**Episode 40 – Violence in the Healthcare Workplace**

**Intro music: 0:00**

**Podcast introduction: 0:10**
Out of all the findings gleaned from the North Carolina Medical Board's most recent Licensee Survey, one of the most sobering is this: Nearly one in three medical professionals who responded told us they had either witnessed or been involved in a violent incident with patients in the last year. Now, if you work in healthcare, especially in a busy hospital setting, this may be old news. But for the Board, this single data point was like a punch to the gut – a grim reminder of the high stakes, high stress environment licensees work in. This is Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters. Thank you for listening. Board Members and staff know that violence in healthcare isn't a problem the medical board can solve. Nonetheless, it has been a topic of frequent discussion and consideration since the survey results came in. The Board's Policy Committee developed a new position statement, with feedback from licensees and stakeholders, on defusing tense situations with patients and family members. And the Outreach Committee is considering additional ways it can help equip medical professionals to protect themselves. NCMB is also continuing to seek more information about the problem of violence in healthcare. To that end, I am delighted to welcome someone who is actively working to keep healthcare workers protected from violence in the workplace. Dr. Tim Reeder is an emergency physician who serves in the NC House of Representatives, representing District 9 in Greenville. Last year Dr. Reeder was the primary sponsor of a bill, now a law, called the Hospital Violence Protection Act. I recently spoke with Dr. Reeder about the Act and what motivated him to push for it.

**Interview with Representative Timothy Reeder, MD: 2:08**
JFB: Well, Dr. Reeder, thank you so much for joining me. I appreciate your time.

TR: Well, thanks very much for having me today. And I'm really interested to share some thoughts with the listeners from the Medical Board.

JFB: Well, great. I wondered if you could start just by giving a brief introduction. Tell us a little bit about yourself.

TR: So, I am an emergency physician. I grew up in Ohio, did all my training at Ohio State, and I moved to North Carolina in '98 and joined the faculty at East Carolina University, where I still practice full time. I have about 40% of my time is clinical and the rest is administrative and teaching. So, I'm on faculty at ECU and I'm now in the second year of my first term in the North Carolina House of Representatives. I was elected in November of 2022 and then started January 1st of 2023.

JFB: Okay, follow up to that. Can you tell me how you got interested in serving in the House of Representatives?

TR: Yeah, that's a good question. It started really in my role in the Medical Society. So, I have been active in advocacy and policy for the Medical Society for a long time. I was on the Board, and I was the

president of the North Carolina Medical Society in 2019. So, representing about 9000 physicians and PAs across the state. And so, I had a very active role in that advocacy effort. And when the election was coming up for 2022, I got a phone call to say there's a seat that's going to be open, would you consider it? And I talked to a number of friends and family and others in the medical community to say we think that you would be good for this. And there was really two things that propelled me, two principles. One is that in my clinical work in the emergency department, I saw firsthand, and I see firsthand the problems in society. So, the broken families, the educational failures, economic failures, substance abuse, mental illness, those are the patients that I take care of. And I thought that having my voice in the legislature would be able to advocate for those things. As your listeners may or may not know, there's only two physicians in the whole General Assembly out of 170 people. There was only one before I got elected. So having that physician voice in the legislature, I think, was important. So, to address some of those societal issues. But the other thing that really was a big consideration was being an advocate for the medical profession and physicians. And that voice wasn't always heard, I didn't think. And so that was the other thing that propelled me to run.

JFB: That's great. Well, thank you so much for that history. And I'm sure you know this because you've worked with our legislative liaisons and our current CEO, Thom Mansfield. But the Medical Board certainly feels that there's value in having physicians and really any licensee serving in the state legislature, because it's very important. It's not often that the Medical Practice Act comes up for consideration and tinkering and amendments and things, but when there are things that involve the practice of medicine, it's very important to have people at the table who understand, who really understand what that means and can ask the right questions and just make informed decisions. So, I know we appreciate having you there.

