

**REPORT OF THE
VIRGINIA STATE CRIME COMMISSION**

**Hospital Emergency Room
Violence (SJR 358, 2009)**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



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**COMMONWEALTH OF VIRGINIA
RICHMOND
2010**



COMMONWEALTH of VIRGINIA

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January 13, 2010

TO: The Honorable Timothy M. Kaine, Governor of Virginia

And

Members of the Virginia General Assembly

The Code of Virginia § 30-156 authorizes the Virginia State Crime Commission to study, report and make recommendations on all areas of public safety and protection. Section 30-158(3) provides the Commission with the power to conduct studies and gather information and data in order to accomplish its purposes as set forth in § 30-156...and formulate its recommendations to the Governor and the General Assembly.

Enclosed for your review and consideration is the final report of the study on Hospital Emergency Room Violence. The Commission received assistance from all affected agencies and gratefully acknowledges their input.

Respectfully,

A handwritten signature in black ink that reads "Janet Howell".

Janet D. Howell
Chair

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**Delegate Melvin resigned as a Member of the House of Delegates effective May 31, 2009. Delegates Ward Armstrong and Onzlee Ware were appointed to the Crime Commission on January 7, 2009 and July 10, 2009, respectively.*

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I. Authority

The Code of Virginia, § 30-156, authorizes the Virginia State Crime Commission (“Crime Commission”) to study, report and make recommendations on all areas of public safety and protection. In so doing, the Crime Commission shall endeavor to ascertain the causes of crime and recommend ways to reduce and prevent it, explore and recommend methods of rehabilitation of convicted criminals, study compensation of persons in law enforcement and related fields and study other related matters including apprehension, trial and punishment of criminal offenders.¹ Section 30-158(3) empowers the Crime Commission to conduct studies and gather information and data in order to accomplish its purpose as set forth in § 30-156 ... and formulate its recommendations to the Governor and the General Assembly.

Using the statutory authority granted by the General Assembly to the Crime Commission, and pursuant to a Senate Joint Resolution, staff conducted a study on the issue of hospital emergency room violence in the Commonwealth.

II. Executive Summary

Senate Joint Resolution 358 (SJR 358),² introduced by Senator Kenneth W. Stolle during the 2009 Regular Session of the General Assembly, directed the Crime Commission to study issues of public safety in hospital emergency rooms. Specifically, it was resolved that the Crime Commission be directed to:

- Research public safety issues that exist in hospital emergency rooms, including the occurrence of violent incidents in hospital emergency rooms across the Commonwealth;
- Compile strategies that can be used by hospitals to prevent or deal with violent incidents; and,
- Identify the most effective methods of preventing emergency room violence and of dealing with violent incidents when they occur.³

Also incorporated into this study was House Bill 2436 (HB 2436), referred to the Crime Commission by the House Courts of Justice Committee. This bill was introduced during the 2009 Regular Session of the General Assembly by Delegate Christopher K. Peace to address violence occurring in hospital emergency rooms across the Commonwealth.⁴ Specifically, this bill sought to amend and reenact section C of § 18.2-57, know as the “protected class” in the assault and battery statute, by adding emergency room personnel defined as physicians, physicians’ assistants, nurses, or nurse practitioners while engaged in the performance of his duties as an emergency health care provider in an emergency room of a hospital or clinic or on the premises of any other facility rendering emergency medical care.⁵

¹ VA. CODE ANN § 30-156 (Michie 2009).

² S.J.R. 358, 2009 Gen. Assem., Reg. Sess. (Va. 2009).

³ Id.

⁴ H.B. 2436, 2009 Gen. Assem., Reg. Sess. (Va. 2009).

⁵ Id.

The Crime Commission utilized several methodologies to address the directives of the mandate regarding emergency department (ED)⁶ violence, including: completing a literature and legislative review; creating a work group of medical and academic practitioners; attending emergency department security awareness training; identifying available data; and, conducting field observations.

There was very little literature available concerning ED violence and the studies that were available typically suffered from limitations that prevented the application of their findings to EDs in general. There has been some legislative activity addressing hospital violence in the last several years by a few states: California, Washington, Oregon, and New Jersey. Unfortunately, as with the literature review, there are practically no known published comprehensive reviews available that detail the results of any of the legislation in reducing violent behavior directed at ED staff. Staff also did a 50 state survey of assault and battery statutes and determined that a little over half (26) of the states provide an enhanced or increased punishment for assaults directed at ED staff.

