PATIENT VIOLENCE AGAINST CLINICIANS: MANAGING THE RISK

THE RISK

Patient violence directed toward clinicians is an ever present risk that requires attention and preparation to decrease the risk and provide for the safety of the clinician. Tragic incidents of violence against clinicians are often reported in the news:

- An NIMH Administrator and expert in the diagnosis and treatment of schizophrenia is beaten to death in his office by a patient. Five years later, this patient is charged with murdering his roommate at a state hospital for the mentally ill.[1]
- A psychiatrist in Virginia is killed in his home office by a patient.[2]
- A physician at Johns Hopkins Hospital is shot by a man who is distraught about his mother's care. The man then kills his mother and himself.[3]

Sadly, these reported incidents are only a glimpse of the overall problem. Patient violence against clinicians in the healthcare setting is prevalent and the overall incidence of violence in the healthcare system is of grave concern.[4] Although commentators opine that the frequency of violence against clinicians is increasing, the true incidence is hard to know. This is due, in part, to information collected from a variety of sources using different methodologies for gathering data (for example, how "violence" is defined, how injury severity is rated, etc.), underreporting or lack of reporting protocols and mechanisms, and failure to report nonphysical violent incidents such as verbal abuse, threats, stalking, etc., of clinicians by patients.[5]

However, data from a number of sources provide a measure of the extent of the problem and the impact on clinicians. OSHA's "Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers" (Guidelines) acknowledge that job-related violence is a significant risk for these professions as shown by a review of data from the Bureau of Labor Statistics (BLS) and the Department of Justice's (DOJ) National Crime Victimization Survey. For example, BLS data from 2000 show that "48 percent of all non-fatal occupational assaults and violent acts occurred in health care and social services."[6] From 1996 to 2000, BLS reports 69 homicides in the health services.[7] The DOJ survey for 1993 - 1999 states "[t]he average annual rate for non-fatal violent crime for all occupations is 12.6 per 1,000 workers. The average rate for physicians is 16.2; for nurses, 21.9; for mental health professionals, 68.2; and for mental health custodial workers, 69."[8] "Of psychiatrists responding to surveys, the average rate during their careers was 40%."[9]

A significant percentage of medical residents are assaulted by patients. "Surveys of psychiatric residents found an assault rate ranging from 19% to 64%; rates of repeated assaults ranged from 10% to 31%."[10] One survey of psychiatric residents found that the problem of patient violence directed at residents is "significant" and "many residents do not report incidents to program

directors or to security, and ... some respondents said they had been so severely affected by a violent incident that it caused them to reconsider their choice of specialty."[11] A study of selected academic psychiatry residency programs surveyed residents about "the prevalence of threats and assaults by patients on psychiatry residents, their consequences and the perceived adequacy of supports and institutional responses."[12] The researchers found that 25% of responding residents experienced physical assaults and a majority experienced threats, physical intimidation or unwanted advances. Residents reported inadequate training, unsafe work environments, and "less than adequate" responses to requests for safety improvements. As in the previous study, residents did not always report the incident (36% reported; 9% to training director) and the psychological consequences were significant in some cases. The study endorses the importance of specific actions to improve safety for psychiatry residents and "to support those who are victimized."[13]

POSSIBLE CONSEQUENCES

Physical and Psychological Injuries

Patient violence against health care workers causes serious physical injuries and psychological trauma. In some cases, both those directly injured by a patient and those witnessing an incident are traumatized. Along with physical injury, victims of patient violence may suffer: "[s]hort- and long-term psychological trauma; fear of returning to work; changes in relationships with coworkers and family; feelings of incompetence, guilt, powerlessness; and fear of criticism by supervisors or managers."[14]

Employment Related Consequences

The consequences of violence against health care workers include, but are not limited to, the cost of "increased turnover, absenteeism, medical and psychological care, property damage, increased security, litigation, increased workers' compensation, job dissatisfaction, and decreased morale."[15]

Malpractice Liability

Depending on the situation and the outcome of patient violence, the treating psychiatrist may face liability risk under federal and state laws, (including state tort laws), that may include but is not limited to:

- As a treating psychiatrist:
    - alleged negligence in:
        - assessing a patient's potential for violence
        - putting into place a proper treatment plan to prevent or reduce the risk to the patient and others, and/or
        - properly warning potential victims of violence
    - complaints against a psychiatrist to the medical licensing board related to a patient's violent behavior

