Emergency Medicine on the Frontline: Workplace Violence in the Healthcare Setting

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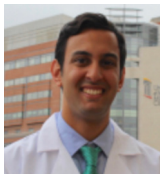

Healthcare workers are affected in the majority of cases of incidents of workplace violence (WPV) in the United States each year. Unsurprisingly to those who work in emergency departments throughout the country, emergency medicine has one of the highest rates of WPV each year. A recent survey of emergency department staff showed that 88% of staff in a Level 1 Trauma Center were exposed to WPV within the last six months.[2] Of assaults on healthcare workers recorded throughout the country, 75% were aggravated assaults and 93% were due to a type II physical or verbal assault, defined as there being a patient relationship between the perpetrator and the victim.[6] Despite these rates of assault, shockingly 98% of respondents felt safe at work and 64% reported that they felt that violence was an expected part of their job as a part of the emergency department.[2] This was a constant theme across many inquiries into the perception of WPV in emergency departments. Not only was WPV experienced at a higher level than almost all other healthcare settings but it was seen as a necessary part of the job—something that could not be avoided and something that they signed up for. This reflects the disturbing state of affairs when it comes to prevention of WPV in the emergency department setting. Emergency providers should not accept a higher level of risk of WPV compared to their counterparts in other specialties but the historical attitude of apathy and powerlessness to the epidemic of WPV is only serving to stall progress in finding solutions to this important problem.

WPV results in increased missed workdays, burnout, job dissatisfaction, and decreased productivity, but it tends to only come to the forefront of the nation's attention during shocking tragedies. Over the years, voices have been raised against the vulnerability of healthcare providers to assault during sensationalist news cycles that do not lead to meaningful change. In the past five years, we have seen healthcare workers gunned down in Chicago, Ohio, and Massachusetts to name a few.[3,4,7] A survey of 154 hospital related shootings between 2000-2011 showed that the emergency department was the site of 29% of shootings, the most of any location, and that 20% of victims were hospital staff, 5% nurses, and 3% physicians.[8] You may ask, why is the emergency department so vulnerable to these episodes of violence? It may stem from the fact that emergency departments run on high emotions and high stakes. Additionally, they are usually one of the most accessible places in a hospital, often with a door from the outside leading directly into the department. By contrast, to enter an operating room, a perpetrator would have to cover more ground to get to their destination. Emergency departments also tend to host a greater population of inmates or suspects brought in by police who are unscreened and violent or potentially violent. 29% of shootings in emergency departments have been perpetrated by individuals in police custody and 8% of the time the gun was taken from the police officer assigned to monitor the patient.[6] WPV is not relegated to those located in urban areas of low socioeconomic status as data has shown that suburban departments are equally vulnerable.[6]

With this compelling data reflecting WPV trends in the past two decades, it is reasonable to question why more has not been done to address the issue. One such reason is that WPV is underreported.[6] If no one was hurt, an incident is often not seen as warranting a report. Lack of policies or clear language related to WPV reporting in hospitals, as well as employees not seeing a benefit to reporting, or fearing retribution due to a report being filed also factor in. In the era of "the customer is always right," healthcare workers can often see patients as not responsible for their actions when it comes to assault and may feel that an assault was due to negligence on their part.[6] Additionally, as mentioned above, expecting violence as a part of the job greatly contributes to the discrepancy between events and event reporting. Data shows that only 30% of nurses and 26% of physicians report incidents of WPV.6 All these factors contribute to the fact that there is a lack of peer-reviewed research regarding impact of WPV and the effect of potential interventions to curb the rise of such incidents. Even when there are studies to this effect they often have no reliable evidence base for their interventions.[6]

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Regarding current policies and interventions into WPV, positive results are often intermingled with setbacks or limitations. Metal detectors have often been touted as a potential solution to the risk of gun or knife violence in the emergency department, but despite studies showing that they led to a greater confiscation of weapons, WPV incidents did not decrease.[6] Importantly, it should be noted that <1% of type II assaults in the hospital setting involve a deadly weapon.[6] Metal detectors