TR: It's meant to be a citizen legislator, right? It's a part time job, and it's meant to get representatives from a broad group of people. And working as a physician and serving in the legislature, it is really hard. And so, trying to find people who are willing and able to do that is important. And so, because the emergency department is open on nights and weekends, I can do my clinical work at those times and still allow me to have the schedule flexibility to serve.

JFB: That's a great point. I wouldn't actually have considered that. So, as you know, today's episode of our podcast is focused on the issue of violence in health care. And the reason why we thought you would be such a great guest for this episode is that you actually sponsored a bill on that very topic called the Hospital Violence Protection Act. I wondered if you could begin by telling me about that bill, and what your hopes were when you decided to sponsor it.

TR: Well, great. And I was really proud that this bill ultimately got passed and signed by the governor. It's now law, and I'm going to step back a little bit about what sort of prompted me to do this and what I know. And what I saw in my clinical practice is that we see violence towards our staff on a daily basis, and in emergency medicine and in emergency departments, there's a disproportionate share of the violence towards our staff for all sorts of different reasons. But I saw that in my clinical practice, and I knew that when I got into the legislature several years ago that it was made a felony to assault a health care worker. And so that's been on the books for a number of years. And so, I asked the Office of Courts

how many people have been charged and convicted over the last several years of a felony assault on a health care worker. And I learned that there was about 300 people charged and only about 30 people convicted across the state in any one year. And what I knew from my clinical practice is that it happened on a near-daily or certainly weekly basis. And it seemed to me that that law that was passed to protect the health care workers wasn't being effective. And so, I started asking a lot of questions. And one of the things that I learned is that reporting the crime didn't happen very often. And in many hospitals, the staff didn't feel like they were safe and protected in their workplace. The other thing that I found very compelling was about 72% of the nonfatal workplace violence episodes happened in health care.

JFB: Yes, I saw that. I was doing some research for this podcast, and I that was just jaw dropping to me. But please go ahead.

TR: Now it was shocking to me as well, because from that you would say that health care is the most dangerous profession that's out there. And I didn't think that that would have been true. I didn't think that most people would. And so, I started to think and gather information from other organizations in other states. What are some steps that we could do to help mitigate this and make sure that our staff was safe? And so that was what was the genesis of the Hospital Violence Protection Act.

JFB: Could you say a little bit more about what it actually does?

TR: Yeah. And so it is, it's a first step. And so, I don't want people to think that this is the be all and end all, because what I learned that this is a very complicated process. But what the bill does is say that we're going to ask hospitals with an emergency department to develop a safety plan for their institution. What are the types of risks associated with the facility? And it's not just about the patients or the people in the emergency department. It's also we…we see active shooters in health care. There's a number of cases. So not just about how do we ensure safety in the emergency department, but from a facility standpoint. And it asks for those hospitals to develop those and then to share them to develop recommendations from the Department of Health and Human Services that can be shared with hospitals. So that was one of that, one of the…the provisions said, we want to get some information back from the Office of Courts about how many people were charged and convicted. And then probably the meat of the bill was to require a law enforcement officer at every hospital that had an emergency department. And one might certainly not be enough, but at least to say that there's going to be somebody there who is a law enforcement who's trained to be able to help provide safety for staff and for the facility and the institution. Now, I know that many hospitals already have law enforcement officers on their campus, but especially when you got out to the smaller hospitals, they didn't have that. And so that's what the meat of the bill is, is to say we're going to have somebody there. And the reason that this was important to me is that if we don't have someone there to protect and then to intervene and to gather the story, that's the first step in making sure if someone is acting criminal, that we start that process.

JFB: That's a that's a really interesting point about larger urban hospitals and health systems would have law enforcement and would have the infrastructure in place, like safety plans and things that the smaller facilities, the further out into the rural areas, rural parts of our state that you get that that would be less

common. So, you know, we talk about sometimes, you know, the differences in standard of care from urban and rural, but this is the difference as well. So that sounds like this is aimed at getting consistency, safety no matter what the setting.

