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DISRUPTIVE PATIENT BEHAVIOR: BALANCING PATIENT RIGHTS AND PROTECTION FOR CALIFORNIA EMERGENCY WORKERS

California is in need of legislation that protects health care workers by increasing the penalty for individuals demonstrating acts of aggression.

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"If you're standing on a street corner and you strike a nurse, we put you in jail. When you're in a hospital and you strike a nurse, we give you a series of drugs and get you out as soon as possible. That's not right."

-Dr. Mike Wilson, Clinical Research Fellow, UCSD[1]

I. INTRODUCTION

Emergency Department nurse Jessica Leigh Taylor recounts an encounter in which a patient threatened to kill her.[2] "Grabbing my hand he squeezed it until I thought it would break. It took several staff members to restrain him. I will never forget how he looked into my eyes and smiled as I screamed in pain." [3] The police arrived and Jessica provided a detailed statement but the patient was not arrested as his attack had not resulted in "serious bodily injury." [4] As defined by California Penal Code§243 serious bodily injury involves impairment of an individual's physical condition.[5] California Penal Code§ 243(b) makes "battery causing serious bodily injury against peace officers, firefighters, emergency medical technicians, lifeguards, security officers and animal control officers engaged in the performance of his or her duties, whether on or off duty, punishable by a fine of up $2,000 or imprisonment not exceeding 1 year in county jail."[6] However, Penal Code §243 only applies to physicians and nurses during the provision of emergency medical care "outside" a health care facility.[7] This confirms the already looming belief that violence within the hospital comes with the job.[8]

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[1] Carlson, J. (2011, October 17). Security Lapses. *Modern Medicine*. Retrieved from http://www.modernhealthcare.com/article/20111017/MAGAZINE/310179953 (emphasis added).
[2] Taylor, J. (2010). Workplace Violence: It's Not a Part of Your Job Description, *Amer J of Nursing*. 10(3)11. Retrieved from http://journals.lww.com/ajnonline/Fulltext/2010/03000/Workplace_Violence.2.aspx
[3] *Id.*
[4] *Id.*
[5] CA Penal Code §243
[6] CA Penal Code § 243(b)
[7] *Id.*
[8] Kowalenko, T., Cunningham, R., Sach, C.J., Gore, R., Barata, I.A., Gates, D., Hargarten, S.W., Josephson, E.B., Kamat, S., Kerr, H.D. & McClain A. (2012). Violence: Recognition, Management, and Prevention. *J. of Emer Med.* 43(3) 523-531.

Several states have already answered the call for increased penalties for those who assault health care workers. [9] But California health care workers are not afforded the same legal protections as police officers and other public servants.[10] While some states have failed to pass laws that would better protect nurses, others have by classifying the assault of a nurse as a class "D" felony.[11] California is in need of legislation that protects health care workers by increasing the penalty for individuals demonstrating acts of aggression. California emergency workers also need greater support from healthcare institutions and increased knowledge about their rights. As concluded in a 2009 study conducted by Smith et. al, of violence in U.S. emergency departments "without legislative action at the state and federal level and innovative strategies at the hospital and department level, there can be no realistic hope of significantly decreasing ED violence."[12]

This study will focus on violent and disruptive behaviors in the emergency department as it is one of the most vulnerable settings for workplace violence.[13] This paper begins with an overview of the ineffectiveness of California legislature in protecting emergency personnel. Part I begins by discussing current legislation and where it falls short in its efforts to protect workers. Part II provides background of the increasing problem of disruptive behavior in the emergency department. Part III describes the establishment of patients' rights and offers some examples of how they sometimes impede the emergency worker's right to a safe work environment. Part IV defines disruptive behavior and identifies contributory factors. Part V examines California law and how it fails to protect emergency department personnel by increasing penalties for assaultive and disruptive individuals. In Part VI, the study will determine the degree to which California legislature pales in comparison to that of some other states and countries. Part VII evaluates the health care worker's attitude about reporting disruptive behavior while Part VIII explores what California healthcare organizations are doing to support and protect workers. Part IX of the study intends to prove the extensiveness of disruptive behavior by demonstrating the financial and staffing implications of workplace violence. The study concludes with Part X by suggesting legislative efforts critical to California's ability to offer greater protections.

II. BACKGROUND

According to the U.S. Department of Justice, "workplace violence accounts for approximately 900 deaths and 1.7 million non-fatal assaults each year in the United States."[14]

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[9] Emergency Nursing Association (2014). 50 State Survey Criminal Laws Protecting Healthcare Professionals. Retrieved from https://www.ena.org/government/State/Documents/StateLawsWorkplaceViolenceSheet.pdf.

[10] *See* CA Penal Code *supra* note 5

[11] Smith, J.G., Juarez, A.M., Boyett, L, Homeyer, C., Robinson, L., MacLean, S.L. (2009). Violence Against Nurses Working in US Emergency Departments. *J Nursing Admin.* 39, 340-349.

[12] *Id*. p. 348

[13] *Id*. p. 340

[14] US Department of Justice (2001). Bureau of Justice Statistics. National Crime Victimization survey; Violence in the Workplace 1993-1999. http://www.bjs.gov/index.cfm?ty=pbdetail&iid=693

The Bureau of Labor Statistics estimated that health care workers had a higher rate of workplace violence than workers in all other industries between 1993 and 2009.[15] As noted in Figure 1, the rate of workplace injury is relatively low among health care workers.[16] Conversely, half of all workplace assaults occur in the health care industry.[17] Healthcare workers are at the greatest risk of assault and injury from the violent behavior of patients, families and visitors.[18]

Figure 1

Source: U.S. Dept. of Labor Occupational Safety and Health Administration, (2016)

The Occupational Safety and Health Administration (OSHA) reports that on average, from 2012-2013, the occurrence of workplace violence resulting in serious bodily injury was significantly higher in healthcare settings than other industries.[19] Healthcare workers in general are at risk for violence; however, emergency settings are among those showing the highest levels of abuse.[20] This is partly due to the fact that the emergency department has historically been the "safety net" for society.[21] Risk factors for the high rate of assault on emergency workers listed in the

[15] Occupational Safety and Health Administration (2016). Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. Retrieved from https://www.osha.gov/Publications/osha3148.pdf
[16] *Id.* p. 3
[17] *Id.* p. 3
[18] *Id.* p. 3
[19] Occupational Safety and Health Administration (2015). Workplace Violence in Healthcare: Understanding the Challenge. Retrieved from https://www.osha.gov/Publications/OSHA3826.pdf
[20] *See* Smith et al. *supra* note 11 p. 341
[21] Heisler, E.J., Tyler, N.L. (2014). Hospital-Based Emergency Departments: Background and Policy Considerations. Retrieved from https://www.acep.org/uploadedFiles/ACEP/Advocacy/federal_issues/Congressional%20Research%20Service%20(CRS)%20Report%20on%20Hospital-Based%20Emergency%20Departments.pdf

Occupation Safety and Health Act's 1998 report include the fact that the criminal justice system relies heavily on hospitals for the management, care and treatment of violent individuals.[22]