In order for the Crime Commission to better understand ED violence, staff invited medical and academic practitioners who were familiar with ED violence to participate in our ED violence work group. The following is a summary of the important issues discussed at the work group meeting:

- Many assaults go unreported;
- Local law enforcement data will not be specific enough to determine if the assaults occurred in the ED;
- Security varies from hospital to hospital, from full time, deputized officers to a few private security officers;
- A significant percentage of the violent or assaultive behavior is caused by patients with mental disorders or patients with drug or alcohol addictions;
- There is a reluctance to press charges against patients with mental disorders, as well as difficulties prosecuting them;
- Security training available to ED staff varies from hospital to hospital; and,
- Strategies to prevent or deal with violent incidents vary by hospital.

Additionally, staff conducted field visits to two local hospitals. During ED visits, staff formally met with police and security personnel to discuss their roles, activities, and difficulties as well as proactive measures undertaken to promote ED safety. These visits helped to provide an understanding of ED operations, allowed staff to observe the environment in EDs and the attached waiting rooms, identify potential data sources and their limitations, and to confirm information gathered from the work group and the literature review.

The most significant problem encountered with the study is the lack of reliable data concerning the prevalence of violent incidents in EDs in the Commonwealth, as well as nationally. Likewise, there are very few reports that address preventative measures that EDs can

⁶ While the study resolution refers specifically to “Emergency Rooms,” the common term used by persons involved in the hospital profession is “Emergency Department.”

take to reduce violence. While there is some data available from the U.S. Department of Labor, Virginia State Police, and local law enforcement departments, this data does not possess the requisite precision to determine if the violent acts occurred in hospital EDs, doctor's offices, or outpatient clinics, or if the incidents were even related to violent acts against ED personnel. Subsequently, there is no way to determine how much of a problem violent incidents are in EDs throughout in the Commonwealth. Given the lack of available data, it is difficult to make informed legislative or policy decisions regarding ED violence in the Commonwealth. As a result of this study, no formal recommendations were made by the Crime Commission.

III. Background and Methodology

Staff conducted a literature review of existing national, state and academic ED violence studies, as well as a national legislative overview, 50-state survey and Code of Virginia statutory review. The following section includes a summary of findings from each.

Literature and Legislative Review

Literature Review

Violence is an issue that pervades all aspects of society. Hospitals are no exception. In particular, EDs have been identified as high risk settings for violence against nurses, physicians, orderlies and other hospital staff.⁷ While this trend is recognized, there are few academic studies that focus on violence against ED employees. Furthermore, the available studies typically suffer from data limitations or other generalizability issues.

For example, a very recent, nationwide study was published, which surveyed ED nurses.⁸ The study was based on 3,518 responses, representing 65 EDs.⁹ One of the findings noted that there was a median of 11 violent attacks per year (for the 5 year reporting period) per site.¹⁰ The authors caution that most of the survey respondents worked in large "academic settings."¹¹ Likewise, a later article also cautioned that most of the survey respondents came from EDs located in the northeastern United States and in "urban settings, which may be associated with higher incidence of violence," so the findings may not be generalizable to all EDs.¹²

Additionally, there is a study that suggests almost 75% of 171 ED doctors reported receiving verbal threats, and 28% of these doctors also reported that they were physically

⁷ See, for example, Kowalenko T, Walthers B, Compton, S, WORKPLACE VIOLENCE; A SURVEY OF EMERGENCY PHYSICIANS IN THE STATE OF MICHIGAN, *Annals of Emergency Medicine*, Vol. 46, 142-7 (2005) and Gerberich, S.G., et al., An Epidemiological study of the magnitude and consequences of work related violence: The Minnesota Nurses' Study, *Occupational and Environmental Medicine*, Vol. 61, 495-503 (2002).

⁸ Kansaraga, S., et al, A Survey of Workplace Violence Across 65 U.S. Emergency Departments, *Academic Emergency Medicine*, Vol. 15, No. 12, 1268-1274 (2008).

⁹ *Id.* at 1269.

¹⁰ *Id.*

¹¹ *Id.* at 1274.

¹² Patricia Howard and Nicki Gilboy, WORKPLACE VIOLENCE, *Advanced Emergency Nursing Journal*, Vol. 31, p. 94-100 (2009).

assaulted.¹³ This study was limited to one state (Michigan) and one discreet group of ED workers (doctors), so it is difficult to make general statements about ED violence based on the results of this study.