TR: And one of the things that from a regulatory body, from the Joint Commission, they have safety standards. But when we when I started to look at this, most of those safety standards are related to patient care. They don't relate to safety of the staff. And so, our regulatory body has not developed policies and procedures and requirements for the protection of staff. And so, I think as I said this is a first step. I think that there's a lot of other things that we couldn't do over time to help ensure our staff is safe.

JFB: It's a really interesting point. I mean, you're absolutely right that patient safety has been at the forefront of any conversation about safety and health care for a very long time. It's only more recently that I've certainly been hearing about the safety of health care medical professionals working in health care settings. How long has this issue of violence and health care been on your radar?

TR: For a long time. When I was practicing, and we are lucky in the setting that I work, we have our own police force who have 100 full time officers and 50 part time officers. I learned from our Chief of police that we are the ninth largest police department east of I-95. So, I even in our setting where we have a police force, we have seen and I've witnessed violence and assaults on our staff for many, many years. And I think that it's really gone unnoticed and unaddressed, I think, for a variety of reasons. But I'm really happy that we can start the conversation and start the process. And one of the things that propelled me to do this is that I know from a clinical standpoint, if staff don't feel safe, if their attention is diverted, they can't give the care to the patients that the patient deserves. And so, if you're a worker and you're worried about being safe and doing your job, that's going to divert your attention. And so ultimately, this really comes back to how do we make sure that our staff can devote the time and the energy to taking care of the patients in a way that we all would want?

JFB: Right. Now, I imagine some listeners are already familiar with this problem of violence and health care, but some may not be. I wondered if you could give a little bit more detail, or but a little bit more background on the issue, and maybe some specific examples of the types of incidents that occur?

TR: Yes. I think if your listeners would Google “healthcare violence” or “violence against workers,” they would find all sorts of stories that happen all the time. There was a case in Idaho where someone came in with a gun to try to break out a prisoner, and he shot two guards that were in the emergency department. We heard about an orthopedic surgeon who came in and was shot. I was just on a panel with a physician assistant in North Carolina, and someone came in to rob the practice and hit her in the face and broke her jaw. And so, again, these are all stories that are out there. Another real personal example from me is one of our attending physicians was working in the emergency department, and a patient sucker punched him, punched him in the face, broke his face, knocked him unconscious. And so, our attending physician went from being the caregiver to being a trauma patient in a matter of minutes. And so, he had permanent damage from that. And so, we see it. And those are extreme examples. But on a daily basis, we have patients and family members, quite honestly, oftentimes it might not be the

patient. It could be a family member or someone else who yells and screams and threatens us. And so that happens all the time. And so, I hear the stories in the news, but from a personal experience, we see that all the time.

JFB: Yeah. And are these, you know, they disagree with the care that they're getting? They think they're being discriminated against? What are the things that spark this sort of violence?

TR: There's a lot of different things. And I think one of the reasons why it's more prevalent in emergency departments is that when people are in the emergency department, that is not something that they planned for. They're usually not in their best state of mind. They are under stress. The emergency department is not a quiet environment all the time. And so, I think all of those compound the issue. I think the other thing that overlays all of this is, it seems to me over the last number of years, there's more societal violence that's out there. And that spills over into the emergency department. It seems like people are willing to resort to violence in a quicker way than they used to and lash out. And I don't have data on that, but that's the sense that we see just looking at other societal issues and problems. That just seems to be at a higher level of violence.

JFB: And it seemed like things got a lot worse during the pandemic.

TR: I think that that's one of the contributing factors. It goes back to people's stress, inability to get care, worry about all sorts of conditions. So, I think that that's absolutely true. Covid exposed a lot of problems in the health care system, and the health care system before Covid was sort of limping and struggling along. But Covid really broke a lot of the health care system.

JFB: Now, what you're describing probably is more pronounced in the emergency department where you work. The violence is not limited to the emergency department, it can happen really anywhere in the health care system. But this has to get into the psyche, I would think, of health care workers. How impactful has this violent environment or the threat of violence been on medical professionals?