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cannot prevent a provider from being punched, kicked, bitten, or verbally abused. Disappointingly, verbal abuse is in fact not quantified into WPV results by the Bureau of Labor Statistics, and this only serves to increase the discrepancy in accurate WPV reporting. Other proposed solutions have often followed a one-size-fits-all approach and this has proven over and over again to fail.[6] The lack of consistency in wording and terminology between existing studies hinders progress as results cannot be widely cross compared to identify strengths and weaknesses.[6] This is vital, as most interventions that have been tried have not led to a decrease in WPV and being unable to build on prior research is a waste of resources and precious time. Finally, on the legal side of the matter, laws with special protection for medical care providers in the emergency department have been passed in some states, including Colorado[9], Delaware,[10] and Idaho.[11] However, the enforcement and wording of these laws are not uniform across the state or country, leading their effectiveness to be diminished.[5,6]

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If all the solutions proposed thus far have failed to achieve radical or promising improvements, in what new direction does research and policy change go to make a difference? Firstly, the impact of WPV on emergency department healthcare workers cannot be ignored or underestimated. A qualitative study of WPV on affected healthcare works showed that differences in cognitive appraisal of WPV led to variability in coping strategies.[12] Hospital policy cannot assume that each incident of WPV will affect each individual the same way. Care needs to be put into addressing each affected staff member's personal needs after an event to decrease burnout, increase a sense of safety, and to mitigate the negative effects of WPV as much as possible. This is also why it is highly critical that verbal assault is not overlooked. Permitting verbal assault allows for the "broken windows" principle to take effect, where a low-level assault being permitting is conducive to a more violent episode in the future.[6] Zero-tolerance needs to be the basis of any sound reporting strategy. Any and all WPV incidents must be reported, and there need to be clear policies regarding what constitutes WPV and how the reporting process functions, so that personal views cannot create discrepancies that make the policy ineffective. The expected increase in reporting that a zero-tolerance policy should have can allow for simple cautions, such as the flagging of charts of known violent individuals as is done in Veterans Affairs hospitals to measurable success, to be implemented on a larger scale across different institutions.[6] Secondly, the creation of an individualized plan for each department incorporating supervisors, workers, and law enforcement is critica.[l6] Each unit has its own unique pattern of WPV and areas of concern so an open dialogue identifying areas that could be improved and what needs to be done to achieve a successful policy change has to occur. That is what can separate future research studies from the cookie-cutter solutions that have already been tried and failed. Overall, an effective WPV reduction policy needs to include policy updates, procedural enhancements, and education for staff and supervisors.[1] Without each of these components, an intervention will not be successful.

"Emergency healthcare providers deserve protection now.

With 25% of emergency physicians and 82% of emergency nurses reporting physical assault in the workplace, this is a problem that can no longer be treated as a part of the job.[6] Emergency healthcare providers deserve protection now. They cannot and will not wait much longer to be taken seriously when it comes to their safety and the safety of their patients. ●

References:

1. Adams, G. (2018) *Evidence-Based Interventions to Address Workplace Violence in the Emergency Department.* (Doctoral Dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 10844861)
2. Copeland, D., Henry M. (2017). Workplace Violence and Perceptions of Safety Among Emergency Department Staff Members. *Journal of Trauma Nursing*, *24*(2).
3. Freyer, F. J., Kowalczyk, L., & Murphy, S. P. (2015, January 21). Surgeon slain, gunman found dead in day of crisis at Brigham - The Boston Globe. Retrieved from https://www.bostonglobe.com
4. Iannitelli, K. B. (2019). The Aftermath of the Shooting at Chicago's Mercy Hospital. *Emergency Medicine News*, *41*(1), 5–6.
5. Maguire, B. J., Omeara, P., Oneill, B. J., & Brightwell, R. (2017). Violence against emergency medical services personnel: A systematic review of the literature. *American Journal of Industrial Medicine*, *61*(2), 167–180.
6. Phillips, J. P. (2016). Workplace Violence against Health Care Workers in the United States. *New England Journal of Medicine*, *375*(7).
7. Rege, A. (2017, February 10). Hospital shootings: How common are they? 8 things to know. Retrieved from https://www.beckershospitalreview.com
8. Rege, A. (2018, November 21). 17 fatal hospital shootings since 2002. Retrieved from https://www.beckershospitalreview.com
9. *See* Colo. Rev. Stat. Ann. § 18-3-202 (West).
10. *See* Del. Code Ann. tit. 11, § 613 (West).
11. *See* Idaho Code Ann. § 18-915C (West)
12. Vrablik, M. C., Chipman, A. K., Rosenman, E. D., Simcox, N. J., Huynh, L., Moore, M., & Fernandez, R. (2019). Identification of processes that mediate the impact of workplace violence on emergency department healthcare workers in the USA: results from a qualitative study. *BMJ Open*, *9*(8).