Surprisingly, incidents of violence in hospitals are vastly underreported.[23] There are unique challenges in healthcare that contribute to the attitude of acceptance regarding violence in the healthcare setting.[24] For instance, some caregivers foster a "professional and ethical duty to do no harm" to patients while some see the abuse as an expression of patients' illnesses.[25, 26] Yet others contribute a lack of reporting and acceptance of violence to the belief that reporting will not bring about change and that it may in fact, result in retaliation.[27] Arguably, if patients were aware that they could be prosecuted for their actions it might serve to deter future assaults.[28] However, when nurses are assaulted in the workplace they are forced to consider many factors before deciding to take legal action against the assailant.[29] This may include the belief that the patient, distraught family member or visitor is unaware of what they are doing.[30] Nurses also express a lack of support from the organization.[31] In a survey of emergency department nurses, over fifty percent concur that "Nurses who take legal action against a patient are in jeopardy of losing their jobs."[32]

In Jersey v. John Muir Medical Center, nurse Ester Jersey, an at-will employee at John Muir Medical Center filed suit against the employer for wrongful termination in violation of public policy.[33] Jersey was terminated because she refused to dismiss a personal injury action against a former patient who had assaulted her at work.[34] According to Jersey, the patient pulled her hair before forcing her to the ground and touching her breast.[35] One year later Jersey filed suit against the patient claiming battery, assault and sexual battery. Her employer, upon learning about the suit, gave Jersey an ultimatum; to dismiss the action or consider herself resigned[36] John Muir representatives noted that the patient was on their head trauma unit and that it would not be unusual for such patients to demonstrate behavior that is erratic and sometimes violent.[37] The trial court ruled in favor of the Medical Center finding that Jersey's employment was at will and that the termination did not violate public policy.[38] The Court of Appeals affirmed the judgement.[39]

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[22] U.S. Department of Justice. Workplace Violence: Issues in Response. Retrieved from https://www.fbi.gov/file-repository/stats-services-publications
[23] *See* OSHA *supra* note 19
[24] *Id.*
[25] *Id.*
[26] Jacobson, J., (2007). Violence and Nursing. *Amer J of Nursing.* 107, 25-26
[27] See Kowalenko *et al. supra* note 8 p. 524
[28] Slovenko., R. (2006). Violent Attacks in Psychiatric and Other Hospitals. 34 *J. Psychiatry & L*. 249.
[29] National Advisory Council on Nurse Education and Practice (2007), Annual Report to Secretary of Health and Human Services and U.S. Congress. An Assessment of Causes and Impact of Violence in Nursing Education and Profession Retrieved from https://www.hrsa.gov/advisorycommittees/bhpradvisory/nacnep/Reports/fifthreport.pdf
[30] *Id*. p. 10
[31] Speroni, K.G., Fitch, T., Dawson, E., Dugan, L. & Atherton, M. (2014). Incidence and Cost of Nurse Workplace Violence Perpetrated by Hospital Patients or Patient Visitors. *J. Emer Nursing.* 40(3)
[32] *See* National Advisory Council *supra* note 29 p.10
[33] Jersey v. John Muir Medical Ctr., 97 Cal. App. 4th 814 (Cal. App. 1st Dist. 2002)
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.*

To further complicate matters, organizational policies regarding how to report violent events are not always clear and health care workers are often confused about what even constitutes assault.[40] However, as incidents of violence become more prevalent in hospitals, nurses, more often the victims, are protesting what they say are inadequate protections.[41] In a 2011 survey of emergency department violence conducted by the Institute for Emergency Nursing Research, participants not only expressed their dissatisfaction with the administrative response but also reported a lack of legal system response to violence.[42] The respondents noted that none of the individuals who injured them were arrested or charged for the violence in the ED.[43] On one occasion in which the assailant was arrested, it was not for injuring the nurse but for an earlier charge of resisting arrest.[44]

By not filing charges, patients are essentially given a license to commit crimes against health care workers without any consequences.[45] Moreover, by not prosecuting, and not holding the offender accountable, we send the message to the offender that his aggression is acceptable.[46] Legislation in every state should ensure that the crime of assault against a health care provider is taken as seriously as assaults against police officers and other public servants.[47]

III. LAWS THAT DEFINE PATIENTS' RIGHTS

Proclaimed in 1948, the Universal Declaration of Human Rights recognized the "inherent dignity" and "equal and unalienable rights of all members of the human family."[48] The idea of patients' rights was founded on the premise of "the person, and the fundamental dignity and equality of all human beings."[49] One such right, passed by Congress in 1985 entitles patients to an emergency medical screening examination and treatment with no regard for whether the patient can pay for the services provided.[50] The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that mandates Medicare-participating hospitals to furnish an appropriate medical screening exam to individuals who present to their emergency departments for treatment of a medical condition.[51] The Act prevents health care facilities from turning away patients with life and health-threatening conditions or discharging patients before their conditions are stabilized.[52] Although EMTALA is vaguely written concerning the rights of emergency workers caring for violent or disruptive patients, it is clear about the fact that hospitals providing substandard or nonexistent medical screening for any reason (including antagonism between the medical personnel and the patient, drunkenness, spite, etc.) may be in

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[40] *See* National Advisory Council *supra* note 29 p. 10
[41] *See* Jacobson *supra* note 26 p. 25
[42] Wright-Brown, S., Sekula, K., Gillespie, G., Zoucha, R. (2016). The Experiences of Registered Nurses Who Are Injured by Interpersonal Violence While on Duty in The Emergency Department. *J of Forensic Nursing*. Retrieved from www.journalforensicnursing.com
[43] *Id.*
[44] *Id.*
[45] *See* Slovenko *supra* note 28 p. 260
[46] *Id.*
[47] *See* Taylor, *supra* note 2
[48] World Health Organization, Patient Rights, retrieved at http://www.who.int/genomics/public/patientrights/en/
[49] *Id.*
[50] Rosenbaum, S., Seigel, B., Regenstein, M. (2005-2006) EMTALA and Hospital Community Engagement: The Search for a Rational Policy. 53 *Buff. L. Rev*. 499.
[51] *Id.*
[52] *Id.*

violation of the law.[53]

Like EMTALA, the Health Information Portability and Accountability Act (HIPAA) is also ambiguous concerning the sharing of information about patients who may pose a threat to themselves and others.[54] HIPAA includes a privacy rule governing "protection of all individually identifiable health information or protected health information" maintained by a covered entity.[55] The intent of HIPAA is to protect patients' personal information but the privacy rule forces emergency physicians to decide what information must be kept in the proverbial vault of secrecy and what must be shared for the health and safety of others.[56] Rather than providing clear guidance for emergency physicians, the privacy rule is confusing at best and misleading at worst concerning the disclosure and documentation of information.[57] Physicians are left to venture into the murkiness of the HIPAA privacy rule.[58] There are some who oppose the stringency of the rule noting that it was not written with those suffering from mental illness in mind.[59] As a result, families are often left in the dark about their loved ones condition, symptoms and treatment options.[60]

