

## Foundations III Curriculum

### Guided Small Group Experience

# Clinical Skills

## “Disaster Management and Workplace Violence”

### ❖ Agenda and Learning Objectives

- Case Part I – Mass casualty Incidents (MCI) and Disasters (20 min)
  - Define mass casualty incidents, disasters and list examples
  - Discuss priorities for field- and hospital-based providers in an MCI situation as well as triage strategies
  - Name key components of the hospital-based team in an MCI and discuss where EM senior residents fall within this structure
- Case Part II – Active shooter situations and workplace violence (20 min)
  - Define an active shooter and discuss how these events are different from other forms of societal violence
  - Discuss how to respond in the event of an active shooter event
  - Name some of the sequela healthcare providers may suffer after they are victims of workplace violence
  - Discuss ways to mitigate the effects of active shooter events and other forms of workplace violence in the healthcare setting
- Case Concludes (10 min)
  - Review Session Teaching Points

### ❖ Note to Facilitators

This is a session covering mass casualty incidents and an active shooter scenario. It is a question guided 50-minute large group discussion. Prior to this session, please familiarize yourself with your own hospital disaster plan and print it off to share with the group during the discussion. There is an optional activity to allow a few minutes for the residents to locate their own hospital disaster plan. A computer would be needed if you choose to include this activity.

### ❖ Case Part I – Mass Casualty Incidents (MCI) and Disaster (20 min)

*It's a predictably busy Monday afternoon in your ED when you hear an overhead page calling all ED providers to the resuscitation bay. Your charge nurse and hospital administrator on duty informs the group that there was a massive shooting at a nearby shopping mall with an estimated 60 wounded and 8 dead; the shooter escaped and law enforcement is on scene. Your hospital's mass casualty incident protocol is being initiated. As you start to gown up and your attendings mobilize the team, providers from trauma surgery, orthopedics, and other services start to trickle into the ED. You wonder to yourself, "What is a mass casualty incident and what should I be doing to help the most?"*

### ❖ Discussion Questions with Teaching Points

- **What is a disaster? What is a mass casualty incident? What are some examples of each?**
  - Disaster: Destructive event that disrupts the normal functioning of a community<sup>1</sup>
  - Mass Casualty Incident: an incident where emergency services are overwhelmed by the number of casualties from an event
  - Occurs when the demand exceeds your hospital's capacity to provide care, which can occur in a number of situations, such as damage to physical plant, too few personnel, lack of specialists, running out of equipment or medication, etc.
  - Disasters can be:
    - Natural (hurricane, earthquake, flood)
    - Human-caused/technologic (shooting, bombing, electromagnetic pulse)
    - Complex humanitarian (riots, wars, genocide)
  - Can also be categorized by:
    - Onset: rapid (earthquake) or gradual (heat wave)
    - Impact: sudden/short lived (mass shooting) or prolonged (earthquake damaging entire city)
  - Likely to encounter multiple waves of patients, presenting via ambulance, law enforcement and on their own
    - May end up with "upside-down triage"-- those who arrive first are the least severely injured (able to bypass EMS field triage and get to the hospital on their own)
  
- **What are the phases of disaster management? What is your hospital's disaster management plan? Do you know where to find it?**

**Note to facilitators:** Give your learners one minute to find their hospital's disaster management plan. If they can't find it, please provide a copy for brief review and discussion.

  - Stages of disaster planning and management:<sup>2</sup>
    - Prevention
    - Preparedness: resource identification (human and logistic) and practice (JCAHO mandates exercises twice a year)
      - Consider the needs of special populations: children, elderly, chronic medical conditions, decreased mobility
    - Response
    - Recovery
  - EM physicians play a role in all four stages!
  
- **Your attending asks you to go out into the parking lot and assist with triage. Discuss the basic principles of MCI triage.**
  - Goal is to provide the best possible care to the most people: "In a MCI, staff may be mandated to try to do 'the best for the most,' which is unlike routine emergency medicine practice where the goal is to do 'everything for everyone.'"<sup>3</sup>
  - Limited personnel, resources, and space
  - Need to perform rapid triage, in the field and at the hospital

- **START** (Simple Triage And Rapid Treatment) or other triage tool quickly divides patients into four categories:
      - **Expectant** (black): deceased or unlikely to survive (based on extent of injuries, lack of resources, or both)
      - **Immediate** (red): needs intervention in  $\leq 60$  minutes; rapid treatment and/or transport; threats to ABCs
      - **Delayed** (yellow): needs intervention in next several hours; delayed transport
      - **Minor** (green): “walking wounded;” need treatment over next several days
    - Patients are sorted into groups, with physical tags on their person, in a geographic area, and/or electronically
  - **Please sort the following patients into the appropriate triage category.** (GSW = gunshot wound).

