Mounting Violence in Healthcare: Is It Time to Harden the Sanctuary?

By

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Financial Disclosures: Professors Adashi and Cohen declare no conflict of interest.

Funding/Support: None

Both authors have participated in the preparation of the manuscript.

Word Count: 1141
On June 1, 2022, an active shooter incident left five people dead at the Saint Francis Hospital in Tulsa, Oklahoma.¹ The perpetrator, a disgruntled patient armed with an AR-15-style rifle purchased just hours earlier, proceeded to gun down four individuals before turning the gun on himself.¹ The intended target of the assailant was Preston J. Phillips, MD, 59, an orthopedic surgeon whom the gunman held responsible for persistent back pain following a recent surgical intervention.¹ Additional victims included sports medicine physician Stephanie J. Husen, 48, nurse Amanda Glenn, 40, and visiting spouse Mr. William Love, 73.¹ That very week, three other U.S. hospitals were the site of violent incidents. The Miami Valley Hospital in Dayton Ohio was in the grip of a county jail inmate in need of care who overpowered and fatally shot a private security guard before killing himself. The Encino Hospital Medical Center in Los Angeles California, for its part, witnessed a patient in the emergency department stabbing a physician and two staff nurses. Finally, the Wayne UNC Hospital in Goldsboro North Carolina endured an active shooter incident that injured a female visitor. In this Commentary we consider the ever-growing violence in U.S. healthcare settings and explore potential measures intent on the curtailment thereof.

The ever-escalating U.S. death toll of gun violence, the byproduct of permissive gun laws, shows no sign of abatement. According to the independent non-profit Gun Violence Archive, the annual number of deaths attributable to gun violence in the U.S. increased from 12,352 to 45,034 over the 2014-2021 interval.² Healthcare professionals have hardly been spared. Kelen at al. enumerated a total of 154 active shooter incidents in U.S. hospitals over the 2000-2011 interval.³ The high case fatality rate (55%) observed was ascribed to the close proximity and determination of the perpetrator, the surprise factor, and the frailty of hospitalized victims.³ A subsequent report of the Government Accountability Office, for its part, concluded that rates of violence against workers in healthcare
facilities were substantially higher as compared to workers overall. A more recent report by Zamore et al. concluded that the frequency with which U.S. physicians are injured or killed in hospital-based active shooter incidents has more than tripled during the past two decades. Close to 20% of the incidents in question appear to have been motivated by a grudge held against a physician for a healthcare outcome.

Hospitals, not unlike schools, or houses of worship, are not designed to guard against the threat of a determined gunman. In fact, hospitals, whether publicly or privately owned, are universally viewed as a communal resource that is (or should be) accessible to the local populace at virtually all hours of the day. Ongoing efforts to preserve this highly prized accessibility have heretofore all but precluded any attempts at target hardening. Instead, hospitals have come to rely on guidance materials, procedural protocols, and regularly scheduled drills in the hope of enhancing their state of readiness in the event of an active shooter incident. Sponsors of such hospital guides include but are not limited to the Occupational Safety and Health Administration (OSHA), the Assistant Secretary for Preparedness and Response (ASPR), The Joint Commission, the Federal Bureau of Investigation (FBI), and the Department of Homeland Security (DHS), to name a few. Notably, however, none of these readily available national resources focuses the prospect of hardening the hospital infrastructure. Faced with this reality, a growing number of U.S. hospitals have taken matters into their own hands. Guiding this trend is the growing conviction that would be perpetrators cannot be ignored nor avoided and that the materialization of an active shooter incident is just a matter of time.

Apart and distinct from the human toll associated with hospital-based active shooter incidents, consideration must also be given to the special risks inherent in the very nature of a hospital. For example, hardening of the operating room suite must be top of mind. Equal scrutiny must be applied
to the intensive care units and the vulnerable patients thereof. The prospect of advertent or inadvertent release of hazardous materials must also be entertained. It is against this backdrop that a panoply of added security measures could be considered. Examples of such upgrades include but are not limited to the curtailment of points of ingress and egress, the deployment of security officers at all entrances, the authentication of a visitor’s destination, the strategic placement of video surveillance cameras, the provision of accessible panic buttons, the posting of gun-free signage, and the establishment of hospital-wide alert systems. Consideration could also be given to installing walkthrough metal detectors and radiographic equipment to screen backpacks, bags and purses for contraband. Visitors, for their part, could also be issued visible wrist bands that are color coded to indicate permissible areas of ingress.

Any and all efforts to reduce the likelihood of an active shooter incident in the healthcare context are bound to benefit from the enactment of relevant adequately funded federal legislation. At the time of this writing, however, the political paralysis plaguing gun laws renders the enactment of gun-constraining statutes an uncertain proposition. Whether or not a hospital-focused gun law might fare better remains to be seen. Perhaps the most promising bill presently under consideration is the Health Care Providers Safety Act of 2022 (H.R.7814). Introduced on May 18, 2022 by Rep. Veronica Escobar [D-TX], the bill, now with the House Energy and Commerce Committee, seeks to amend the Public Health Service Act to authorize grants to health care providers to enhance the physical and cyber security of their facilities, personnel, and patients. Similar promise is afforded by the STOP Violence Act of 2022 (H.R.7541) which was introduced on April 18, 2022 by Rep. Joe D. Neguse [D-CO]. Seeking to amend the Homeland Security Act of 2002 and the Victims of Crime Act of 1984, the bill seeks to authorize the use of certain grant funds for active shooter preparedness. Although the near-term
enactment of the aforementioned bills remains uncertain, some hope can be derived from the recent enactment of the Bipartisan Safer Communities Act (Public Law 117-159) which comprises the first gun control legislation in nearly 30 years.

A Milliman Research Report commissioned by the American Hospital Association concluded that U.S. hospitals and health systems dedicated approximately 0.5% of their total expenditures to the advancement of security. Expanding such target hardening efforts will doubtlessly require governmental support. Until such time that bills like the Health Care Providers Safety Act of 2022 are enacted, support of hospital target hardening efforts will be limited to DHS-derived state resources. Additional governmental assistance could be secured from the Federal Emergency Management Agency (FEMA) by way of its Nonprofit Security Grant Program (NSGP) which funds soft target hardening and other physical security enhancements. Failure to capitalize on the aforementioned resources could be deemed imprudent. Expecting the worst may be just what the doctor ordered.

References


