with alcohol, and often place enormous emotional and physical pressure on the healthcare professionals (HCPs) who have to deal with their medical and behavioural problems. Data on alcohol-intoxicated trauma patients' encounters with the health system are very limited in South Africa and have often excluded HCPs' perceptions and experiences at district hospitals. Therefore, we used a qualitative design to explore HCPs' perceptions of alcohol-intoxicated patients who had been assaulted at South Rand Hospital, in the hope that the understanding provided by this study will assist in increasing HCPs' awareness of their experiences and attitudes, and also assist health managers in planning healthcare delivery to this common subset of patients in South African district hospitals. This article reports on the findings and discusses the implications for healthcare delivery.

Setting

This study was conducted at South Rand Hospital, Rosettenville, Johannesburg, a 282-bed district hospital with an academic Department of Family Medicine linked to the University of the Witwatersrand. It comprises an emergency department (ED) rendering 24-hour services, several ambulatory clinics and 10 wards for surgical, medical, paediatric, rehabilitative and psychiatric service admissions. On a typical week day, there are two doctors on duty in the ED until 16h00, and another pair of doctors from 16h00 until 08h00. The nurses work 12-hour shifts. Two registered nurses and one enrolled nurse are on duty at a time.

Method

All the doctors and nurses caring for patients in the ED in South Rand Hospital constituted the target population. The adopted sampling strategy entailed selecting HCPs who were willing to participate and able to express their perceptions and feelings about assaulted patients who were under the influence of alcohol. Fifteen participants (nine doctors and six nurses) were purposively selected across professional categories, qualifications, work experience, gender and age.

Four focus group interviews were conducted in English by the researcher (two for doctors and two for nurses), each consisting of 3-5 participants. The interviews lasted between 45 and 60 minutes, and started with an exploratory question: "Tell me in your own words how you feel about assaulted patients who are under the influence of alcohol when you have to attend to them". The researcher then facilitated the discussions, which were audio-taped and supplemented with field notes.

The audio-taped interviews were transcribed verbatim and cross-checked by a peer for correctness. Themes were then identified from individual transcripts by the researchers, using colour coding and the cut-and-paste method. The themes were systematically coded and a list of categories was created. The results were integrated with the information from the field notes to enrich and clarify the data. A model that combined the themes from the four interviews was created to show the interrelatedness thereof. In order to ensure credibility, two members of the team read all the interview transcripts and each member constructed independent interpretive summaries of the interview in order to achieve consensus. Findings were subjected to peer review and member check and were compared with the existing literature.

Written informed consent was obtained from participants before starting the interviews. Participants' confidentiality was ensured by using anonymous quotes in the results. Only the research team and participants had access to the data. Ethics approval and permission were obtained from the Research Ethics Committee of the University of Pretoria, and the Chief Executive Officer of South Rand Hospital, respectively.

Results

A total of 15 HCPs participated in the four focus group interviews. The participants' characteristics are summarised in Table I.

The identified themes from the interviews were:

- Emotional expression of HCPs.
- Challenges facing HCPs.
- Wastage of state resources.
- Safety concerns.

The subthemes are summarised in Table II.

Emotional expression of healthcare professionals

Emotions expressed by the HCPs when encountering alcohol-intoxicated assaulted patients included feelings of frustration, anger, depression and intimidation. Working with intoxicated patients who had been assaulted was very frustrating because of the patients' behaviour, the heavy workload and long working hours: "Levels of frustration are very high, and most of our time is dedicated to people who are drunk and who have been assaulted". Frustration resulted because these difficult patients demanded the HCPs' time and attention, and also took time away from other patients who could have benefitted more from the HCPs' care. A common view was that alcohol-intoxicated patients were more prone to injuries, brought it upon themselves, got what they deserved, and that it was useless to treat them as they would never learn and were likely to incur repeated injuries and visits to the ED.

Table I: Summary of the demographic data of the participants

Gender	Age range (years)	Qualifications	Experience
Focus group 1			
Male 1	45-50	MBChB, MFamMed, Principal Family Physician	21 years
Male 2	25-30	MBChB, Registrar, Family Medicine	3 years
Male 3	25-30	MBChB	3 years
Female 1	40-45	MBChB, Registrar, Family Medicine	16 years
Female 2	40-45	MBChB, Registrar, Family Medicine	6 years
Focus group 2			
Male 1	30-35	Assistant Nurse	4 years
Female 1	25-30	Registered Nurse	3 years
Female 2	20-25	Registered Nurse	2 years
Focus group 3			
Female 1	25-30	MBChB	4 years
Female 2	40-45	MBChB, DipTropMed	14 years
Male 1	35-40	MBChB	10 years
Female 3	30-35	MBChB, DipHIV, DMH, Registrar, Family Medicine	8 years
Focus group 4			
Female 1	30-35	Diploma in Human Resources Management, Diploma in Bookkeeping, Diploma in Psychiatric, Community and Midwifery, Registered Nurse	8 years
Female 2	25-30	Registered Nurse	2 years
Female 3	30-35	Registered Nurse, Trauma-Trained Sister	8 years