TR: It certainly has. And I wish that I had hard data to say, here's the impact, but we don't have that. One of the things that we asked in the bill is for hospitals to actually collect and report this data, because right now nobody gathers data on when a nurse was yelled at or when someone was threatened. We just don't have that. And so that's one of the components of the bill. But in talking to people, the stories where people were injured are ubiquitous. We see and hear those all the time. But I think what we don't often hear about and people don't talk about is, is how is that affected their willingness or ability to show up for their job? And I know that it does because it does for me. When you have someone who's yelling at you or threatening you, it does make you question why is it that I show up to try to deliver care and help people out when they're not appreciative of it or, you know, just even decent about not screaming at me.

JFB: Or actively fighting you.

TR: Yes.

JFB: Yeah. So, and I have to think that this is a factor that's contributing to the burnout epidemic among medical professionals.

TR: Yes, absolutely. When we look at what are the factors, so, loss of control is a big predictor of burnout. But individual safety is also one of those contributing factors. And I don't want the listeners to think that we're trying to go after our patients. What I know is that the clinicians, we are able to differentiate when it's an 80-year-old patient who's demented and has an infection, and they're acting out versus the people who are volitional and really criminal in their actions. And I think that we as clinicians know how to differentiate that. And when we know that when someone's suffering from a mental illness or a medical issue, we have ways with which to deal with that, and that doesn't require putting people in handcuffs and charging them with crimes. And so, I'm confident that we can figure out that difference.

JFB: That's an interesting point. I was about to say that it's not just a medical professional versus a patient. There are other patients receiving care who are impacted by the violence that's occurring as well. So, I was going to ask you to say, you know, how is patient care affected by this? You said earlier that it's got to affect, you know, patient care if people don't feel safe in their workplace. But could you say a little bit more?

TR: So absolutely, if the emergency department is as a crowded environment sometimes, or the hospital, and when you have a patient who's threatening or yelling, that's not a good therapeutic environment for all the patients around. And so those patients will get scared as well, just like we do. And so, I think what I'd like to be able to do is to say we're going to take care of our patients in a nice therapeutic environment. And when you have this threat or underpinning of violence, it will impact that. And when someone is acting out, it diverts the time and attention from the rest of the patients who are around.

JFB: Now I wanted to ask, you know, what the response has been to your bills, particularly among hospitals and health systems, health care employers. What have you been hearing from them? Are they happy to have the bill?

TR: So, from the front-line workers, overwhelming support. I think the people who show up every day on the front lines, who face this, overwhelming support. I think from the health care systems, it's been a little bit mixed and none of them don't want to help protect their staff. Okay? But I think that their main concerns that I heard when we were working on the bill was there's a shortage of law enforcement officers across the state. And are we going to be able to find the law enforcement officers to do that? Okay. So that was probably the biggest concern is finding the bodies. There's a cost factor for some hospitals as well, was an issue, and those were the two biggest things that I heard. I had an interaction with one health care system is that they were worried about the perception of their hospital having armed law enforcement officers. Okay. And that's legitimate. But what I know from the emergency medicine literature, when we've studied metal detectors and armed officers, the emergency medicine literature says patients feel better being cared for in that environment because there's a level of safety. And so that was some information that I could share from my clinical practice with some of these

hospital systems to say, your patients are actually going to appreciate this, and you ought not to be fearful that they're going to think that this is an unsafe place.

JFB: The other thing that occurred to me is when you mentioned the reporting requirement, that's an administrative burden as well. And I wondered if that was something that was concerning to any of the health care employers out there.

TR: They didn't articulate that to me. And it might be that they just were looking at the other things, and they didn't think this was going to be a big deal. It will be an issue, I think, because it will require hospitals to collect some information that they hadn't otherwise done. And so, I'm anxious to see what that data looks like, because even in my hospital, I don't think we have a good mechanism by which clinical staff can report that. Oftentimes we have normally this deviant behavior. I mean, there's a term out there about normalizing deviance. And we have come to accept that it's part of the job to have someone screaming and yelling at you and threatening you, and that's not right. And so I think we have some work to do with our staff to say, you don't need to take this. You shouldn't have to put up with this. And we need to start reporting it and collecting that data.