**Note to Facilitators:** There is some subjectivity to triage—assigned categories are suggestions only. You may omit cases as needed for time.

- 29-year-old with GSW to right chest. In significant respiratory distress with absent breath sounds in right hemithorax.
  - BP: 74/45 HR: 133 RR: 35 O2 sat: 86% on room air
  - **RED**
- 38-year-old with multiple lacerations on face and arms from a broken window. All bleeding is controlled.
  - BP: 130/75 HR: 90 RR: 18 O2 sat: 99% on room air
  - **GREEN**
- 56-year-old with 3 GSWs to left thorax. Initially moaning and now unconscious.
  - BP: 60/30 HR: 140 RR: 40 O2 sat: 82% on room air
  - **BLACK**
- 46-year-old with GSW to right calf. + exposed muscle and bone. 2+ distal pulses and bleeding is a slow ooze.
  - BP: 150/85 HR: 118 RR: 20 O2 sat: 98% on room air
  - **YELLOW**
- 14-month-old child found underneath his deceased parent, who shielded him from gunfire. The child is screaming inconsolably and has no visible injury.
  - BP: 82/50 HR: 153 RR: 45 O2 sat: 100% on room air
  - **GREEN**
- 28-year-old with several GSWs to abdomen. Steady pulsatile flow of blood from all wounds, and eviscerated bowel is visible.
  - BP: 70/35 HR: 153 RR: 45 O2 sat: 92% on room air
  - **BLACK**
- 53-year-old with GSW to neck. GCS 15, no other injuries, and rapidly expanding neck hematoma is visible. Initially conversant → hoarse → stridulous.
  - BP: 134/70 HR: 122 RR: 36 O2 sat: 85% on room air
  - **RED**

- 27-year-old, 36 weeks pregnant, with GSW to L foot. Her foot is clearly broken, though bleeding is minimal. She is experiencing intermittent abdominal pain and can feel normal fetal movement.
      - BP: 132/74 HR: 103 RR: 24 O2 sat: 99% on room air
      - **YELLOW**
    - 3-year-old with GSW to head. Brain is visible.
      - BP: 50/30 HR: 43 RR: 5 O2 sat: undetectable
      - **BLACK**
    - 73-year-old with abrasions to bilateral palms and knees after a trip and fall in the chaos. She is able to ambulate to the triage area.
      - BP: 174/92 HR: 85 RR: 18 O2 sat: 96% on room air
      - **GREEN**
    - 65-year-old with GSW to left distal thigh. Brisk pulsatile bleeding. No other injuries.
      - BP: 80/45 HR: 125 RR: 28 O2 sat: 96% on room air
      - **RED**
    - 18-year-old complaining of abdominal pain after she fell from the second story railing onto a table below. She has a deformity to her right wrist with normal distal pulses and extensive abdominal ecchymoses and tenderness to palpation with guarding.
      - BP: 115/78 HR: 97 RR: 22 O2 sat: 98% on room air
      - **YELLOW**
- **What is your role as an EM senior resident/future attending in the ED during a disaster? What is ideal MCI leadership structure?**
  - Goal is to provide timely, efficient care to as many patients as possible frequently with minimal information
    - Best if all personnel are performing similar roles to those they usually perform, though faster
  - May be called upon to triage patients, set up treatment areas, recruit personnel and disseminate information (within the hospital, to the media, to families) in addition to direct patient care
    - “During disaster management, EM physicians are expected to triage, rapidly assess, decontaminate, care for, and provide for the disposition of a potentially large influx of patients while interacting with fire and prehospital health care providers, law enforcement, consultants, hospital staff, and administrators.”<sup>2</sup>
  - While some studies advocate that an attending trauma surgeon should be in charge during an MCI<sup>4</sup> others<sup>5</sup> name emergency physicians as the providers most well-versed in disaster management
  - Regardless of who the hospital names as in charge, there should be a clear leadership structure that must be followed
  - Familiarize yourself with your hospital’s disaster management plan including chain of command!
- **What are some factors that may affect providers’ coming to work during a disaster? Do you think residents should have to? Should they be punished if they don’t?**