DMH: Diploma in Tropical Medicine and Hygiene, DipHIV: Diploma in HIV Care, DipTropMed: Diploma in Tropical Medicine, MBChB: Bachelor of Medicine and Bachelor of Surgery, MFamMed: Master of Family Medicine

Anger was exemplified by the statement: "When I come to work, I come to help people who really need help, but I'm forced to concentrate on these ones (intoxicated patients)". Anger caused some HCPs to punish such patients: "You have about 30 patients on your hands, and somebody expects you to make use of lignocaine on these alcoholic patients. I decided that once these people come in, I need not use any of the local anaesthetic. I did that until I started studying Family Medicine". Other HCPs found it easier to ignore the intoxicated patients and to continue with their duties: "In my case, for those patients who are drunk and

Table II: Themes and subthemes

Emotional expression of healthcare professionals
<ul style="list-style-type: none"> • Frustration • Anger • Reaction of the staff (stitching without local anaesthesia) • Intimidation from aggression (swearing, shouting and insults)
Challenges facing healthcare professionals
<ul style="list-style-type: none"> • Recurrent problems • Medico-legal issues • Shortage of staff • Exposed to health hazards • Language barriers
Wasting of state resources
<ul style="list-style-type: none"> • Free treatment • The mobilisation of more resources
Safety concerns
<ul style="list-style-type: none"> • Escorts • Poor security system

insulting us, what I normally do is ignore therapy. That helps me because I do not become emotionally involved to an extent that I end up exchanging insults with these people". Although negative emotions were experienced, HCPs still had a strong sense of professional obligation and loyalty to the ethos of care, which enabled them to continue caring for these patients.

Most of the HCPs experienced aggression, especially during night shifts. Male patients tended to be aggressive towards female HCPs, and verbal abuse was the most common type of experienced aggression: "When you are busy suturing them, they continue swearing at you".

Challenges facing healthcare professionals

Most assaulted intoxicated patients are likely to incur repeated injuries and visits to the ED: "The assaulted patients who you see in January are the same ones who you will see two weeks later, in the same month. You will see them in February again, and so forth. It is the same patients that you will continuously see". Initial assessment of these patients was usually very poor because they were often uncooperative and participants found it very taxing to work under these conditions: "In a small district hospital you are expected to do everything, stitch them and put up intravenous lines and the nurses just run around, just to bring everything that you need".

HCPs reported that they were exposed to needle-prick injuries while dealing with intoxicated patients who had been assaulted: "It is difficult to deal with these patients when you are suturing them, and they are not cooperative. You explain what you are going to do, and once you start to administer the local anaesthetic, then that is when they start to fight you and you end up getting injuries in the process".

Respondents reported that sometimes communication was a problem when they took the patients' history, or when

they gave instructions to patients who could not speak any of the local languages.

Wastage of state resources

There is a perception that intoxicated patients waste state resources as their hospital attendance imposes a high economic burden on the hospital through ambulance costs, ED treatment, medication, and hospitalisation, transfer and administrative costs. All these impact heavily on the state and taxpayers: "In terms of the Department of Health or the hospital budget, it's a total waste of money because someone decided to get drunk and fool around and end up getting assaulted or assaulting others. So a lot of money ends up being spent on things that are irrelevant".

Safety concerns

Patients' escorts were perceived to interfere with HCPs' work and safety by creating a high volume of traffic of people moving in and out of the ED. This causes chaos and confusion in an overcrowded environment: "You find that the patient is intoxicated, and is accompanied by a group of people who are also intoxicated. They crowd the area in which we have to work. Most of them arrive in a group and exaggerate the injury of the patient. So, basically, we are dealing with a group of aggressive people. They swear at you and sometimes force their way into casualty. You become scared. These people overpower our security guard at the gate, and when they come in, they simply tell security : "We want to go in because our brother has been stabbed".

The security system is perceived to be inadequate in controlling escorts, making it unsafe and frightening to work at night, especially on weekends and during night shifts. Since security guards are not armed and are mostly women, one HCP said: "I wish that they would put in an electronic gate that will limit their movements in and out of casualty".

Discussion

This study found that alcohol-intoxicated patients who had been assaulted evoked negative emotions in HCPs, which included feelings of frustration, anger, depression, aggression and intimidation. These negative emotions resulted from perceived negative behaviour associated with alcohol intoxication. This behaviour has been reported in several studies from other settings,⁷⁻⁹ according to which between 30 and 95% of ED nurses have experienced verbal or physical aggression, either daily or within the last 12 months, or at any time during their careers. If not addressed properly, these negative emotions and experiences have the potential to adversely affect the client-provider relationship, the well-being of the HCPs and the quality of health care that is rendered to these patients.