JFB: The other thing I wanted to ask about, as you may know, the Medical Board is in the process of developing a position statement that offers our licenses guidance on diffusing tense situations with patients and family members. The hope there is that licenses might be able to prevent violent incidents from occurring. Some of our licensees, though, when we published that position statement and sought feedback on it, have shared that there are just some situations that can't be defused and they are concerned that might not be realistic or practical for all situations, which I think is certainly a fair point. Can you speak to what else hospitals and medical practices are doing to try and keep providers safe? You've mentioned the law enforcement aspect, but I'm wondering if there are other approaches.

TR: I think that there are a lot. There are physical things that practices in particular could and should do to help provide safety for their staff. There's one example that I was talking about, where the medical practice was robbed. They had a practice of propping open a back door when people were delivering things, and they didn't have any cameras. And so, this person came into the practice because the door was propped open. And so, what it prompted her in her practice to do was to say, we need to look at that. And so, they set a policy. We're not going to pop the door open, we're going to have locks, we're going to install cameras, we're going to escort people in and out in order to provide safety. So, I think, you know, we talk about this, and a lot of this has to do with hospital violence. It can happen in the outpatient clinics as well. So, I think that was one of the rationales to say we need to share between health systems the stories and best practices of what you can do. And so, there's some physical things that places can do, making sure you know who's coming and going through whatever process you have and making sure that when there are ways to get in the building that they're locked and secure. From the individual, I think that there's a lot of training that can be done to help defuse situations. That is part of the bill for the law enforcement officers and things that we can do. But you're right, there are sometimes where we can't defuse, and then we as health care providers and health systems have to say the behavior of this person has gone beyond what is acceptable. And this is a criminal offense. If someone is threatening to do violence to you, that's an assault, that is illegal. And we as individuals and

health systems need to work with our district attorneys to prosecute those. One of the things that I learned in this whole process was that when we talk about the conviction rate, the DA told me that a lot of health care workers are reluctant to prosecute these. They don't want to tell the stories. They don't want to have to show up in court. And that's, again, that continuum of things that we want to address. One of the things that I found from health systems was that if there was an assault or something, the staff would have to leave and go to the magistrate to start the criminal process. That's the process. It's not like on TV where the police officer just puts you in handcuffs. That doesn't happen. But some of the health systems, the employee would actually have to clock out of work to go to the magistrate. Now, so now in some of the health systems weren't aware that that was true. Or then when criminal case if it did go forward, the staff member might have to take PTO to go to the criminal case.

JFB: Oh, wow. Yeah, that doesn't seem fair.

TR: Yeah. And I think it's not because of a lack of care. I think it just never occurred to people and groups to say we ought to be supportive of our employees as they go through this process. And so, I think that, again, there's a number of things that maybe require a legislative fix, maybe just conversations with our health system to say, here's some best practices as how you can support your staff when they're going through this very, very difficult situation.

JFB: Yeah, that all sounds great. Now, you mentioned in earlier in our conversation that you considered your bill or the law now to be a first step. Are you continuing to work on this issue and are you working with any organizations on it?

TR: So, I got through my first term, and we're looking to get back into the short session here in a little while. I think the short answer is yes. The longer answer is where are the next steps that we need to go? Is it, and I know and believe that it's working with the DA to say this is a real issue and this could and should be a priority for you. And whether that needs a legislative fix or more just conversations, I think, with the prosecuting attorneys, but also helping our health systems, our health care workers to say this is not acceptable, this is criminal behavior. And if we're going to change behaviors, then we need to do things about that. And so, I don't know, again, if those are legislative fixes or just having conversations with individuals and groups, but it's really the entire continuum of observing, reporting, and prosecuting again that criminal behavior.

JFB: Yep. So, the other thing I wanted to ask about, and I need to be careful asking the question because I wanted to ask if you're aware of resources that we can share with our licensees, you know, to help them protect themselves or learn how to respond in situations of conflict. But as we've been saying, I'm wary of trying to make it seem that we're putting the responsibility all on the licensee or all on the medical professional, because, as you've said, their job is to take care of patients and it shouldn't fall on their shoulders to keep themselves safe solely.