Finally, to compound the aforementioned issues is the limited scope of available data. One study noted that “(t)he true incidence of violence in U.S. EDs is not known because there are no reporting requirements, much of the research involves retrospective surveys, and there are no standards or definitions of workplace violence.”¹⁴

While there is no way to concretely ascertain the level or amount of violence directed at ED staff, some studies suggest reasons for violent behavior in EDs. It is thought that ED employees are subject to an increased risk for violent behavior due to exposure to:

- Patients under the influence of drugs and/or alcohol;
- Patients with psychiatric disorders;
- Prolonged waiting periods and overcrowding;
- Open, 24-7 access to EDs;
- Stress on patients’ families; and,
- Criminal and street gang activity, victims, and affiliates.¹⁵

In order to cope with violence in EDs, there are some steps that hospitals can make that may minimize violent behavior. Increased police and/or security presence, environmental barriers, and metal detectors are cited by ED employees as a way to reduce violence.¹⁶ A recent article outlined “five starting points toward a safer ED,” based on recommendations from hospital security directors and other experts:

- **Access Control** - limiting the persons authorized to enter treatment areas from the ED and other areas of the hospital;
- **Staff IDs** – any member of the ED staff, or anyone else that normally visits the ED, should wear identification badges, conspicuously displayed;
- **Metal Detectors** – the use of full body or hand-held metal detectors, at points of entry to the ED;
- **Surveillance** – switching from analog to digital surveillance cameras, because they produce sharper images and images are easier to retrieve; and,
- **Emergency Alerts** – make sure EDs have “panic buttons” available and encourage staff to run drills, so they can be familiar with the process if the buttons are used.¹⁷

¹³ Kowalenko *at* note 7.

¹⁴ *Id.* at 96.

¹⁵ Donna M. Gates, Clara S. Ross, and Lisa McQueen, VIOLENCE: RECOGNITION, MANAGEMENT AND PREVENTION, *The Journal of Emergency Medicine*, Vol. 31, No. 3, 331-337 (2006); *see also* Howard, *at* note 12, p. 97.

¹⁶ *Id.* at p. 335.

¹⁷ Terese Hudson Thrall, Stopping Workplace Violence before it happens, Hospital and Health Networks, September (2006), *available at* http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/PubsNewsArticle/data/2006September/0609HHN_FEA_Safety&domain=HHNMAG.

Since the focus on ED violence has only been gaining attention for the past few years, there are no known additional studies or articles that document success hospitals have had in addressing ED violence.

National Legislative Overview

There have been legislative efforts by other states to address hospital violence. The first state to make such an effort was California, which passed the “California Hospital Safety and Security Act” in 1993.¹⁸ This Act requires hospitals to track violent incidents, create a plan to prevent and cope with violent incidents, and implement security training for employees of EDs.¹⁹ The security training included topics such as identifying aggression and violence predictive factors, obtaining history from a patient with violent behavior, characteristics of aggressive and violent patients and victims, verbal and physical maneuvers to diffuse and avoid violent behavior, and strategies to avoid physical harm.²⁰

Four other states attempted to follow this general format, including Washington, Oregon, Massachusetts, and New Jersey. Washington was the second state, in 1999, to pass safety and security procedures for hospitals.²¹ The Oregon Legislature passed a similar set of requirements in 2007, which included a mandate that hospitals “conduct periodic security and safety assessments” to identify current or potential threats to employees.²² Oregon’s statutes require very detailed information to be collected and reported for on-site assaults against hospital employees, similar to Occupational Safety and Health Administration (OSHA) reporting requirements.²³

Additionally, in 2007, two bills were introduced in Massachusetts to address ED violence. Senate Bill 1345, as introduced, would require health care employers to develop and implement programs to prevent workplace violence.²⁴ This Bill was very similar to other states’ comprehensive safety/security programs. House Bill 1700 was introduced to increase the penalty

¹⁸ 1993 Cal. Legis. Serv. 936.

¹⁹ *Id.*

²⁰ *Id.*

²¹ 1999 Wash. Legis Serv 377 (West).

²² 2007 Or. Laws ch. 397.