On June 16, 2015, Virginia state senator Robert Creigh Deeds discussed the HIPAA Privacy Rule in his address to congress stressing that the restriction placed on the release of protected health information excludes the family and other caretakers from the patient's care team.[61] His address was prompted by a November 2013 attack that the senator himself sustained at the hand of his son who suffered from schizophrenia.[62] The attack resulted in permanent injuries for Senator Deeds and the death of his 24 year old son by suicide.[63] Senator Deeds argued that HIPAA's restrictive nature creates a barrier; preventing the passing of vital information about patients who are on involuntary psychiatric hold to the patient's loved ones and caretakers[64] Providers risk violating the privacy rule by simply calling the family to inform them that their loved one is in the hospital.[65] The very law that set out to protect the rights of individuals also impairs the provider's ability to obtain the information necessary to make an accurate assessment and treatment plan.[66]

The privacy rule is also vague regarding the documentation of disruptive incidents. Patient record flags are alerts placed in the electronic health record (EHR) and intended to alert employees to patients whose behavior may pose a threat to themselves or others.[67] The question is however, what should be documented in the patient record about the disruptive behavior and

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[53] Cleland v. Bronson Health Care Group, 1990 U.S. App. LEXIS 18863 (6th Cir. Mich. 1990)
[54] Raines, R. (2016). Evaluating the Inebriated: An Analysis of the HIPAA Privacy Rule and Its Implications for Intoxicated Patients in Hospital Emergency Departments. *University of Dayton Law Review* 40(3) 479-498.
[55] Gibson, D. (2010). HIPAA Maybe This Will Help. *Mississippi Lawyer* 56(4) 33-35.
[56] *See* Raines *supra* note 54 p. 481
[57] *See* Raines *supra* note 54 p. 498
[58] *Id.*
[59] Piercing the Privacy Veil: Toward a Saner Balancing of Privacy and Health in Cases of Severe Mental Illness, 66 Hastings L.J. 1769
[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] MENTAL HEALTH WEEK, 161 Cong Rec H 6826
[66] *Id.*
[67] Department of Veterans Affairs, Office of Inspector General (2013) Management of Disruptive Patient Behavior at VA Facilities. Retrieved from www.va.gov/oig/pubs/VAOIG-11-02585-129.pdf

how should it be documented. Not providing enough information may prevent providers from identifying and implementing strategies to prevent harm.[68] Nevertheless, some feel that patients may be stigmatized by putting too much in the EHR.[69] Health care organizations are faced with the challenge of balancing the rights and health care needs of disruptive patients, families and visitors with the health and safety of others.[70]

Patients' rights were designed to establish expectations for the public with regards to the treatment and respect that they should expect from the government and those who care for their medical needs.[71] California is in need of laws that afford the same direction, respect and protection for health care workers. According to Margaret Brazier, Professor of Law, Centre for Social Ethics and Policy, "a moral duty to behave with courtesy and consideration in sickness as much as in health may be perceived as a mere pious aspiration.[72] But what must be examined is whether such an aspiration should or could create concrete legal obligations incumbent on patients in their dealings with doctors, nurses and others."[73] Brazier further argued that one's ethical obligation does not disappear with the onset of illness.[74] Towards the end of his judgement in *R. v. Collins and Ashworth Hospital Authority ex. p. Brady*, Judge Kay J. delivered the following:[75]

> "…….*it would seem to me a matter of deep regret if the law has developed to a point in this area where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing.*"[76]

IV. DISRUPTIVE BEHAVIOR

Disruptive behavior can be defined as behaviors demonstrated by patients, families, visitors, and all other persons that (1) pose a threat to the health or safety of others (2) creates a barrier to the safe delivery of care (3) impedes the operations of the facility.[77] Disruptive behavior can take the form of verbal abuse, which includes name calling, racial epithets, sexual harassment, or physical aggression such as hitting, kicking, biting, throwing objects, spitting, stabbing and shooting[78,79] Emergency nurses experience more physical and verbal abuse than non-emergency nurses.[80] Emotional stress, long wait times, communication gaps and 24 hour accessibility all make the emergency department particularly susceptible to violence.[81]

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[68] *Id*.
[69] *Id*.
[70] *Id*.
[71] *See* World Health Organization s*upra* note 48
[72] Brazier, M. (2006). Do No Harm Do Patients Have Responsibilities Too. *Cambridge Law Journal* 65(2) 397-422.
[73] *Id.*
[74] *Id*.
[75] *Id.*
[76] *Id.* p. 397 (emphasis added).
[77] *See* Department of Veterans Affairs *supra* note 67 p. 8
[78] *Id.*
[79] *See* Kowalenko et al. s*upra* note 8 p. 524
[80] *Id.*
[81] Kao L., Moore, G., (1999). The Violent Patient: Clinical Management, Use of Chemical and Physical Restraint, and Medicolegal Concerns *Emergency Medicine Practice* 1(6).

Most problematic for emergency personnel are the violent patients who arrive to the emergency department involuntarily; often agitated and confrontational.[82] These patients commonly present with mental illness and/or substance abuse which significantly increases the risk of disruptive behavior.[83] Nurses in various studies of violence in the ED noted that perpetrators were altered by drugs and alcohol in 27% -60% of the cases.[84] The ED staff is usually exposed to these individuals for long periods of time as they are often left by law enforcement until deemed clinically sober.[85] Mental health funding cuts have also imposed a significant burden to emergency departments across America.[86] Patients suffering from mental illness present with conditions that have deteriorated with the lack of structure and proper care.[87] With the limited availability of mental health facilities, the emergency department often serves as the pathway for hospitalization and treatment.[88]

However, much debate has ensued regarding use of the mental health system in controlling dangerous individuals.[89] One proponent, Thomas Szasz, author of "The Myth of Mental Illness" argued that the criminal justice system should be responsible for managing these individuals instead.[90] Szasz contends that "the aggressive paranoid person, who threatens violence, legally he should be treated like a person charged with an offense; psychiatrically it would be desirable of course, if he were not incarcerated in an ordinary jail, but in a prison hospital where he could receive both medical and psychiatric attention." [91]

Nonetheless, not every patient who demonstrates disruptive behavior suffers from mental illness or substance abuse. Patients who have little knowledge or understanding of what is involved in delivering care often feel a loss of control.[92] Denial of services and the health care worker's attempt to limit disruptive behavior may also trigger violence.[93] Pain and discomfort, long wait times, lack of privacy and cramped space all contribute to patients, family members, and visitors striking out at emergency personnel.[94] Family members may also have a misconception of emergency staff as being cold and uncaring.[95]

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[82] *Id.*

[83] Petit, J., (2005). Management of the Acutely Violent Patient. *Psychiatric Clin N Am* 28 701-711

[84] *See* Kowalenko et al. *supra* note 8 p. 525

[85] *Id.*

[86] Baker, J.O., Gutheil, T.G. (2011) Are You Kidding; Effects of Cutbacks in the Mental Health Field on Patient Care and Potential Liability Issues, 39 J. Psych. & L. 425

[87] *Id.*

[88] *Id.*

[89] Huber, G.A., Roth, L.A., Appelbaum, P.S. & Ore, T.M. (1982) Hospitalization Arrest or Discharge: Important Legal and Clinical Issues In the Emergency Evaluation of Persons Believed to Be Dangerous to Others. 45 *Law & Contemp. Probs*. 99.