TR: Yeah. I wish I was better prepared to say, here's the top five resources. I think, for health systems, one of the terms that's used all the time is non crisis intervention. And so looking at programs that will do that. I think in that example of the practice is engaging with either a security group or even starting

with the local law enforcement to say, would you come out and help us look at our practice, our physical environment, to say what are things that we could be doing to make us safer? So, I think that there's a number of things that are out there. Unfortunately, I'm not as familiar to be able to tell you all right now.

JFB: Are there opportunities to get involved where you work through the medical staff, you know, being a voice in your facility to say this is a priority. And, you know, I don't know, get yourself on a safety committee or something to make sure that your facility is taking seriously the planning and the obligation to develop that safety plan.

TR: I think absolutely, one of the conversations I had with a lot of health systems and staff members is, is there a committee, a process, a group to look at staff safety in the institution? And what I found is that many of them do not. Again, the Joint Commission focuses on patient safety. And so, my encouragement was to say what are the policies, procedures internally? What can you do to help demonstrate to the staff that you take their safety seriously?

JFB: I mean, I know, gosh, even at the medical board, and I suspect that a lot of other employers, I want to say it was maybe about five years ago or so, we had active shooter training and had a more focused approach towards safety. So, the things that you were mentioning, like not propping doors open, making sure people don't follow you into a secure building or a secure area of your building, those are all things that we're doing outside of health care. Certainly, seems like, you know, health care facilities should be doing that too.

TR: Unfortunately, sometimes what happens when there's this initiative is that we think we can change this with education. We're going to have this staff watch a PowerPoint or do some online module. And education is good. But I teach a lot of quality improvement. And if we're going to change behavior, we have to go beyond education. So just like we practiced disaster drills, could and should we practice an active shooter drill? Could and should we practice some of those role plays to say, how are you able to practice some of those de-escalation techniques? And so, I think it's not enough to just say we've checked the box and we've given some education. I think that we have to be a little bit more active in our systems to practice and do these things.

JFB: Absolutely. Dr. Reeder, I don't have any more prepared questions for you, but I always do like to give my guests the opportunity to add any final words. If there's anything I haven't asked about that you feel is important to this conversation, now's your chance.

TR: I want to thank you for this opportunity. As we've been discussing, this is really just a start. And one of the things that I want the licensees to hear is that you shouldn't have to feel unsafe in your workplace, and it's the responsibility of the employer of the institutions to help do that. And so, you, as licensees, need to make sure and raise those issues and questions to the systems in which you work. And I think that too often we have become numb to what is really deviant behavior. And we have to increase that voice. And it's really hard. I know if you've suffered an injury or violence to go through the whole process, the criminal process takes a long time. And every time that you have to interact with

that, it's emotionally charged. And so, what I'd say is find people to help support you. And for institutions, develop processes to help support your employees when they're facing, or suffered, some of these episodes.

JFB: Thank you very, very much, Dr. Reeder. This has been illuminating for me, and I'm sure it will be for our listeners as well.

TR: Well, thank you very much. And, my door is always open, and if somebody has questions or needs or wants to discuss more, I am happy to do that.

JFB: All right. Well, we can put your contact information for your legislative office on our show page, and we're happy to do that. Thank you again.

**Episode closing: 31:28**
That brings us to the end of this episode of MedBoard Matters. If we piqued your interest in more information about violence in healthcare, good news: we have more on our podcast show page, which you can find at www.ncmedboard.org/podcast. Visit the page to find the text of the Hospital Violence Protection Act, and a link to NCMB's new position statement on defusing tense situations. We have also linked to some statistics about violence in healthcare. If you are a medical professional, we would love to hear about your experiences. Have you encountered violence when providing patient care? What steps are hospitals, health systems and other employers taking to keep you safe? What other resources do medical professionals need to stay safe in the workplace? Share your thoughts by sending an email to podcast@ncmedboard.org. Thanks so much for listening. I hope you will join us again.