²³ *Id.* “(1) A health care employer shall maintain a record of assaults committed against employees that occur on the premises of the health care employer or in the home of a patient receiving home health care services. The record shall include, but need not be limited to, the following: (a) The name and address of the premises on which each assault occurred; (b) The date, time and specific location where the assault occurred; (c) The name, job title and department or ward assignment of the employee who was assaulted; (d) A description of the person who committed the assault as a patient, visitor, employee or other category; (e) A description of the assaultive behavior as: (A) An assault with mild soreness, surface abrasions, scratches or small bruises; (B) An assault with major soreness, cuts or large bruises; (C) An assault with severe lacerations, a bone fracture or a head injury; or (D) An assault with loss of limb or death; (f) An identification of the physical injury; (g) A description of any weapon used; (h) The number of employees in the immediate area of the assault when it occurred; and (i) A description of actions taken by the employees and the health care employer in response to the assault. (2) A health care employer shall maintain the record of assaults described in subsection (1) of this section for no fewer than five years following a reported assault.”

²⁴ S.B 1345 Mass. Leg. (2007).

for assault and battery upon health care providers from its current penalty of a misdemeanor to a felony.²⁵ These bills never made it out of their respective houses and were left in committee.

In 2008, New Jersey passed the “Violence Prevention in Health Care Facilities Act,” which, like the California statutes, mandated hospitals to adopt a series of programs and policies.²⁶ Specifically, these facilities are to produce a formal written “violence prevention program,” design and implement a “prevention plan” that identifies workplace risks and outlines specific actions to address risks, and record all violent acts against employees at work.²⁷ While the requirements of this legislation apply to EDs, the overall goal was to reduce general workplace violence in New Jersey hospitals.

While there are four states with comprehensive statutory requirements for hospitals to address employee safety, there has been little attention focused on determining the overall effectiveness of these measures. The recent measures in Oregon and New Jersey have only been in effect for two years, so it would be difficult to measure any kind of meaningful improvement in employee safety. However, California’s safety requirements have been in place for nearly 17 years, and there is no known, published state review of the measure’s effectiveness. The same can be said of Washington, whose safety requirements have been in place for almost 10 years.

There has, however, been an independent review²⁸ of California’s “Hospital Safety and Security Act” as compared to similar EDs from New Jersey. This study compared the existence of safety and security programs at a discrete number of hospitals in California and compared them to similar facilities in New Jersey. The overall conclusion from this study determined that hospitals in California were more likely to have comprehensive safety/security programs than the similar hospitals in New Jersey, due to the legislative requirements.²⁹ Additionally, the authors noted that not one hospital in California, as of September 2006, has been cited for violating the Hospital Security Act.³⁰ Likewise, the authors also pointed out that no hospital in New Jersey had been singled out for inadequate safety performance.³¹ Finally, the authors suggested any state considering enacting comprehensive safety/security legislation should realize that each plan should be tailored to meet each hospital’s specific needs and that legislation would be more effective when enforced.³²

There is also another independent review of California’s “Hospital Safety and Security Act,” which focused on answering the question of whether the Act lowered the assault rates in hospitals.³³ The report’s conclusion was that there was a lower instance of reported assaults;

²⁵ H.B. 1700 Mass. Leg. (2007).

²⁶ 2008 N.J. Laws 236.

²⁷ *Id.*

²⁸ Corrine Peek-Asa *et al*, WORKPLACE VIOLENCE PREVENTION PROGRAMS IN HOSPITAL EMERGENCY DEPARTMENTS, (2007). This study was completed before passage of New Jersey’s “Violence Prevention in Health Care Facilities Act.”

²⁹ *Id.* at p. 763.

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ Carri Casteel *et al*, HOSPITAL EMPLOYEE ASSAULT RATES BEFORE AND AFTER ENACTMENT OF THE CALIFORNIA HOSPITAL SAFETY AND SECURITY ACT, (2008).

however, the baseline used for the pre-enactment review was based on the California OSHA reporting system, which, at that time, had the same limitations as the U.S. Department of Labor’s Bureau of Labor Statistics’ (BLS) data.³⁴

Another way in which states may address ED violence is to increase the penalty of assault, much like the proposal in HB 2436, introduced during the 2009 Regular Session of the Virginia General Assembly. Recently, Oklahoma passed a bill that increased the penalty from a misdemeanor to a felony for an assault upon “doctors, residents, interns, nurses, nurses' aides, ambulance attendants and operators, paramedics, emergency medical technicians, and members of a hospital security force.”³⁵ This measure passed by the Oklahoma legislature with an emergency clause, making it effective immediately after “passage and approval.”³⁶

In sum, while a few states have directly addressed ED violence with comprehensive legislative action, there are few, if any, studies that document positive results or a reduction in ED violence as a result of the legislation.