[90] *Id.*

[91] *Id.*

[92] Rodr´ıguez-Acosta, R.L,, Myers, D.J., Richardson, D.B., Lipscomb, H.J., Chen, J.C. & Dement J.M. (2010) Physical Assault Among Nursing Staff Employed in Acute Care. Department of Epidemiology, School of Public Health, University of North Carolina at Chapel Hill,
Department of Community and Family Medicine, Division of Occupational and Environmental Medicine, Duke University Medical Center 35, 191–200

[93] *Id.*

[94] *See* Smith et al. *supra* note 11 p. 341

[95] *See* Smith et al. *supra* note 11 p. 347

There are many reasons why incidents of violence and disruptive episodes in the healthcare setting are on the rise. [96] Among the reasons are dynamics associated with economics, job loss and the increase in patients presenting to the emergency department with drug-seeking behavior.[97] The widespread increase of violence in health care settings compelled The Joint Commission to publish a sentinel event alert issue 40 "Behaviors that Undermine a Culture of Safety."[98] Sentinel event alerts identify trending concerns from data gathered by the commission.[99] The Joint Commission notes in Sentinel Event Alert Issue 40 that "intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats as well as passive activities such as refusing to perform tasks or quietly exhibiting uncooperative attitudes during routine activities."[100]

There are always challenges and legal considerations that further complicate the work of those caring for violent and disruptive individuals; mainly, the rights of the patient, duty of the provider, and concern for third parties.[101]

V. CALIFORNIA LAW

The Lanterman Petris Short Act (LPS) concerns the involuntary commitment of individuals with a mental disorder, chronic alcoholism or those who are gravely disabled and pose a danger to themselves or others.[102] Section 5150 of the California State Welfare Institute Code allows the involuntary commitment or "5150 hold" for short term monitoring of such individuals.[103] These patients present to the emergency department for medical assessment and clearance before transfer to the appropriate setting for treatment.[104] Many California mental health facilities require blood work to rule out co-occurring medical problems as a condition of acceptance. Unfortunately, the Welfare Institute Code is silent about when or if a patient deemed dangerous loses the right to refuse treatment and tests.[105] According to California Welfare and Institute Code §§5326.5(d) "an involuntary psychiatric hold alone does not negate the presumption of competency to make treatment decisions."[106,107] As such, patients are often left boarding in the emergency department for extended periods of time and emergency workers are left to manage them.

In 2014 Governor Jerry Brown signed California Senate Bill 1299.[108] This bill tasked the Occupational Safety and Health Standards Board with ensuring that general acute care hospitals, among others, develop and include workplace violence prevention in their illness and injury

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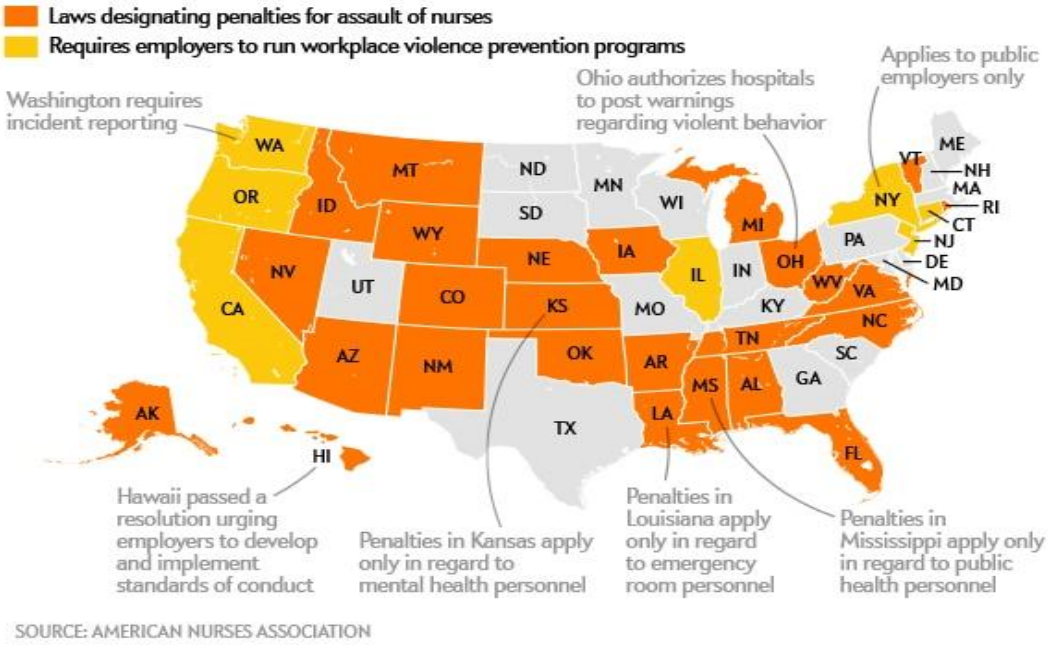
[96] American Society for Industrial Security (2010). Managing Disruptive Behavior and Workplace Violence in Healthcare. Retrieved from https://www.asisonline.org/Pages/default.aspx
[97] *Id.*
[98] *Id.*
[99] *Id.*
[100] The Joint Commission. Behaviors that Undermine a Culture of Safety. Sentinel Event Alert Issue 40. Available at http://www.jointcommission.org/assets/1/18/SEA_40.PDF
[101] *See* Kao *supra* note 81. p. 20
[102] 38 Ca Jur Incompetent and Disordered Persons § 106
[103] Cal Wel & Inst Code § 5150
[104] *See* Wright-Brown *supra* note 42 p. 190
[105] *See* Rodr´ıguez-Acosta et al. *supra* note 92
[106] Cal. Welf. & Inst. Code §§5326.5(d)
[107] Riese v. St. Mary's Hosp. & Med. Ctr., 271 Cal. Rptr. 199, 208 (Ct. App. 1987)
[108] 2013 Legis. Bill Hist. CA S.B. 1299

plan, providing greater protection for healthcare workers.[109] The bill requires hospitals to train staff involved in direct patient care on recognizing, responding and reporting incidents.[110] Hospitals also have to report events resulting in injury or involving firearms or other dangerous weapons to Cal/OSHA within 24 hours.[111] Furthermore the bill prevents hospitals from taking punitive or retaliatory action against employees who seek assistance or intervention from law enforcement.[112] Some states have elected to implement state plans which must be at least as effective as the federal mandate and must cover public sector workers.[113] See Figure 2[114]

Figure 2



SB 1299 is sponsored by the California Nurses Association whose members have not only expressed their frustration with the lack of adequate protection in the workplace but also their belief that the bill provides a remedy.[115] On the contrary, the California Hospital Association (CHA) opposes the bill, arguing that it is unnecessary and duplicative of Cal/OSHA efforts currently underway.[116] The effort that CHA refers to is the California Hospital Safety and Security Act passed in 1993 requiring hospitals to develop comprehensive security plans to address prevention of and response to violent events.[117] The plans were to include provisions for the development of policies and procedure, physical layout, staff training, appropriate staffing