- Some factors include:
    - Lack of infrastructure (don't hear about the disaster, can't get to the hospital, no hospital to go to)
    - Injury or illness of providers or their families
    - Sense of duty
    - Monetary factors
    - Availability of personal protective equipment
    - Fear for safety (personal or family)
    - Concern about ability to help
  - A survey of EM residents and faculty<sup>2</sup> found that the three most important factors affecting willingness to respond to work during a disaster were concern for family (overwhelmingly the most important factor, regardless of other characteristics), sense of duty to provide care and availability of personal protective equipment
  - Another survey of ED personnel (including non-physician staff)<sup>6</sup> in 8 EDs found that subjects were much more likely to present to work after an airplane crash (98%) than a radioactive bomb (85%) or biologic agent (54%)
  - Residents fall into a gray area between employees who could be held accountable for abandoning their posts and learners, who come to the ED for their own benefit
  - Most residencies don't have established expectations for residents during an MCI or disaster
- **With the following scenarios, discuss whether or not you'd: 1) stay longer in the hospital if you were already at work, and b) come into work from home. Why or why not? What contribution from your institution might change your decision?**
- Commuter train crash with hundreds of casualties
  - Sarin gas release in a crowded convention center
  - Anthrax outbreak via contaminated packages
  - Large earthquake, which has caused fires across your city
  - Accident at a nuclear power plant outside of town, with significant fallout expected to your city
  - Hurricane expected to last for at least 24 hours, already causing massive flooding

❖ **Case Part II – Active Shooter and Workplace Violence (20 min)**

*You are taking care of a pediatric victim from the shooting in the ED when you suddenly hear what sounds like gunfire coming from the direction of the ambulance bay. There is pandemonium as people begin screaming and running down the hallways. You become terrified as you realize that you might be involved in one of those active shooter events you've seen on the news. You were aware that your patient had an active CPS investigation against the father but the parents are separated and he was here with his mother so you didn't think much more about it. You're panicked as you think to yourself, "Where should I go and what should I do?" You are also torn because you don't know whether you should stay with your patient or not.*

### ❖ Discussion Questions with Teaching Points

- **What is an active shooter? How are these events different from other forms of societal violence?**
  - An active shooter is an individual or individuals actively engaged in killing or attempting to kill people in a confined and populated area<sup>7</sup>
  - While the shooter may have a specific target, there is generally no pattern or method to their selection of victims → there is a difference between an active assailant and an active shooter and active shooter events do not include gang violence
  - There is no monetary motivation like many other shooting events such as robberies
  - The perpetrator is in an irrational emotional state and not necessarily trying to survive the event
  
- **How can you best be prepared for an active shooter event or other types of workplace violence?**
  - Active shooter events and hospital-based violence are both increasing
  - Active shooter events are not only becoming more frequent but they are resulting in more casualties and higher mortality rates<sup>8</sup>
  - Maintain situational awareness while at work and be aware of risk factors for impending violent events
  - Potential reasons for violence in healthcare settings include prisoner escape, suicide, euthanasia of a sick relative, a grudge or revenge, or acts carried out by mentally unstable individuals
  - Be familiar with emergency protocols at any facility in which you are working.
  - Participate in any hospital readiness drills that you can
  - Know the alerts that hospitals use to announce threats to providers and patients
    - Code Silver is commonly used to alert hospital employees to the presence of an active shooter → it is most often not announced overhead like other warnings to avoid causing people to leave areas that would otherwise be safe and provide additional targets for the shooter
  
- **What should you do in a the event of an active shooter?**
  - The phrase that is most often used to remind people how to react in an active shooter scenario is “Run, Hide, Fight”<sup>7</sup>
  - These steps should be carried out in order based on what options are available to you → you should only fight as a last resort and when your life is in imminent danger
  - As a healthcare provider, you may also be called on to treat victims of an active shooter event after the threat has been neutralized
  