50 State Survey

Staff conducted a review of existing assault statutes in the other 49 states to determine how many states offer an enhanced penalty for a simple assault and battery upon an ED employee. There are 26 states that punish simple assaults upon ED employees as a felony, enhanced from a misdemeanor.³⁷ Of those 26 states, 9 of them require physical harm or significant bodily contact to qualify for the enhanced penalty;³⁸ the other 19 states merely require the traditional acts for simple assault or battery.³⁹ As with the comprehensive legislation

³⁴ The BLS data for California, as with the same data for Virginia, does not differentiate where the violence occurs in the hospital, so it is difficult to determine whether the assault took place in the ED, or in another part of the hospital.

³⁵ 2009 Oka.Ch.337.

³⁶ *Id.*

³⁷ ALA. CODE § 13A-6-21 (West 2009); ARIZ. REV. STAT. ANN. § 13-1204 (2009); DEL. CODE ANN. tit. 11 § 613 (West 2009); FLA. STAT. ANN. § 784.07 (West 2009); 720 ILL. COMP. STAT. ANN. 5/12-4 (West 2009); IND. CODE ANN. § 35-42-2-1; IOWA CODE ANN. § 708.3A (West 2009); ME. REV. STAT. ANN. tit. 17, § 752-C (2009); MINN. STAT. ANN. § 609.2231 (West 2009); MO. ANN. STAT. § 565.082 (West 2009); NEV. REV. STAT. ANN. § 200.471 (West 2009); N.J. STAT. ANN. §. 2C:12-1 (West 2009); N.M. STAT. ANN. § 30-3-9.2 (West 2009); N.Y. PENAL LAW § 120.05 (McKinney 2009); N.C. GEN. STAT. ANN. § 14-34.6 (West 2009); N.D. CENT. CODE, § 12.1-17-01 (2009); OKLA. STAT. ANN. tit. 21, § 650.3 (West 2009); 18 PA. CONS. STAT. ANN. § 2702 (West 2009); R.I. GEN. LAWS § 11-5-16 (2009); S.C. CODE ANN. § 16-3-635 (2009); TEX. PENAL CODE § 22.01 (Vernon 2009) (assault), TEX. HEALTH & SAFETY CODE ANN. § 773.003 (Vernon 2009) (definition of “emergency medical provider”); UTAH CODE ANN. § 76-5-102.7 (West 2009) (assault on a “health care provider”), UTAH CODE ANN. § 78B-3-403 (West 2009), (definition of a “health care provider”); VT. STAT. ANN. tit. 13, § 1028 (2009); WASH. REV. CODE ANN. § 9A.36.031 (West 2009); W. VA. CODE ANN., § 61-2-10b (West 2009); WIS. STAT. ANN. § 940.20 (West 2009).

³⁸ IND. CODE ANN. § 35-42-2-1; ME. REV. STAT. ANN. tit. 17, § 752-C (2009); MINN. STAT. ANN. § 609.2231 (West 2009); N.M. STAT. ANN. § 30-3-9.2 (West 2009); N.C. GEN. STAT. ANN. § 14-34.6 (West 2009); 18 PA. CONS. STAT. ANN. § 2702 (West 2009); S.C. CODE ANN. § 16-3-635 (2009); W. VA. CODE ANN., § 61-2-10b (West 2009); WIS. STAT. ANN. § 940.20 (West 2009).

³⁹ ALA. CODE § 13A-6-21 (West 2009); ARIZ. REV. STAT. ANN. § 13-1204 (2009); DEL. CODE ANN. tit. 11 § 613 (West 2009); FLA. STAT. ANN. § 784.07 (West 2009); 720 ILL. COMP. STAT. ANN. 5/12-4 (West 2009); IOWA CODE ANN. § 708.3A (West 2009); MO. ANN. STAT. § 565.082 (West 2009); NEV. REV. STAT. ANN. § 200.471 (West 2009); N.J. STAT. ANN. §. 2C:12-1 (West 2009); N.Y. PENAL LAW § 120.05 (McKinney 2009); N.D. CENT. CODE, § 12.1-17-01 (2009); OKLA. STAT. ANN. tit. 21, § 650.3 (West 2009); R.I. GEN. LAWS § 11-5-16 (2009); TEX. PENAL

previously discussed, there are no known reports or studies which attempt to quantify the effectiveness of enhancing the penalty for simple assault and battery upon ED employees.