[109] *Id.*
[110] *Id.*
[111] *Id.*
[112] *Id.*
[113] Occupational Safety and Health Administration (2015). Preventing Workplace Violence: A Roadmap for Healthcare Facilities. Retrieved from https://www.osha.gov/Publications/OSHA3827.pdf
[114] Jacobson, R. (2014) Epidemic of Violence Against Healthcare Workers Plagues Hospitals. Scientific American retrieved from https://www.scientificamerican.com/article/epidemic-of-violence-against-health-care-workers-plagues-hospitals/
[115] *See supra* note 108
[116] *Id.*
[117] Casteel, C., Peek-Asa, C., Nocera, M., Smith, J., Blando, J., Goldmacher, S., O'Hagan, E., Valiante, D., Harrison, R., (2009) Hospital Employee Assault Rates Before and After Enactment of the California Hospital Safety and Security Act. *Ann Epidemiol* 19(2) 125-133

and reporting of violent incidents.[118] No formal measure of the Act's success in reducing assaults against California healthcare workers has been found; however, a study conducted by Casteel et. al set out to compare assault rates of California emergency workers pre and post enactment, with that of New Jersey where no state legislature for workplace violence prevention exists.[119] California assault rates were consistently higher pre enactment but rates for both states became similar post enactment.[120] Nevertheless, assault rates in both states began increasing in the late 1990 as a result of emergency department overcrowding; a trend recognized nationally.[121]

CHA also notes that Cal/OSHA's mandate to establish "effective procedures for obtaining assistance from the appropriate law enforcement agency" is not feasible as several hospitals have reported local law enforcement's refusal to cooperate and take reports on patient assaults against staff.[122] Some California hospitals have reported law enforcement's failure to respond at all.[123] Moreover, CHA disagrees with the "prohibition on a hospital's ability to direct employees to contact internal security staff rather than local emergency services or law enforcement is not in the best interest of employee safety or patient care because contacting internal security can provide the assistance and support needed in a timelier manner."[124] While SB 1299 forces California health care organizations to focus on much needed planning and training, it is questionable as to whether it will prevent or act as a deterrent for individuals demonstrating disruptive and violent behavior as some workplace violence cannot be prevented[125] In 2009, Gillespie et al. conducted a study to test the effectiveness of implementing workplace violence reduction plans in the ED.[126] The six emergency departments that participated in the study were community based suburban as well as level 1 trauma and urban tertiary.[127] Three of the EDs implemented interventions for 9 months and 3 did not.[128] The researchers hoped to prove that assaults and threats of physical violence against ED workers by patients and visitors could be reduced by instituting interventions such as training, policies and procedures and environmental changes.[129] The hypothesis that the sites with interventions in place would experience a greater decrease in the number of workplace violence incidents than the comparison sites was not proven.[130] Instead, both groups experienced fewer threats and assaults during the study period.[131]

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[118] *Id.*
[119] *Id.*
[120] *Id.*
[121] *Id.*
[122] California Hospital Association (2014) Final Letter to Occupational Safety and Health Standards Board. Retrieved from http://www.calhospital.org/sites/main/files/file-attachments/final_letter_to_calosha_re_healthcare_workplace_violence_prevention__regulations_v2_8-10-16.pdf
[123] *Id.*
[124] *See supra* note 108
[125] *See* California Hospital Association *supra* note 122
[126] Gillespie, G.L., Gates, D.M., Kowalenko, T., Bresler, S., Succop, P., (2014) Implementation of a Comprehensive Intervention to Reduce Physical Assaults and Threats in The Emergency Department. *J Emerg Nurs* 40:586–91.
[127] *Id.*
[128] *Id.*
[129] *Id.*
[130] *Id.*
[131] *Id.*

Unfortunately, the most significant opponent to the idea of increasing penalties to provide greater protection for California health care workers is California Governor Jerry Brown.[132] Assembly Bill 172 relating to hospital emergency departments was introduced by California Assemblyman Freddie Rodriguez in 2015.[133] AB 172 was intended to increase penalties for an assault or battery committed "inside" the hospital against emergency personnel.[134] California State Assembly and Senate both passed the bill unanimously; however, Governor Brown vetoed the bill and in part stated "If there were evidence that an additional six months in county jail (three months, once good-time credits are applied) would enhance the safety of these workers or serve as a deterrent, I would sign this bill. I doubt that it will do either."[135]

VI. LAWS IN OTHER STATES

Several states including New York, Colorado and Texas have stiffened their laws for greater protection of emergency department personnel.[136] For instance, New York legislation now makes the penalty for second degree assault of a registered nurse, license practical nurse and other emergency personal, while in the line of duty, the same as that of other responders.[137] Assaults previously charged as misdemeanors are now charged as class D felonies.[138] In 2013, Texas Governor Rick Perry signed HB 705 increasing the penalty for those who assault emergency personnel from a class A misdemeanor to a third degree felony.[139] Colorado's SB 15-067 also increased the class of offense for certain acts of assault against emergency medical care providers.[140] Interestingly, Louisiana law makes "willful interference in the performance of a health care provider's duties relating to the care and treatment of patients, punishable by a fine not less than one hundred dollars or more than two hundred and fifty dollars upon conviction of a first offense, and not less than two hundred fifty dollars or more than five hundred dollars or ten days in jail or both upon conviction of any subsequent offense."[141]

VII. EMERGENCY WORKERS' ATTITUDE ABOUT VIOLENCE AND THE LAW

In 2009, the Emergency Nurses Association (ENA) launched a surveillance study of violence in U.S. emergency departments.[142] Data was collected from 7,169 participants from 2009-2011.[143] Before this study, data regarding violence and verbal abuse in emergency departments was scant and it did not accurately depict the frequency of occurrences due to the underreporting of events.[144] Research indicates that the more nurses are assaulted, the less likely

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[132] 2015 Legis. Bill Hist. CA A.B. 1959
[133] 2015 Bill Text CA A.B. 172
[134] *Id.*
[135] *Id.*
[136] *See* Emergency Nurses Association *supra* note 9
[137] NY CLS Penal § 120.05
[138] *Id.*
[139] Tex. Penal Code § 22.01
[140] 2015 Colo. ALS 337, 2015 Colo. Ch. 337, 2015 Colo. SB 67
[141] La. R.S. § 14:332
[142] Institute for Emergency Nursing Research (2011). Emergency Department Violence Surveillance Study. Retrieved from https://**www.ena.org**/practice-research/research/Documents/ENAEDVS
[143] *Id.*
[144] *Id.*

they are to report.[145] This is a phenomenon known as "habituation" whereas individuals with an initial emotional response to violence becomes less emotional with repeated incidents.[146] As a result, the true extent to which violence occurs in the emergency department remains relatively unknown to the general public and not fully recognized among health care institutions.[147] The ENA identified the need for this study in order to bring awareness of the extent of violent events in the ED and the impact to emergency workers.[148] As with the study conducted by Rodriguez-Acosta et al., results of the ENA study also indicates under-reporting of all forms of abuse amongst emergency personnel.[149,150] In a 2014 study, emergency nurses were asked to submit narrative responses regarding their experiences of assault in the ED.[151] A common theme amongst respondents was a feeling of vulnerability and a lack of administrative support and judicial protection.[152]