- **Do you think that leaving a patient in the midst of an active shooter event is patient abandonment? Why or why not?**

- If you have to leave a patient that is immobile or otherwise unable to be moved during an active shooter event, it is not considered patient abandonment → secure the room or hide the patient as best as you can before leaving the area
  - No employer can require you to risk your life in the course of your job
  - Healthcare providers are a valuable resource during these events → by protecting yourself you will be available to care for patients if necessary after the situation is addressed
- **Name some of the consequences healthcare providers may suffer after they are victims of workplace violence.**
  - Healthcare providers are at high risk of experiencing violence of some kind in their workplace → the rate of assaults on healthcare workers is higher than for workers in other fields<sup>8</sup>
  - Symptoms of posttraumatic stress disorder (PTSD) and depression are common among victims in addition to any physical injuries they sustained
  - Frequent emotions reported include anger, fear, surprise, disgust, and sadness<sup>9</sup>
  - Impacts on work functioning may include a deterioration of the relationship with patients, impacts to the quality of care, and decreased job satisfaction → this can ultimately lead to burnout
  - There may also be financial consequences following an event due to missed work or an inability to work
- **Do you think that installing metal detectors at every entrance to a hospital would reduce the risk of violent events? In which circumstances would they be more or less beneficial?**
  - Most experts believe that installing metal detectors does not lead to a significant decrease in the rate of violence in healthcare settings
    - One study showed that after the metal detectors were installed they confiscated more weapons but the rate of assaults did not decrease<sup>10</sup>
    - Another study estimated that less than half of the weapons used inside hospitals would have been discovered this way<sup>8</sup>
  - Metal detectors require 24-hour manning by trained personnel and would not help with any situation on the hospital grounds or when the weapon is obtained from a security guard or police officer
  - They are also less helpful in the case of a determined shooter
- **What can we as physicians do to help prevent gun violence?**
  - Counseling patients about safe gun practices is important
  - Patients at particularly high risk for gun related violence are children, victims of domestic violence and those with mental health or substance abuse histories
  - Gag laws preventing physicians discussing gun safety with patients are thought by many to violate the physician-patient relationship

### ❖ Case Concludes (10 min)

*Amidst the melee, you and your patient's mother make eye contact and you gesture toward a window above the patient's gurney. After turning off the lights in the room, you quietly unlock the window and lift your patient out, then assist his mother in escaping. Once you visualize them running away, you crouch between the gurney and the wall and wait. After what seems like an eternity, filled with gunshots and screams, your local SWAT team neutralizes the shooter and you and your coworkers slowly emerge from your hiding places to assess the scene and start caring for victims. Luckily, your staff had engaged in an active shooter drill the week earlier and all were able to run or hide well enough that there were no fatalities.*

*Following the event and clearing of the area by local law enforcement, the hospital sought to identify exactly who and what was affected. Although there were no fatalities and the ED had been relatively well prepared, many providers harbored guilt or anger following the event. The hospital was able to begin crisis debriefing within 24-72 hours by utilizing local mental health resources in the community. They also gave information briefs to all of the employees at the facility to clarify what actually happened and provided points of contact for those that may need resources in the future. In the weeks that followed, they reviewed and revised the hospital's active shooter plan. Due to multiple children being in the ED during the event, several local schools provided counselors for those affected.*

### ❖ Case Teaching Points Summary

- **Mass casualty incidents/disaster**
  - A disaster is any event where demand exceeds your hospital's ability to provide care, and may result from a number of causes
  - The four stages of disaster management are prevention, preparedness, response, and recovery
  - Becoming familiar with your hospital's disaster plan is *vital* for adequate preparedness and response
  - Triage in a multi-casualty incident is different from our usual ED triage -- in an MCI, the goal is to provide care to as many people as possible, rationing out limited resources. Patients are sorted into:
    - **Black - Expectant** (deceased or near-death, no transport)
    - **Red – Immediate** (critical injury, emergent transport)
    - **Yellow – Delayed** (non-severe injury, delayed transport)
    - **Green – Minimal** (minor injury, able to leave scene and self-present hours-days later)
  - Providers may or may not present to work during a disaster, most commonly affected by concern for their families, a sense of duty, and availability (or lack thereof) of personal protective equipment