Virginia's Assault and Battery Statute: Code of Virginia § 18.2-57

In general, Virginia Code § 18.2-57 outlines the penalty for simple assault and battery.⁴⁰ As originally passed in 1975, it simply read “Any person who shall commit a simple assault or assault and battery shall be guilty of a Class 1 misdemeanor.”⁴¹ Over the last 30 years there have been several additions to the statute. In 1994, the statute was modified to provide an enhanced penalty, mandatory minimum of 30 days, for an assault or battery committed against a person because “of his race, religious conviction, color or national origin.”⁴²

The first of the so called “protected class” of victims was added to Virginia Code § 18.2-57 in 1997, when a simple assault on a law enforcement officer or firefighter was enhanced to a Class 6 Felony.⁴³ There have been additional groups of individuals added to the “protected class,” including correctional officers,⁴⁴ game wardens and regional jail officers,⁴⁵ volunteer firefighters,⁴⁶ judges,⁴⁷ full-time sworn members of the enforcement division of the Department of Motor Vehicles,⁴⁸ and, most recently, police officers of the Metropolitan Washington Airports Authority.⁴⁹ The acts that define a criminal assault are defined in case law or common law, and not by statute. Previously under common law, criminal assault was defined as an “attempted battery,” an attempt by one person to strike or touch another.⁵⁰ Over the years a feature of civil assault, putting a person in apprehension of a battery, has been merged into criminal assault.⁵¹ Under current law criminal assault consists of a person attempting or offering to hurt or strike a person, holding up a fist at person in a “threatening manner or insulting manner,” or pointing a weapon at a person “within reach.”⁵²

CODE § 22.01 (Vernon 2009) (assault), TEX. HEALTH & SAFETY CODE ANN. § 773.003 (Vernon 2009) (definition of “emergency medical provider”); UTAH CODE ANN. § 76-5-102.7 (West 2009) (assault on a “health care provider”), UTAH CODE ANN. § 78B-3-403 (West 2009), (definition of a “health care provider”); VT. STAT. ANN. tit. 13, § 1028 (2009); WASH. REV. CODE ANN. § 9A.36.031 (West 2009). Simple assault and battery, which will be discussed in the next section, can consist of mere touching or threatening words and gestures.

⁴⁰ The acts that constitute assault or battery are defined in case law.

⁴¹ 1975 Va. Acts ch. 14 & 15.

⁴² 1994 Va. Acts ch. 658. Additionally, if the act involves bodily injury, then the penalty is a Class 6 Felony.

⁴³ 1997 Va. Acts ch. 833. The actual language added was: “ In addition, if any person commits an assault or an assault and battery against another knowing or having reason to know that such other person is a law-enforcement officer, as defined hereinafter, or firefighter, as defined in § 65.2-102, engaged in the performance of his public duties as a law-enforcement officer or firefighter, such person shall be guilty of a Class 6 felony, and, upon conviction, the sentence of such person shall include a mandatory, minimum term of confinement in jail for six months.”

⁴⁴ 1999 Va. Acts ch. 771.

⁴⁵ 2000 Va. Acts ch. 288.

⁴⁶ 2004 Va. Acts ch. 420.

⁴⁷ 2006 Va. Acts ch. 270.

⁴⁸ 2008 Va. Acts ch. 460.

⁴⁹ 2009 Va. Acts ch. 257.

⁵⁰ Ronald J. Bacigal, VIRGINIA PRACTICE: CRIMINAL OFFENSES AND DEFENSES, Assault, Battery and Wounding, II(B), 2008-2009.

⁵¹ *Id.*

⁵² *Vaughn v. Commonwealth*, 263 Va. 31, 557 S.E.2d 220 (2002).