- As an employer:
    - a psychiatrist or healthcare facility may face allegations of failing to protect employees, other patients and visitors from violence by a patient under state tort law. Specific allegations may include:
        - negligence in training and supervising employees to properly manage and respond to patient violence and
        - failure to take security measures that would protect staff and others from patient violence, etc.
    - a psychiatrist or healthcare facility may be responsible for complying with specific state laws or regulations, e.g., Connecticut enacted a law, effective July 1, 2011, requiring "health care employers" to take specific actions to develop a workplace violence prevention and response plan to prevent violence against health care workers.[16]
    - OSHA relies on the "General Duty Clause" to enforce the general duty of employers to provide a workplace free from recognized hazards likely to cause death or serious physical harm (Section 5(a)(1) of the OSH Act. "[E]mployers can be cited for violating the General Duty Clause if there is a recognized hazard of workplace violence in their establishments and they do nothing to prevent or abate it."[17]

Allegations against clinicians and healthcare employers are often based on the issue of "forseeablilty", e.g., did the clinician or healthcare facility know, or should they have known that a risk existed and were reasonable steps taken to mitigate the risk? Risk assessments and specific actions based on such assessments, along with documentation of the process, are critical to reducing risk.

Accreditation

As well as legal liability issues, noncompliance with requirements of accreditation organizations may lead to citations or possible loss of accreditation for health care facilities in violation. For example, The Joint Commission requires accredited institutions "to address and maintain a written plan describing how an institution provides for security for patients, staff and visitors" and "to conduct risk assessments to determine the potential for violence, provide strategies for preventing instances of violence, and establish a response plan that is enacted when an incident occurs."[18] Psychiatrists practicing in accredited facilities may be involved in risk assessment and planning activities. In fact, all practices and facilities would do well to heed these measures as part of a violence prevention and mitigation plan.

MANAGING THE RISK

While clinicians are well aware of the issue of patient violence, they may not evaluate the specific risk or have a plan for reducing it in their day-to-day practice. Psychiatric healthcare providers may downplay or avoid the idea that their patients present a potential safety risk. Additionally, there is a "persistent perception within the health care industry that assaults are part

of the job"[19] and this is particularly prevalent in psychiatric treatment settings. Healthcare professionals, organizations, governments, and other stakeholders are increasing efforts to address this problem.

A basic plan to reduce risk must include identifying and analyzing risks related to patient violence, implementing plans to manage the risk and continuously evaluating and modifying the plan.

REDUCE THE RISK

Identify the risk

Of patients: The psychiatrist's assessment of a particular patient's risk for violent behavior is part of the identification of the risk an individual poses to the clinician and others. It is not always possible to do a thorough violence risk assessment before working with a patient. Potential risk increases in situations when the patient is unknown and where a therapeutic alliance has not been established. The clinician must take into account her/his personal safety, and that of others, when deciding how, where and when to first see a patient as well as continuing patients. Clinicians must stay professionally current with violence assessment literature and research.

Of the practice setting: Ascertaining the specific risks in a practice setting requires a system to identify those areas and/or activities where clinicians are at high risk for assault and a mechanism for reporting and documenting incidents of violence. Establishing an effective and workable system to identify and report risks will depend on a particular practice setting's size and other factors. The goal of this system is to increase a clinician's or facility's understanding of when, where and how incidents of violence are most likely to occur so steps can be taken to avoid or reduce these incidents.

Reporting and documenting incidents of patient violence should be required for all incidents (physical assaults, verbal threats and abuse, etc.) and be consistent with a violence prevention policy and program. Often clinicians do not identify and report the entire range of violent actions by patients so this information is not available when assessing and planning for reducing risk. Fatal and severe physical assaults are not common events but, when they occur, they are usually reported. Lesser incidents of physical assaults and verbal threats or abuse, stalking (including cyberstalking), harassment, etc., are not as likely to be reported consistently but may be daily occurrences in some treatment settings and can indicate the potential for an escalating risk of violence. These violent behaviors by patients, even if not physical assaults, can have a significant effect on clinicians' wellbeing and their practice, they may be daily occurrences in some treatment settings and can indicate the potential for an escalating risk of violence.

