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Embracing Risk

Healthcare Threat Management: Patients & Guns

By Sheridan Ryan

Mr. Green was angry at his physician. A earlier, he told his doctor he was experie dizziness and nausea; not surprisingly, h advised him to have someone bring him emergency department. There, he was a and tests were run. Mr. Green's health h declining in recent years and he required treatments every two weeks. He was frustrated, didn't know how long he had l viewed the recent hospitalization as an unnecessary expense and a waste of l was angry that he had once again wasted a weekend in the hospital and he bl wondered – how many more weekends did he have left?

Mr. Green knew he needed to make a follow-up outpatient appointment, but in to the clinic. The staff, long familiar with him, brought him back to an exam roo inust s-9smther provider agreed to see him. Part way through the appointment gun in his pocket.

A Growing Problem

Even when patients make no mention of a gun or shooting anyone, "What if they come back with gun?" is foremost among providers' concerns after an interaction with an angry or threatening patient. And with good reason – consider the gun environment providers work:

Recently a Canadian trauma surgeon and founder of "Canadian Doctors for P was the target of an aggressive, coordinated campaign of political intimidation lobby group.[1] Around the same time in the United States, doctors were warned by Association (NRA) to "stay in their lane."[2] For years NRA gun lobbyists have aggress pressured American politicians who plainly fear them. At the same time, while Americans supported common sense gun control reform, it remained a low pri[3]

After a mass shooting in Port Arthur, Tasmania in 1996, Australia swiftly passe laws which were widely praised because of Australia's resultant low incidence Until May 11, 2018, that is, when Australia's worst mass shooting in decades o between 1996 and 2018? Pro-gun lobby groups in Australia mounted a high-p

against Australia's government and laws gradually eroded.[4] In the U.S., post-Sandy Hook[5]

and got in touch with Robert Martin at Gavin de Becker & Associates – world leaders in personal protection, threat assessment and management. I described the situation and inquired whether it was the type of matter on which they advise.
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Most healthcare facilities are designed for people to come onto the premises rather than keep them out, which means there is likely no effective means to prevent a banned person from returning if they choose to. Dismissing a patient does not mean they cannot come back with a gun – something that could occur in the short-term, or many years later. In Houston, the son of a patient harbored a grudge for more than 20 years before he returned with a gun and shot his mother's cardiologist.[27] Termination by the healthcare organization does not necessarily mean the end of the story for the person terminated.

Moreover, if everyone in healthcare took the position of routinely dismissing patients who brought in weapons, healthcare facilities would be trading these patients among themselves, but without the knowledge of what occurred.

By continuing medical care, communication is continued which may provide insight into the patient's thinking so that grievances can be addressed and the situation improved. Additional information can be gathered to aid the threat assessment. Continuing care avoids introducing the rejection of termination from care; rejection being a common trigger to violence. "It is contrary to the practice of threat assessment to actually be responsible for further escalating a situation."[28] Unless a facility has effective physical barriers to prevent unwelcome armed persons from entering, there really is no choice to make; the safer plan likely is to continue medical care, but within a broader threat management safety plan.

Safety Planning

Mr. Green had contemplated suicide several years earlier, going so far as to put a loaded gun in his mouth. He battled depression over the years but refused mental health treatment.

By bringing a loaded firearm to his clinic appointment, Mr. Green introduced a major obstacle to the delivery of healthcare services. His mindset was not ideal for firearm possession. He was dying, depressed, had a history of suicidal ideation, and was angry. While he had recently been cancelling appointments, after bringing the gun to clinic he decided he wanted to continue with medical treatment after all.

Rather than try to figure out how to ensure Mr. Green doesn't bring a gun into the clinic, a good place to start may be a conversation with Mr. Green about the pros and cons of firearm possession at this particular time in his life.