Battery, as defined by case law, is generally considered the touching of another, willfully or in anger.⁵³ There are also some other acts that qualify as battery: touching done in a “rude” or “insulting” manner;⁵⁴ making contact with a person by setting an object in motion;⁵⁵ and spitting on a person in a rude, insolent and angry manner.⁵⁶

In sum, under the proposed changes to Virginia Code § 18.2-57 by HB 2436, if a person committed an assault or battery against one of the named individuals “engaged in the performance of their duties” or “rendering medical care,” they could be convicted of a Class 6 felony, with a mandatory minimum confinement of six months.⁵⁷ Under the current statute, a person can only be convicted of a Class 1 Misdemeanor for an assault on an ED employee.⁵⁸

Work Group

In order for Crime Commission staff to better understand ED violence, staff requested help from practitioners who were familiar with the nature of ED violence.⁵⁹ Specifically, staff invited representatives from the following areas to participate in an ED Violence work group, including ED nurses and doctors, hospital administrators, Commonwealth’s Attorneys, law enforcement, mental health/substance abuse services, and health policy experts. One meeting was held. The following is a summary of the important issues discussed at the meeting:

- Many assaults go unreported;⁶⁰
- Local law enforcement data will not be specific enough to determine if the assaults occurred in the ED;
- Security varies from hospital to hospital - from full time, deputized officers to a few private security officers;⁶¹
- A significant amount of violent or assaultive behavior is caused by patients with mental disorders or patients with drug or alcohol addictions;⁶²
- There is a reluctance to press charges against patients with mental disorders, as well as difficulties prosecuting them;
- Security training available to ED staff varies from hospital to hospital; and,
- Strategies to prevent or deal with violent incidents vary by hospital.

⁵³ *Id.*

⁵⁴ *Hinkel v. Commonwealth*, 137 Va. 791, 119 S.E. 53 (1923).

⁵⁵ *Wood v. Commonwealth*, 149 Va. 401, 140 S.E. 114 (1927).

⁵⁶ *Gilbert v. Commonwealth*, 45 Va. App. 67, 608 S.E.2nd 509 (2005).

⁵⁷ H.B. 2436, 2009 Gen. Assem., Reg. Sess. (Va. 2009).

⁵⁸ VA. CODE ANN. § 18.2-57(A) (Michie 2009).

⁵⁹ For a list of the work group participants, please see the Acknowledgements section of this report.

⁶⁰ This notion is also reflected in what little research is available on ED violence. *See* Howard *at* note 12, p. 97; *see also* Gates *at* note 15, p. 335.

⁶¹ This was verified by staff field visits to ED security departments.

⁶² *See* Gates *at* note 15, p. 331.

Emergency Department Field Visits

Crime Commission staff also conducted field visits to a couple of hospitals in order to more fully understand ED operations and safety procedures. During ED visits, staff formally met with police and security personnel to discuss their roles, activities, difficulties and proactive measures undertaken to promote ED safety. Afterwards, staff was typically taken on a tour of the ED. These field visits were instrumental in appreciating the nature of ED security, as well as helpful in understanding day-to-day ED activities, resources, equipment, and relationships with key stakeholders. The visits also helped to identify potential data sources that could be used to further examine reported incidents of assault in the ED.

Emergency Department Employee Security Training

Available research examining ED violence has underscored the importance of ED staff attending violence prevention training that affords them with tools to better cope with the unique situations that often arise in EDs.⁶³ For instance, such training programs typically include training components on hospital safety policies and procedures, aggression and violence predicting behaviors, verbal and physical methods to diffuse aggressive behavior, resources available for victims of workplace violence, and how to report a violent event.⁶⁴

Staff also had the opportunity to attend two ED Security Awareness Training seminars that were offered by VCU Health Systems. The training seminars were developed for the ED employees by VCU Security Specialists. All VCU Health Systems ED employees are required to attend this training. Each four hour course covers topics such as situational awareness, client assessment, crisis prevention and intervention, physical escape methods, and specific role-playing. This training is very similar to the training required by states that have passed comprehensive workplace safety legislation for hospitals and EDs.

Emergency Department Data and Limitations

There are several sources identified as having potential data relating to ED violence, including: Virginia Health Information (VHI); Bureau of Labor Statistics (BLS); Virginia State Police (VSP); and, local police departments and sheriff's offices. However, limitations exist for each of these sources of data.

Virginia Health Information

According to VHI, there are 80 hospitals with EDs in the Commonwealth.⁶⁵ Of the 80 hospitals with EDs, 53 have psychiatric/substance abuse emergency services available 24 hours a day, seven days a week and 13 of those hospitals have psychiatric services separated from the general ED. There were over 3.1 million patients statewide that were attended to in EDs across the Commonwealth during the fiscal year ending in July 31, 2007. While this data is helpful in

⁶³ See Gates *at* note 15; Therese Hudson Thrall *at* note 17; Peek-Asa et al. *at* note 28.