According to the study conducted by Smith et. al, ED nurse dissatisfaction and the low rate of reporting violent incidents is due largely to the belief that violence is part of the job, lack of support from the organization, inadequate staffing, the perception that reporting will reflect negatively in patient satisfaction scores and fear of retaliation from management.[153] Yet nurses reported in the Wolf et.al study that they received well intended support from their managers but were then discouraged by hospital administrators, law enforcement and other officials from pressing charges against assailants.[154] In the same study, one respondent noted receiving a call from the district attorney's office informing her that she could bring charges against the perpetrator but that there would probably be no sentencing.[155] Another respondent reported that the district attorney refused to get involved and said that the case would be a waste of taxpayer money.[156] Even more disturbing was one participant's account of the judge remarking "Well, isn't that the nature of the beast being in the emergency room and all?"[157]

In the aforementioned case, *Jersey v. John Muir Medical Center*, Esther Jersey filed suit against the medical center for wrongful termination and argued that it was her right to file suit against the patient who assaulted her.[158] The appellate court ruled that there was no strong public policy that prevented the termination despite the absence of a policy or agreement prohibiting employees from suing patients.[159] John Muir representatives wrote in its letter to Jersey "suing a patient who cannot be held accountable for his actions because of a medical or psychological condition fits neither our mission nor its values. We expect you as a provider of

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[145] Erickson, L., Williams-Evans, S.A., (2000). Attitudes of Emergency Nurses Regarding Patient Assaults. *J Emer Nursing*. 26(3) 210-15
[146] Id.
[147] *See* Institute for Emergency Nursing *supra* note *142* pg. 7
[148] *See* Institute for Emergency Nursing *supra* note *142* pg. 8
[149] *See* Rodr´ıguez-Acosta et al. *supra* note 92
[150] *See* Gillespie *supra* note 125
[151] Wolf, L.A., Delao, A.M., Perhats, C. (July 2014) Nothing Changes, Nobody Cares: Understanding the Experience of Emergency Nurses Physically or Verbally Assaulted While Providing Care. *J Emer Nursing.* 40 (4).
[152] *Id.*
[153] *See* Smith et. al s*upra* note 11 p. 343
[154] *See* Wolf et. al *supra* note 151 p. 307
[155] *Id.*
[156] *Id.*
[157] *Id.*
[158] See *Jersey v. John Muir Medical Center supra* note 33
[159] *Id.*

patient care to assist our patients through their acute stages of illness and support them as they move through the health care continuum. Suing patients for non-intentional behavior does not meet these goals."[160] But in reality, determining whether behavior is intentional or not is not easy.[161] Providers typically avoid reporting violent incidents that they attribute to such medical conditions as altered mental status.[162] But the average healthcare worker is not qualified to make such a judgment.[163] As noted by Dr. James Phillips, board-certified emergency medicine specialist and faculty member at Beth Israel Deaconess Medical Center "if a nurse is beaten by a psychotic patient who later screens positive for PCP, shouldn't the criminal justice system determine whether the act meets the required elements for battery?"[164] He adds "While we must continue to be particularly careful to protect our patients suffering from delirium, psychosis, or dementia, we also must remember that alcohol- and drug-related assault and battery is a crime on the street as well as inside the ED. Intoxication, drug seeking, and withdrawal leading to violence shouldn't be tolerated and are no excuse for abusing health care workers. It's a police matter and should be reported to protect health care providers and help prevent recidivism."[165]

As previously mentioned, the law is ambiguous and in some cases silent about protections afforded healthcare workers who want to file charges against assaultive patients. California law must make clear the emergency worker's rights when caring for violent and disruptive patients including the right to refuse assignment of a violent patient. The American Nurses Association (ANA) supports the nurses' right to reject assignments that place themselves or patients at risk for harm.[166] Of course there are legal and ethical implications that must be considered when doing so to avoid charges of abandonment.[167] The ANA defines patient abandonment as "a unilateral severance of the *established* nurse-patient relationship without giving reasonable notice to the appropriate person so that arrangements can be made for continuation of nursing care by others. Refusal to accept an assignment (or a nurse-patient relationship) does not constitute patient abandonment."[168] Legal protection is also offered under 29 CFR§1977.12 when employees are faced with carrying out their assigned duties or rejecting the assignment that they fear will place them at risk for serious injury or death.[169] The Act states that "if the employee, with no reasonable alternative, refuses in good faith to expose himself to the dangerous condition, he would be protected against subsequent discrimination."[170]

The concept of patient abandonment was originally reserved for the inappropriate severance of the physician-patient relationship. The termination usually occurs as a result of the patient's non-compliance or abusive behavior. Patient Brenda Payton, subject of the landmark

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[160] See *Jersey v. John Muir Medical Center supra* note 33

[161] Phillips, J.P. (2016) A Safe Space: Violence Toward Emergency Department Providers Isn't Just Part of the Job. *Amer College of Emerg Physicians.* Retrieved from http://www.acepnow.com/violence-toward-emergency-department-providers-isnt-just-part-job/?singlepage=1

[162] *Id.*

[163] *Id.*

[164] *Id.*

[165] *Id.*

[166] Graner, Becky (2015) Accepting a Patient Care Assignment Reaffirms Nurses' Contract with Society. American Nurses Association: *American Nurse Today* 10:2 Retrieved from https://www.americannursetoday.com/accepting-patient-care-assignment-reaffirms-nurses-contract-society

[167] *Id.*

[168] American Nurses Association (2009) Position Statement: Patient Safety: Rights of Registered Nurses When Considering a Patient Assignment. Retrieved from http://nursingworld.org/rnrightsps

[169] 29 CFR 1977.12

[170] *Id.*

Payton v. Weaver case, was a 35 year old with end stage renal disease who was dependent on hemodialysis treatment three days a week.[171] According to Dr. Weaver, Payton's continued drug use, failure to follow diet restrictions and keep appointments made the provision of care difficult.[172] The trial court also concluded that Peyton's behavior had been disruptive and abusive.[173] As such, Dr. Weaver sought to terminate the physician-patient relationship.[174] But what rights do emergency physicians have to discontinue care of the chronically ill, non-compliant and disruptive patients who routinely seek care in the emergency department? According to EMTALA, they have none as emergency department physicians are uniquely challenged with having to evaluate and treat every patient who presents to the ED.[175]

Some emergency physicians, like nurses, feel that violence in the ED is part of the job and even possess a sense of pride for how well they and their colleagues function in such a volatile and unpredictable environment.[176] But the violent and often uncontrolled environment of the emergency department can take a toll on emergency physicians.[177] In the United States, one physician commits suicide every 24 hours and 17% of physicians surveyed reported knowing a colleague whom they said was impaired.[178] This suicide and substance abuse rate is higher than that of other professions and has been directly associated with work related stress.[179] In a 2005 survey of emergency physicians in Michigan, 75% of the 171 respondents reported verbal threats while 28% said that they had been physically assaulted within the last year.[180] According to the study, 16% of the participants report that they have considered leaving the profession because of violence in the emergency department.[181]

VIII. RESPONSIBILITY OF THE HEALTHCARE ORGANIZATION

According to the Occupational Safety and Health (OSH) Act of 1970 Section 5(a)(1) also referred to as the General Duty Clause, employers have a general duty to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."[182] The Bill of Rights for registered nurses, published by the American Nurses Association in 2001, states that "nurses have the right to work in an environment that is safe for them and their patients."[183] Researchers have found that workplace violence continues to be a problem due to healthcare organization's failure to adequately address the problem.[184] Employers fail to clearly define rules