- **Active shooter situations and workplace violence**
  - An active shooter is generally defined as an individual or individuals actively engaged in killing or attempting to kill people in a confined or populated area<sup>7</sup> → these events differ from other forms of violence such as robberies or gang violence
  - You can best prepare for these events by being familiar with your facility's emergency action plan and participating in drills as well as by maintaining situational awareness at work and being alert for potential high-risk situations
  - The paradigm taught for dealing with an active shooter situation is "Run Hide Fight" → only fight as a last resort
  - Healthcare providers may also have an additional responsibility of treating patients after an event
  - If you must leave an immobile or critical patient to seek safety during an active shooter event it is not considered patient abandonment
  - When healthcare providers are victims of workplace violence it can impact many aspects of their functioning as a provider and can possibly lead to PTSD or depression
  - Debriefing after acts of violence is extremely important in assisting individuals cope with the incidents

## ❖ Facilitator Background Information

### Mass casualty incidents/disaster

A *disaster* is a “destructive event that disrupts the normal functioning of a community”<sup>1</sup> and can have causes that are natural (ex. earthquake), man-made (ex. Bombing) and complex humanitarian (ex. genocide). Disasters also vary in their onset (rapid versus gradual) and impact (sudden or prolonged). The main goal of a hospital is to preserve its function even in the face of threatened or limited resources, in order to provide care to as many patients as possible. Disaster management consists of four key stages, all of which are influenced by emergency medicine (EM) physicians: prevention, preparedness, response, and recovery. Preparedness and response are the two stages which we focus on during this lesson.

Preparedness consists of analyzing risks and planning ahead. Though some disasters allow for real time preparation, such as an impending hurricane, others, such as earthquakes or bombings, are unexpected and require planning prior to the incident. Hospitals and physicians should anticipate future occurrences of these devastating events and formulate clear disaster plans specific to their systems, considering the unique needs of special populations such as children, the elderly and those with chronic medical issues. A key component of a disaster plan is a hospital Incident Command System (ICS), which clearly delineates a chain of command as well as specific roles and responsibilities affiliated with those roles. Ideally, all personnel will be performing their standard roles, only much faster; hospitals should have a detailed list of all personnel, with phone numbers and home addresses, available twenty-four hours a day. Multiple authors<sup>4,5</sup> have examined who (EM attending physician, general surgeon, trauma surgeon) is the ideal person to be in charge in a disaster, with varied findings; the most important point is to establish a leadership structure in advance, then adhere to it during a disaster situation. Per Joint Commission recommendations, hospitals must test their disaster plans and ICSs with a practice disaster drill twice a year. Despite these requirements, only 48% of EM residents and 56% of EM faculty reported receiving formal disaster training,<sup>2</sup> and in a survey assessing familiarity with hospital disaster plans and standardized triage protocols<sup>5</sup>, not only did 50% of EM physicians and 20% of surgeons incorrectly identify where in the hospital to perform triage, the original survey had to be rewritten because of respondents’ lack of familiarity with common disaster and ICS terms!

When a disaster strikes, the response phase has one main goal, which differs slightly from standard emergency department (ED) practice: to provide the best care to the largest number of people, rather than the best care to each individual patient. Resources—personnel, equipment, medications, space—are limited during a disaster and the EM physician will need to rapidly

triage patients' needs to provide care to those with the greatest probability of survival without exhausting supply. Patients may be triaged in the field as well as in the ED and will frequently be triaged into four main categories:

- Black - Expectant (deceased or near-death, no transport)
- Red – Immediate (critical injury, emergent transport)
- Yellow – Delayed (non-severe injury, delayed transport)
- Green – Minimal (“walking wounded,” minor injury, able to leave scene and self-present hours-days later)