⁶⁴ See, for example, Peek-Asa et al. *at* page 758.

⁶⁵ As of October 31, 2008, information *available at* <http://www.vhi.org/>.

determining the number and locations of each hospital with an ED, VHI does not compile the number of assaults upon ED employees.

Bureau of Labor Statistics

The BLS compiles data concerning on-the-job injuries and illnesses.⁶⁶ From this data, there is specific information available for each injury including the “demographics of the worker disabled, the nature of the disabling condition, and the event and source producing that condition.”⁶⁷ While this data provides a location for the injury, it is not specific enough to differentiate if the injury occurred in a specific part of the hospital, or in another part of the health care field. In other words, there is no way of knowing from this data if the person injured by an assault was working in a hospital ED or a doctor’s office.⁶⁸ Additionally, another limitation with this data is that the statistics only track injuries resulting in a day or more of missed work.⁶⁹ Since, under Virginia law, assault may occur with no physical contact or slight contact, there would be a strong chance that the BLS data significantly under-represents assaults in Virginia hospitals.

Virginia State Police

The VSP compile and publish crime statistics on an annual basis.⁷⁰ One of the crimes they track is assault. However, the VSP do not mandate law enforcement to report assaults by location; therefore, available data is limited to a few law enforcement agencies that do report the specific location.⁷¹ Again, this is problematic because while the assault may have occurred at the hospital, there is no way to differentiate between violence in the ED and other areas of the hospital.

Local Police Departments and Sheriff’s Offices

It is possible to obtain data from local law enforcement “calls for service” which could include calls to hospital EDs. The problem with calls for service is that they often do not reflect the true nature of the incident; the call may be to the ED, but the reason may be completely unrelated to an assault. Incident reports may be requested; however, even then it is unclear as to whether all law enforcement agencies will be able to distinguish whether the assault took place in the ED or another part of the hospital.

In conclusion, while there is information available from multiple sources, the data does not possess the requisite precision to determine the level of violence in EDs across the Commonwealth. Even though some hospital administrators indicated there were some internal reporting mechanisms (i.e., administrative reports) that collected such information, the ability to

⁶⁶ U.S. Bureau of Labor Statistics, *available at*, <http://www.bls.gov/>.

⁶⁷ U.S. Bureau of Labor Statistics, INJURIES, ILLNESSES, AND FATALITIES, *available at* <http://www.bls.gov/iif/oshcase1.htm>.

⁶⁸ U.S. Bureau of Labor Statistics, INJURIES, ILLNESSES, AND FATALITIES: State Occupational Injuries, Illnesses, and Fatalities, *available at* <http://www.bls.gov/iif/oshstate.htm>.

⁶⁹ See note 7.

⁷⁰ *Available at* http://www.vsp.state.va.us/Crime_in_Virginia.shtm.

⁷¹ Personal Communication, Virginia State Police, July 2008.

collect and compile these reports in a consistent and meaningful manner would be extremely difficult, if not impossible.

IV. Conclusion

Violence in EDs has clearly gained increased attention in recent years. The most significant impediment to determining the level of violence in EDs throughout the Commonwealth is the lack of reliable data documenting violent acts. While there is some data available, this data does not possess the accuracy required to determine if the violent acts occurred in hospital EDs, doctor's offices, outpatient clinics, or if the incidents were related to violent acts against ED personnel. Given the lack of available data, it is difficult to make informed legislative or policy decisions regarding ED violence in the Commonwealth.

Theoretically, it is possible to make changes to the way VSP collects data, by requiring precise locations of violent incidents to be reported by all Virginia law enforcement agencies to the VSP. Likewise, a requirement for hospitals to report verbal and physical assaults against ED employees in a uniform manner may also be useful in collecting meaningful statistics. These measures, however, might not succeed unless some of the cultural reasons are corrected that contribute to assaults going unreported, such as the unwillingness of ED employees to report these acts because it's "part of the job" or because of the psychological or physiological condition of the patient. Unless there is some change in the way violent acts are reported, internally and externally, there is no way to get an accurate picture of the pervasiveness or infrequency of violent acts in EDs. As a result of the data limitations identified during this study, no formal recommendations were made by the Crime Commission.

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