In a small practice the reporting system may be less formal but requires ongoing and open communication among clinicians and with other staff about incidents and "near misses," a clear understanding about the types of incidents to be reported and an evaluation of incidents because "[e]very case of patient violence against clinicians provides lessons to be learned in safety management."[20] There are several resources available that provide guidelines, checklists, sample incident forms, etc., for establishing workplace violence prevention programs which can be adapted to psychiatric treatment settings. (See resources listed below in "Elements of Plan to Reduce Risk").

Ongoing identification of environmental risks is essential for an effective violence prevention program. Depending on the treatment setting, coordination and planning with building security, safety and risk managers, other clinicians and staff sharing offices and space, etc., is required. Every clinician must identify her/his personal safety risks in the workplace as well as take part in identifying potential problem areas in the larger environment. For example, a clinician may have a "panic" alarm in her/his office to alert security or police but, in addition, adequate security procedures for entering the building and reception area are needed to prevent unwarranted entry in the first place. Known high risk areas, such as Emergency Departments (ED) and inpatient psychiatric units, require attention to environmental safety to prevent or minimize possible violent behavior.[21] Of course, any treatment area can become high risk given certain circumstances so no treatment area should be without evaluation and plans for prevention of violence.

Evaluate the risk and develop a safety plan

Data gathered through the process of identifying risks associated with patient violence toward clinicians should be analyzed to aid in planning to manage the risk. This is an ongoing process so that newly identified risks can be addressed and so that clinicians do not become complacent about ever-present risks related to patient violence. The Joint Commission's Sentinel Event Alert "Preventing violence in the health care setting" listed causal factors of violence most frequently found in reviewing the Sentinel Event Database regarding criminal events in health care institutions:

- "Leadership,..., most notably problems in the areas of policy and procedure development and implementation.
- Human resources-related factors,..., such as the increased need for staff education and competency assessment processes.
- Assessment,..., particularly in flawed patient observation protocols, inadequate assessment tools, and lack of psychiatric assessment.
- Communication failures,...., both among staff and with patients and family.
- Physical environment,..., in terms of deficiencies in general safety of the environment and security procedures and practices.
- Problems in care planning, information management and patient education were other causal factors identified less frequently."

It is highly likely that any clinician or health care facility that evaluates the causes of patient violence in a particular setting will find many of the same factors present and requiring improvement. The analysis of information from incident reports and other sources related to patient violence will guide the planning of safety measures. Attention to the frequency and severity of violent incidents allows resources to be directed where they will likely be most effective. Consultation with security and safety experts should be seriously considered. Collaboration with your risk manager(s) will provide information about managing potential risks to avoid or reduce liability and increase safety.[22]

A critical step that should not be overlooked is what the analysis of incidents reveal about the clinical needs of patients with violent behaviors. For example, are clinicians adequately trained in recognition and early intervention to de-escalate potential violence? Is there an opportunity to educate and involve patients in avoiding and managing factors that lead to their threatening

and violent behaviors? Does the analysis reveal other information that is useful for the clinical treatment of patients? Is that information incorporated into the patient's treatment plan to improve safety for clinicians who will continue to treat the patient and to improve patient outcomes?

Implement a safety plan and re-evaluate

Develop and implement a safety plan based on the evaluation of the risk factors; the highest risks should be addressed initially but it is unrealistic to try to tackle too many issues at once. Documenting the elements of the plan and setting a firm timeframe for re-evaluating and updating the plan is a critical step so that the plan is not stored on the bookshelf and forgotten. The importance of safety for all clinicians, staff, patients, and visitors requires ongoing work on this issue. Plans, policies and procedures become outdated. Often, they are not followed as written and need regular revision and re-commitment to continue to be effective.

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[21] See Policy Statement of The American College of Emergency Physicians on "Protection from Physical Violence in the Emergency Department Environment" at http://www.acep.org, Emergency Nurses Association violence toolkit at www.ena.org/IENR/ViolenceToolKit/Documents/toolkitpg1.htm and National Association of Psychiatric Health Systems safety resources at https://www.naphs.org/teleconference/safetystandards.
[22] International Association for Healthcare Security and Safety (IAHSS) at http://www.iahss.org.

Additional Resources:

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