Providers may feel conflicted withholding transport and resources from a severely injured patient in extremis and will need to revisit the concept that in a disaster scenario, the needs of many outweigh the needs of one. Mental health providers should be accessible to assist staff in dealing with this psychic stress as well as to provide assistance to patients dealing with acute stress reactions. Adhering to a clear triage algorithm such as START can help providers maintain objectivity and efficiency, although especially in pediatrics, triaging providers frequently deviate from algorithms, operating instead on gestalt.<sup>11</sup> Classically, field triage has been performed by attaching paper cards to patients with their assigned triage categories but electronic triage has demonstrated similar accuracy and speed to manual and was preferred by all providers tested.<sup>12</sup> In addition to leading a team and providing direct patient care in a disaster, EM physicians may also be asked to disseminate information to other departments, media, and families and interact with entities such as law enforcement, fire and prehospital providers, government representatives and hospital administration. This re-emphasizes the importance of familiarity with basic disaster management and specific guidelines for one's hospital. Snipes et al describe EM physicians' disaster role very well: ““During disaster management, EM physicians are expected to triage, rapidly assess, decontaminate, care for and provide for the disposition of a potentially large influx of patients while interacting with fire and prehospital health care providers, law enforcement, consultants, hospital staff and administrators.”<sup>2</sup>

Not unexpectedly, personnel vary in their ability and willingness to stay at or come to the hospital during a disaster; this variation stems from a variety of factors, including concern for personal or family welfare, damaged infrastructure, a sense of duty to work and monetary incentives. EM residents and attendings in a variety of hospitals across the country were given a survey assessing their likelihood of responding to work during several examples of disaster (explosion, epidemic, natural disaster, radioactive event); the lowest hypothetical response rate was seen during a natural disaster and the highest in an explosion (see Figure 1 below).<sup>2</sup> Respondents with children were more likely to stay at home or bring their families with them to work, and not surprisingly, concern for family was overwhelmingly the most important factor in determining a respondent's willingness to come to work, regardless of location, age, or faculty or trainee status. The other two most important factors were a sense of duty to provide care and availability of personal protective equipment. In a similar survey<sup>6</sup> of ED personnel (physicians, nurses, techs, and other employees) at 8 Chicago hospitals, respondents were much

more likely to present to work after airplane crash (98%) than radioactive bomb (85%) or biologic agent (54%), regardless of gender, occupation, or whether or not they had children. In this survey, however, while employees with children were slightly less likely to report to work in a disaster the difference was not statistically significant. These two studies offer important information to hospital and ED leadership—training staff on how to protect themselves and their families during disasters, as well as providing resources for employees’ families (on- or off-site) may help recruit as many personnel as possible during a disaster.

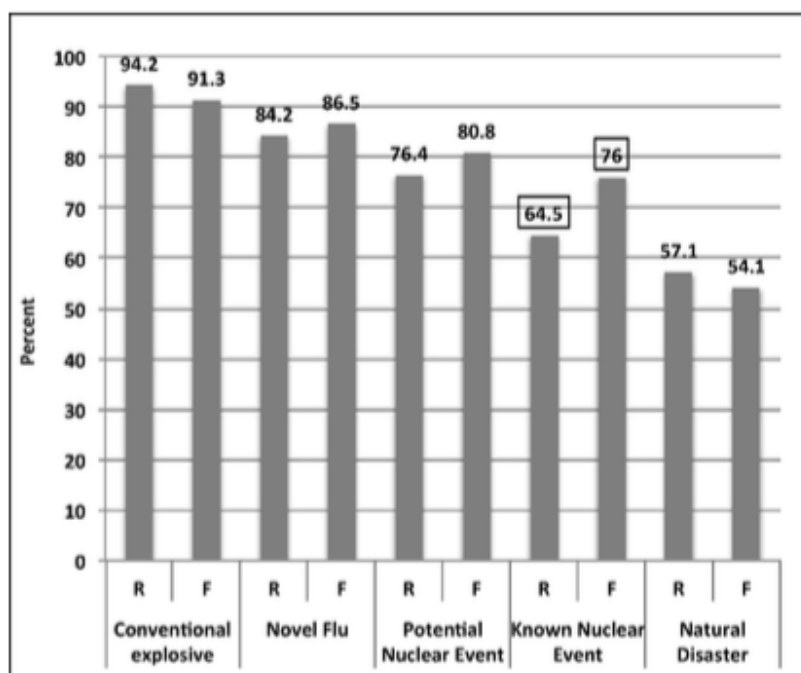


FIGURE 1 | **OVERALL PERCENTAGE OF RESIDENTS (R) AND FACULTY (F) WILLING TO RESPOND FOR VARIOUS DISASTER SCENARIOS**

(from Reference 2)