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[171] Payton v. Weaver, 182 Cal. Rptr. 225 (Cal. App. 1st Dist. Apr. 26, 1982)
[172] *Id.*
[173] *Id.*
[174] *Id.*
[175] *See* Rosenbaum et al. *supra* note 50.
[176] *See* Kowalenko et al. *supra* note 8 p. 526
[177] *Id.*
[178] Lee, M., Brown, D., Cabrera A., (2016) Physician Burnout: An Emergent Crisis. *Progress in Pediatric Cardiology* 44 (2017) 77–80.
[179] *Id.*
[180] *See* American Society for Industrial Security *supra* note 96 p. 3
[181] *Id.*
[182] *See* OSHA *supra* note 113 p. 3
[183] Clements, P.T., DeRanieri, J.T., Clark, K,, Manno, M., Wolcik, K.D., (2005) Workplace Violence and Corporate Policy for Health care Settings. Nursing Economics 3(23). Retrieved from http://www.ncdsv.org/images/WorkplaceViolenceCorporatePolicyHealthCare.pdf
[184] *Id.*

for appropriate conduct and fail to institute and enforce reporting of threatening and disruptive behavior and violent events.[185] Also, employers fail to take immediate action against those who commit acts of violence or demonstrate disruptive behavior.[186] Although it may not be intentional, failure to address workplace violence may result in a sense of administrative abandonment.[187] This feeling of abandonment manifests from inadequate staffing, the organization failing to improve safety when promised, concerns that go ignored and lack of support from administrators after a violent event.[188]

One major responsibility of the organization is to respond appropriately after a traumatic event.[189] Organizational response plays a very important role in the recovery process.[190] Healthcare workers feel further victimized and have a harder time recovering when the organization is more concerned about public perception than the welfare of its staff.[191] Hospital administrators often want to avoid negative publicity and the risk of harming the organization's image which may occur when law enforcement is involved in disruptive and violent events.[192] However, California Health and Safety Code Section 1257.7 and now SB 1299 requires California hospitals to report to law enforcement within 72 hours any assault and battery on healthcare workers resulting in injury or involving firearms or other dangerous weapons.[193]

In 2010, the California Nurses Association suggested in addition to stiffer penalties for those who assault healthcare personnel, that stronger penalties be imposed on healthcare organizations that fail to comply with the 1993 security plan requirement.[194] This came after the tragic death of a nurse who died after an inmate she was caring for struck her in the head with a lamp in a Northern California correctional facility.[195] The facility personnel had previously suggested changes that would have made the environment safer; however, the facility failed to implement the changes until after the tragic event.[196] A Cal OSHA investigation of the incident resulted in the imposition of "Citation and Notification of Penalty" violations in addition to proposed penalties for violation of the General Duty Clause in the amount of $14,060.[197] Cal OSHA found that "the employer did not effectively implement corrective methods and/or procedures for unsafe conditions or work practices involving physical assault hazards."[198] It is imperative that healthcare organizations comply with the laws and regulations established with the intent of creating safer work environments for California healthcare workers.

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[185] *Id*.
[186] *Id*.
[187] *Id*.
[188] *Id*.
[189] *See* American Society for Industrial Security *supra* note 96 p. 9.
[190] *Id*.
[191] *See* American Society for Industrial Security *supra* note 96 p. 9.
[192] *See* U.S. Department of Justice *supra* note 22 p. 38.
[193] California Health and Safety Code 1257.7(d).
[194] National Nurses United (2010) Press Release: Following the Death of an RN Killed on the Job CA Nurses Call for Better Protections. http://www.nationalnursesunited.org/press/entry/following-the-death-of-a-rn-killed-on-the-job-ca-nurses-call-for-better-pro/
[195] *Id*.
[196] National Nurse (February 2012). Workplace Violence: Assessing Occupational Hazards and Identifying Strategies for Prevention. Retrieved from http://nurses.3cdn.net/4cd804c2355d96de20_rtm6bat6w.pdf
[197] *Id*.
[198] *Id*.

Research indicates a consistent lack of administrative and judicial support in the aftermath of violent events.[199] Fear of negative publicity or reputational risk is a contributing factor.[200] When asked about his experience with violence, one nurse who had been assaulted in the emergency department of a children's' hospital reported the lack of support by noting "because they want the children's hospital to appear friendly, they have not secured the doors."[201] Internal incident reports are confidential and protected from discovery.[202] Healthcare administrators often use such confidential reporting mechanisms to keep violent events from becoming public knowledge.[203]

Hospitals are likely to be concerned with civil liability questions, confidentiality and what information can be disclosed to the police.[204] Likewise, law enforcement officers have information that might benefit healthcare organizations that they too are legally bound to protect regarding criminal records, firearm ownership and past reports of violence.[205] Both healthcare workers and law enforcement have to balance the duty to keep patient information confidential with that of the duty to disclose.[206] Further complicating the situation for healthcare organizations is the special attention that must be paid for the population of HIPAA-protected patients.[207] This group includes patients in correctional institutions.[208]

According to SB 1299, Cal/OSHA's mandate for workplace violence prevention in California, institutional plans should outline post-incident response of the organization.[209] The organization's post-incident response should include psychological and medical care, debriefing, documentation, investigation and correction of identified safety risks and hazards.[210] Healthcare organizations should view workplace violence as a systems issue instead of individual or isolated occurrences.[211] As part of its ethical duty to workers, healthcare organizations should conduct assessments to evaluate the effectiveness of its violence prevention program as well as the ongoing safety of its workers and the environment in which they work.[212]

Saint Agnes Hospital in Baltimore Maryland has pioneered a model workplace violence prevention program that should be followed by all. Saint Agnes has taken steps to show the staff, patients, visitors and other associates that violence is unacceptable and that there are consequences for violating polices related to disruptive behavior.[213] With administrative support, Saint Agnes has informed its most violent offenders that they are not welcome and will no longer be admitted to the hospital.[214] This does not of course, apply to the emergency

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[199] *See* Wolf et. al *supra* note 151 p. 308
[200] Erickson, L., Williams-Evans, S.A., (2000) Attitudes of Emergency Nurses Regarding Patient Assaults. *J. Emerg Nurs* 26(3).
[201] *See* Wolf et. al *supra* note 151 p. 307
[202] *See* Slovenko *supra* note 28 p. 250
[203] *Id.*
[204] *See* U.S. Department of Justice *supra* note 22 p. 38.
[205] *Id.*
[206] Doughterty, J., Kiel, J.M., (2009) Patient Rights and Emergency Medicine. *J Emerg Nurs* 35(6)
[207] *Id.*
[208] *Id.*
[209] Blanchard-Saiger, G., Thornburg, C., Lackey, C., (2014) Workplace Violence Prevention: Cal/OSHA's Impending Regulations. Retrieved from http://www.calhospital.org/sites/main/files/file-attachments/workplaceviolence_final.pdf
[210] *Id.*
[211] *See* American Society for Industrial Security *supra* note 96 p. 8
[212] *Id.*
[213] *See* OSHA *supra* note 113 p. 8
[214] *Id.*

department.[215] Saint Agnes also offers financial assistance to employees who wish to press charges against their assailants and helps them navigate through the legal system.[216]

