A Safe Space: Violence Toward Emergency Department Providers Isn't Just Part of the Job

June 28, 2016 by James P. Phillips, MD

In April this year, I published an article in the *New England Journal of Medicine* entitled "**Workplace Violence Against Healthcare Workers in the United States**" that addressed the universal problem of workplace violence (WPV) perpetrated by patients or family members against medical providers. The article depicts the prevalence of violence in all areas of medicine and highlights studies showing that the emergency department (ED) may be the most violent setting overall.[1] The statistics are alarming: Nationwide, 78 percent of emergency physicians reported being **targets of WPV in the previous 12 months**.[2] Outside of law enforcement, such numbers do not exist in any other industry.

Recently, Congress asked the Government Accountability Office to study the effectiveness of the **Occupational Safety & Health Administration** (OSHA) in its ability to recognize, respond, and correctively manage workplaces that are deficient in worker protection. **The report**, released this March, recommends that OSHA reevaluate its overall efforts in reducing WPV.[3] OSHA does currently provide **guidelines** to health care employers about how to reduce WPV, but the guidelines are only voluntary.[4] When deficiencies that put employees at risk are found, OSHA doesn't have adequate policies in place to ensure that citations against employers can be levied consistently or appropriately, nor does it follow up with formally cited employers to ensure the hazards have actually been addressed. So what's an emergency physician to do to keep the ED as safe as possible? The first step is to define exactly what does and does not constitute WPV.

Standard Definition

A consensus definition of WPV has been elusive. The **National Institute for Occupational Safety and Health (NIOSH)** definition is "violent acts including physical assaults and threats of assaults directed toward persons at work or on duty."[5] Many WPV researchers have developed definitions that are more specific and include specific acts such as kicking, squeezing, spitting, throwing objects, etc.

Two problems exist, however: First, there's no accepted standard definition of assault, physical assault, battery, threat, or harassment among governmental agencies. This makes comparing studies difficult or impossible. Second, the definitions used don't correlate with the legal classifications of these acts (ie, assault and battery), which seems unnecessarily complicated and certainly confusing. In my opinion, establishing standardized definitions is the logical next step for research and tracking purposes. And since we're dealing with criminal acts in many cases, we should refer to them using criminal law–based definitions.

Criminal Versus Non-criminal Offenses

Differentiating between intentional and inadvertent violence can be challenging. As specialists trained in both acute and chronic causes of altered mental status (AMS), we can often determine if an action was intentional or not. Studies have shown that providers tend not to report events when they feel that AMS, a medical problem, is a contributing factor to violence. But are we really qualified to judge? If a nurse is beaten by a psychotic patient who later screens positive for PCP, shouldn't the criminal justice system determine whether the act meets the required elements for battery?

While we must continue to be particularly careful to protect our patients suffering from delirium, psychosis, or dementia, we also must remember that alcohol- and drug-related assault and battery is a crime on the street as well as inside the ED. Intoxication, drug seeking, and withdrawal leading to violence shouldn't be tolerated and are no excuse for abusing health care workers. It's a police matter and should be reported to protect health care providers and help prevent recidivism.

Reporting Barriers

WPV researchers have noted that health care providers severely underreport violence for many reasons. But when personnel are threatened with harm (assault) or physically touched with the intent to harm (battery), why wouldn't they report it? Foremost, there's often no reporting mechanism in place for employees—and if one exists, employees may not be trained how to use it. Also, reporting violence is time-consuming and may even require the victim to appear in court. Studies have shown there is a large number of employees who feel that nothing will be done about it anyway, so they choose not to report incidents to supervisors, managers, security, or law enforcement.

By uncertain mechanism, supervisory support has even been shown to be protective against both **assault and battery.**[6] Thus, it seems reasonable that the lack of support may lead to less reporting and the potential for continued violence. Providers need to be taught how the law applies to such acts in the ED and what responsibilities the police have to protect us.

Suggestions for Improvement

Unfortunately, there are no evidence-based approaches to reducing violence that have been proven effective in the literature. But that doesn't mean we can't establish universal definitions, measures, and metrics ourselves in an effort to improve the validity of WPV research. Prevention programs, training, reporting processes, and the development of infrastructure require money and buy-in from facility administrators. Our best chance of receiving budgetary support is to present our administrators with proposals that have been shown to work in similar settings. In lieu of such evidence, expert consensus opinion should be sought to guide efforts.

Here are some ideas for improving awareness and safety of WPV in EM:

• **Establish a WPV committee.** Creating a multidisciplinary WPV committee should be the first step for each facility or practice, and it should meet regularly. The committee should include security/police, patient relations, nursing, physicians, ancillary staff, legal, and hospital administration. It's critical that

employees feel appropriately represented by their peers.

• **Perform a hazard vulnerability analysis.** A hazard vulnerability analysis is a tool facilitating regular analysis of deficiencies to prepare for unwanted events. The WPV committee or expert consultant can evaluate for facility and unit-level vulnerabilities in infrastructure, security/police, staffing, reporting, case review, and necessary interventions. Deficiencies are scored and prioritized, and funds are applied where they would be the most impactful.

• **Guarantee reviews.** In addition to efficient reporting methods, there must be a guarantee that each incident will undergo review to ensure that appropriate action is taken. Results of this process should include follow-up with the complainant, with referral for psychological support and debriefing, flagging of the patient's chart to alert other providers, discussion with the patient if possible, and legal action if appropriate.

• **Expand WPV training to medical students/interns.** It's incredible to realize that health care WPV is rarely, if ever, discussed in medical school and residency-training programs. It seems bizarre that such a serious, widespread issue is completely unknown to students entering the field. It's even more concerning that EM residents can graduate without ever understanding there's even an issue—but there will certainly be WPV victims among them. When I was a resident in Chicago, I had to undergo six months of testing after a combative intoxicated patient intentionally spit blood in my face and eyes, knowing that he had been positive for hepatitis C for years. I had no idea there was any law broken or any recourse, and the incident went unreported despite my occupational health follow-up. We need to inform residents about the reality that they have a high likelihood of experiencing violence during their career and how to avoid it.

We can do a better job of protecting our coworkers and ourselves. It first requires an understanding of the breadth of health care WPV; it's an issue at every facility. EDs and psychiatric units are statistically the most violent health care settings. Medical students and EM residents have a right to be informed about their risk of harm and how to best handle high-risk situations. And more federal oversight may not be popular, but OSHA has promised to revamp its regulatory and punishment processes. It's time for states to enact laws and health care systems and individual EDs to adopt strategies for improvement.

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Topics: **assault**, **ED Critical Care**, **Education**, **Emergency Department**, **Emergency Medicine**, **Emergency Physician**, **Patient Care**, **Safety**, **Violence**, **Workplace**