### Active shooter situations and workplace violence

Active shooter events in healthcare settings are steadily increasing and becoming more lethal. Approximately one third of events happen in the ED.<sup>8</sup> The most widely accepted definition of an active shooter is someone who is “an individual or individuals actively engaged in killing or attempting to kill people in a confined or populated area.”<sup>7</sup> The shooter in these incidents is in an irrational emotional state and generally attempting to cause as many casualties as possible. While there may be a specific target, the selection of victims is usually based on target of opportunity. Active shooter events are different than other forms of societal violence with

different motives than gang violence or theft and the perpetrator is not necessarily trying to survive the event.

Preparation is the key to maximizing your chances of survival during active shooter or other violent events that may take place in a hospital. Maintain a high level of situational awareness and be alert for high risk situations that may escalate. Always be familiar with your local emergency action plans, participate in any drills and know possible escape routes from areas of the hospital you may be working in. The most common way to alert hospital employees to a violent event involving a weapon such as a hostage situation or an active shooter is with a Code Silver. This is usually not announced directly overhead to avoid the possibility of providing additional targets to the assailant when a lockdown would provide more safety. Methods hospitals have used to announce this include sending emails, a banner appearing on a computer screen or a predetermined innocuous overhead announcement that employees understand the meaning of. A Code Gray is commonly utilized for other forms of abuse or combative behavior not involving a weapon. The American College of Emergency Physicians has multiple available resources for addressing violence in the ED.<sup>13</sup>

The paradigm most frequently used to guide people in how to react to an active shooter situation is “Run, Hide, Fight.”<sup>7</sup> These should be carried out in that order based on what situation you find yourself in. If you are able to run, have an escape route in mind and exit the building as quickly as possible while leaving your belongings behind. Keep your hands visible so that law enforcement can see you’re not armed and do not make sudden movements toward them. If you cannot run, hide in the most inaccessible place that you can get to and block and/or lock the doors. Remember to silence your phone or pager. If you are discovered or in a position where you have to engage the shooter, fight as aggressively as possible and with any weapon at your disposal. It is always more effective to attempt to incapacitate a shooter when working as part of a team. If you are required to leave the bedside of a patient that cannot be moved, it is not considered patient abandonment. Hide the patient and/or secure the room as well as you are able and exit the area as quickly as possible. You cannot be compelled to risk your safety or your life as part of your job duties regardless of your level of responsibility. Healthcare providers are also a scarce resource in these situations that need to be protected to care for the injured following the event.

Other forms of workplace violence in the healthcare setting also continue to increase and healthcare providers are at a higher risk of being assaulted than those in other work environments.<sup>14</sup> A report from OSHA noted that 70-74% of all nonfatal injuries from occupational assaults and violent acts occurred in healthcare and social service settings.<sup>15</sup> Nurses, particularly ED nurses, are the most likely among healthcare workers to be assaulted. One survey noted that 82% of ED nurses had been physically assaulted in the ED in the past year and 100% had been verbally assaulted.<sup>16</sup> Possible motives for violent acts include prisoner escape, suicide, the euthanasia of a sick relative, a grudge or revenge or acts carried out by mentally unstable individuals. There can be grave and long-lasting consequences for healthcare

providers that are exposed to violence in their workplace. Symptoms of PTSD and depression are common in addition to any physical injuries and these can lead to missed work and resultant financial difficulties. There may also be a deterioration of the relationship with patients and decreased work satisfaction and burnout.

Physician counseling on gun safety is a key component in the prevention of injuries and deaths from firearms.<sup>17</sup> While several proposed or enacted state laws have sought to limit the ability of physicians to engage in these conversations, numerous medical, legal, and public health organizations believe these so called “gag laws” violate the physician-patient relationship.<sup>18</sup> High-risk populations for access to firearms include those patients with suicidality, children, the cognitively impaired, perpetrators or survivors of domestic violence and those with substance abuse issues. Adept physician counseling regarding firearm safety has been referred to as a new form of cultural competency.<sup>19</sup> People have different reasons for owning firearms and physicians need to approach this conversation in as respectful and unbiased way as possible for it to be effective.

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- **Editors:** Dr. Natasha Wheaton and Katie Runde MFA
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