IX. OTHER CONSEQUENCES OF DISRUPTIVE BEHAVIOR

In addition to public image, inadequate staffing and budgetary constraints play a part in the perceived lack of support from organizations.[217] Workplace violence may result in temporary loss of staff due to injury which can affect the daily operations of an organization by creating high turnover and low morale.[218] Moreover, staff may experience increased anxiety and low job satisfaction all of which affects the provider's ability to care for patients.[219] In a study of 1,209 ED nurses in Pennsylvania, 17% said that they have considered leaving the profession while 14% have considered transferring out of the ED due to fear of assault.[220]

California has a minimum nursing ratio of 1 nurse to 5 patients for the ED and medical surgical areas.[221] California is the only state with laws and regulations that require that this minimum staffing be maintained.[222] However, many hospitals have a difficult time filling vacancies for ED nurses as well as recruiting and retaining physicians due to the intense environment.[223] Facilities are sometimes faced with lowering their standards when under pressure to fill positions which puts patients and the organization at risk.[224] Furthermore, crowding in emergency departments contribute to both nurse and physician shortages by creating job dissatisfaction and fear of unsafe conditions.[225] According to Dr. J. Brian Hancock, former president of The American College of Emergency Physicians, overcrowding is a growing concern throughout the U.S. and emergency physicians and nurses are reaching their breaking point.[226] Overcrowding not only impacts the staff's ability to effectively deliver care but it also fuels patient frustration.[227] As one patient stated "do I have to hit someone to be seen by a doctor?"[228] In addition to precipitating violence, inadequate staffing also creates a barrier to the safe delivery of care.[229]

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[215] *Id.*
[216] *Id.*
[217] Pich, J., Hazelton, M., Sundin, D., Kable, A. (2010) Patient-Related Violence Against Emergency Department Nurses. *Nursing and Health Sciences* 12:268-274.
[218] Wei, C.Y., Chiou, S.T., Chien, L.Y., Huang, N., (2015) Workplace Violence Against Nurses – Prevalence and Association with Hospital Organizational Characteristics and Health Promotion Efforts – Cross Sectional. *International Journal of Nursing Studies* 56:63-70.
[219] *Id.* p. 65
[220] *See* Erickson and Williams-Evans *supra* note 145 p. 214
[221] California Department of Health Services (2014). Information Regarding Licensed Nurse to Patient Ratio Regulations. Retrieved from https://archive.cdph.ca.gov/services/DPOPP/regs/Documents/AFLpostSupCourtDecision.pdf
[222] *Id.*
[223] *See* Heisler and Taylor *supra* note 21 p. 26
[224] *See* National Advisory Council *supra* note 29 p.11
[225] *See* Heisler and Taylor *supra* note 21 p. 26
[226] *See* Baker et. al *supra* note 86 p. 428
[227] *Id.*
[228] *See* Slovenko *supra* note 28 p. 251
[229] *See* National Nurse *supra* note 196 p. 21

Often overlooked is the financial impact of workplace violence on healthcare institutions.[230] The Bureau of Labor Statistics reports that assault on healthcare workers accounts for most nonfatal injuries and illnesses resulting in days off than any other in the healthcare and social assistance industry.[231] Each year workplace violence results in an average of 1.7 million nonfatal assaults and 900 homicides.[232] Although not exact, it is estimated that costs associated with reduced productivity, missed work days, workers compensation, medical costs and security expenses are in the billions.[233] For instance, one hospital incurred cost of $94,156 as a result of violent injuries inflicted on thirty nurses in one year.[234] This cost included $78,924 for treatment and $15,232 in lost wages.[235]

X. **Conclusion**

As the media and the streets have become more violent, so too has the workplace.[236] As such, it is vital that the issue of violence in the ED is addressed with urgency through legislation as well as cooperation from law enforcement and active commitment from healthcare organizations.[237] Ironically, individuals at the highest risk of assault are those who have committed themselves to caring for others.[238] We must dispel the normalization of violence so embedded in the emergency department culture and shatter the myth that violence is an expected and acceptable part of the job.[239] We must also make those who demonstrate disruptive and violent behavior towards healthcare workers accountable for their actions. Both can be accomplished by (1) increasing the penalty for assaults against healthcare workers performing their duties inside or outside of a healthcare institution and making the penalty the same as that for other public servants (2) balancing the rights and healthcare needs of patients with the health and safety of workers by making laws concerning such issues as EMTALA and HIPAA less ambiguous for emergency physicians and nurses[240] (3) and by holding healthcare institutions responsible for creating a safe environment for patients, visitors and staff and penalizing organizations that fail to do so.[241]

Healthcare institutions can begin demonstrating a commitment to reducing ED violence by removing barriers to reporting and by implementing and enforcing prevention programs and zero tolerance policies.[242] Prevention programs should clearly define the employee and the organization's responsibility to the prevention of violence but should also include the responsibility of each during and after a violent event.[243] The purpose of SB 1299 is to prevent

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[230] Hahn, S., Zeller, A., Needham, I., Kok, G., Dassen, T., Halfens, R. (2008). Patient and Visitor Violence in Hospitals: A Systematic Review of the literature. *Aggression and Violent Behavior Review Journal* 13: 431–441

[231] *See* Wolf et. al *supra* note 151 p. 305

[232] Speroni, K.G., Fitch, T., Dawson, E., Dugan, L., Atherton, M. (2014). Incidence and Cost of Nurse Workplace Violence Perpetrated by Hospital Patients or Patient Visitors. *J Emer Nursing* 40(3).

[233] *See* U.S. Department of Justice *supra* note 22 p. 12

[234] *See* Occupational Safety and Health Administration *supra* note 19 p. 4

[235] *Id.*

[236] *See* Erickson and Williams-Evans *supra* note 145 p. 214

[237] *See* U.S. Department of Justice *supra* note 22 p. 63

[238] See National Nurse supra note 196 p. 18

[239] *See* Pich et al. *supra* note 217 p. 268

[240] *See* Raines *supra* note 54

[241] *See* National Nurses United *supra* note 194

[242] *See* Smith et al. *supra* note 11 p. 347

[243] *See* American Society for Industrial Security *supra* note 96 p. 9.

violent incidents and to protect employees when violent events do occur.[244] It is too soon to know how effective the bill will be in reducing workplace violence. However, aside from the latter, the most important thing that SB 1299 can accomplish is to encourage organizational support of staff affected by violence and restore emergency worker confidence in administration. SB 1299 may also serve to heighten policymaker and community awareness of the impact, including the financial cost, of disruptive and violent behavior to healthcare organizations.[245]

Lastly, several studies report judicial systems unwilling to pursue charges against perpetrators which makes efforts to increase penalties useless unless we shift societal complacency regarding violence against healthcare workers.[246] This is why nurses and physicians need to continue making the fight for greater protections through increased penalties a legislative priority.[247]

[244] 2013 Legis. Bill Hist. CA S.B. 1299
[245] *See* U.S. Department of Justice *supra* note 22 p. 61
[246] *See* Wolf et. al *supra* note 151 p. 206
[247] *See* Smith et al. *supra* note 11 p. 348