Burnout has been associated with low performance and productivity, poor well-being and poor job satisfaction.¹⁰ HCPs are at risk of developing emotional distress, which if not addressed, could lead to high rates of absenteeism or HCPs leaving their profession. This is a situation that South Africa can ill afford to have, given the perennial shortage of HCPs. Therefore, programmes which assist HCPs to regularly dissipate negative emotions are urgently needed to mitigate against these negative perceptions. They may include periodic debriefing, counselling and ongoing psychosocial support, all of which have been shown to be effective in the management of professional burnout.¹¹ More HCPs should be recruited to alleviate staff shortages in the hospital in the hope that this will relieve the already overburdened HCPs, and reduce the emotional stress that arises from their work.

Neglecting to address these negative emotions and perceptions could lead to poor quality of care and the victimisation of intoxicated patients, given that ED staff regard them as taking up considerable time and effort; time that could be better spent treating other "genuinely" ill patients.¹⁰

A common HCP perception was that these patients were more prone to injuries, brought it upon themselves, got what they deserved, and that it was useless treating them as they would never learn and it was likely that they would incur repeated injuries and visits to the ED. The increased utilisation of ED services was confirmed in a previous report in which it was stated that frequent ED users are twice as likely to be problematic, as well as being risky alcohol users (odds ratio of 1.99, p-value < 0.01).¹² Intoxicated patients' repeat visits to the ED have financial and ethical implications that include costs to the health system, costs to other patients, patients' right to be treated versus distributive justice and the HCPs' duty to care.

Most patients who attend public hospitals are uninsured and their treatment costs are covered by taxpayers. The fact that most HCPs fall within the highest tax bracket in South Africa may influence them to think that alcohol intoxication (being self-inflicted) and the resultant injuries unfairly place a substantial financial burden on taxpayers and consume resources that could be devoted to other illnesses.^{13,14} Therefore, alcohol abuse needs to be addressed at different levels to prevent injury and the accompanying costs, so that much-needed resources can be redirected to other health priorities. HCPs' perceptions that these patients place a financial burden on taxpayers and that it is useless to treat them could result in HCPs providing suboptimal treatment, a situation that might result in medico-legal issues. Ethical dilemmas arise when HCPs castigate patients for being drunk during ED visits. Being intoxicated does not justify a judgemental attitude and lack of compassion. Rather, it should call for a sober look at self-destructive behaviour, so that the desires that give rise to it can be honestly addressed.

The finding that HCPs experience communication difficulties when taking patients' history and when giving instructions to patients may be owing to the location of South Rand Hospital within the urban setting. It caters for a significant number of internal and external immigrants who may not communicate well in the local languages. This communication gap could negatively affect the quality of care rendered to these patients. Therefore, HCPs should be trained on how to handle the cultural diversity associated with urban settings. In order to favourably improve interaction between HCPs and their patients and escorts, this training should include interpersonal and transcultural communication, conflict resolution and stress management.

In line with the literature, in this study, HCPs were faced with the threat of needle-prick injuries, exposure to body fluids, cuts from ampoules and violent and aggressive behaviour, while attending intoxicated patients.¹⁵ Alcohol intoxication, by causing loss of inhibition and control, increases risky behaviour. Therefore, HCPs are at high risk of contracting blood-borne infections from such patients, especially if stuck by needles.¹⁶ The fear of contracting human immunodeficiency virus, in particular, during work-related injuries has serious implications as it has been cited as one of the reasons for HCPs emigrating from South Africa or leaving the health profession.¹⁷ Therefore, it is important that protective clothing is made available in the ED at all times to mitigate against these dangers.

Uncontrolled access to the ED by patient escorts entering and leaving the ED may pose a serious threat to the safety of HCPs, especially at night and over weekends, given that guards are unarmed and that chaos may spontaneously erupt in an overcrowded environment. Therefore, waiting areas need to be designed for patients and their escorts. Entrances and hallways should be fitted with security gates, metal detectors, cameras and good lighting. Increasing the number of security officers, and providing training for them on how to handle alcohol-intoxicated patients, should also be prioritised. Since alcohol-intoxicated patients constitute a significant proportion of patients who are seen in public hospitals, especially after hours, protocols and guidelines on their clinical and operational management should be developed and made available in the ED.

This study was a qualitative study. Therefore, the findings cannot be generalised. Information bias could also have resulted from the fact that the main researcher was a staff member and could have influenced participants' responses. However, given the methodological rigour that was employed in the study, as exemplified by the researchers' self-awareness, the exploration of researchers' preconceptions, the mental triangulation of findings, and the peer-review process and the member checks, this study provides an understanding of HCPs' perceptions regarding alcohol-intoxicated patients who have been assaulted, and

could inform interventions aimed at improving the structures of healthcare services rendered to alcohol-intoxicated patients in South African district hospitals.

Conclusion

HCPs experience several negative emotions and develop negative attitudes in response to alcohol-intoxicated patients who have been assaulted. In this study, several challenges, safety concerns and apprehension about a wastage of resources characterised HCPs' perceptions. As this was a qualitative study, future quantitative studies should be conducted to validate these findings.

Declaration

This article is a summary of the dissertation by the first author, in fulfilment of the requirements for the Master's Degree in Family Medicine at the University of Pretoria.

Acknowledgement

Dr Omole is thanked for guidance and his contribution to developing, revising and finalising the final manuscript.

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