Here are some facts:

- 94% of gun-related suicides WOULD NOT occur under the same circumstances had no gun been present[29]
- 41% of gun-related homicides WOULD NOT occur under the same circumstances had no gun been present[30]
- 1000% is the increase in risk of intimate partner homicide if a gun is present[31]

The benefit to Mr. Green of getting rid of his gun(s) is immediate and significant: it would show a good faith effort toward re-establishing a trusting relationship with his healthcare team, it would probably allow his care to continue earlier than if he retains his guns, and it would greatly reduce the risk of gun violence, whether suicide, homicide, or mass-murder suicide. Perhaps most importantly, asking Mr. Green if he would consider giving up his guns shows him that he retains some control over the situation, which in itself can promote safety.[32] So even if we don't expect anyone to give up

allow for safely continuing medical care, continuing communication, reducing anger, and moving away from – rather than toward – a violent outcome. Even without the ability to screen every patient at every entrance, weapons screening can play an important role. “The ability to screen specific individuals under unique circumstances allows us to assess patients who have raised safety concerns, but for whom simply distancing is not a reasonable, reliable option.”[38]

What Can the C-suite Do to Help?[39]

There are several ways executive leadership can help workplace violence prevention efforts. First, because violence affects everyone whether at home, work, or anywhere else, gaining a fundamental understanding of violence and clearing up myths can help defeat violence in the workplace and beyond through informed decision-making. People do not just “snap,”[40] gun violence is not inevitable, through a comprehensive public health approach, it can be prevented and our workplaces and communities made safer.[41]

Second, leadership can support the formation of healthcare threat assessment teams and prioritize ensuring team members are able to obtain proper training in the handling of non-immediate threatening situations (i.e., threat assessment and management). Resisting long-standing practices of dismissing or seeking restraining orders against threatening patients takes significant education to overcome; sending one person for threat assessment training and expecting that person to effectively convey the rationale for changing long-standing practices is not likely to succeed. Healthcare organizations at the forefront of threat assessment and management invest in education and training.

For example, Mayo Clinic is known for its team approach to healthcare and uses that same lens with their Global Security Threat Assessment Team. At Mayo Clinic, we invest in training, because we have world-class healthcare providers and staff who can’t provide world-class healthcare if they don’t feel safe,” says Matt Horace, Mayo Clinic Chief Security Officer.

Recently, that investment at Mayo Clinic included partnering with the Rochester Police Department and adding Hospital Resource Officers (HROs) modeled after School Resource Officers (SROs) who are staffed on site in the hospital. According to Melissa Zavielfelhofer, Senior Security Specialist at Mayo Clinic, “We asked their leaders to invest in their training relating to threat assessment, recognizing that it will be different than the traditional law enforcement role. We have already begun to stress the importance of avoiding short-term solutions (e.g., restraining orders), that risk escalating the situation long-term. As a team we can engage the HROs in our specialized approach to manage the situation. This includes using a fact-based method of assessing behavior as a team and a unified team approach to mitigation strategies and recommendations. We are working toward an environment of safety, free of silos, where safety and security is everyone’s responsibility.”

Third, leadership can assure those managing violently-inclined situations they won’t be second-guessed for decisions made based on solid threat assessment and management principles. Because security often the first to be blamed if violence occurs, it’s no wonder that security may be hesitant to advise *or do* such things as filing for a restraining order or dismissing a patient – no doubt they foresee criticism for not taking what may seem like basic safety measures, which too often actually risk worsening the situation.

Fourth, leadership can prioritize funding for physical environment changes such as controlled access entryways and weapons screening. Metal detectors not only aid detection of weapons, they serve as a deterrent to those seeking to bring in firearms. Guns are so prevalent today that we need both threat assessment and management knowledge AND weapons screening. Without any ability to screen for weapons, threat management options are limited. Even inexpensive handheld screening wands can be helpful. For example, with a patient like Mr. Green who still had his gun, needed medical care, but was willing to comply with restrictions for his future medical appointments, if no metal detector entrance was available for him to walk through, he instead could have been screened with a hand wand, which would allow for continuation of his care as well as staff’s safety and peace of mind.

Finally, leadership can support doing away with so-called “zero tolerance” violence policies. While OSHA has called for such policies for years, violence prevention experts have not and the 2020 revisions to the ANSI standards specifically call for avoiding the use of the term “Zero Tolerance” because the term diminishes reporting and decreases safety.[42] Such policies, like other policies that aim for a “one size fits all” approach, result in skipping threat assessment altogether – by contrast, a properly conducted threat assessment may reveal management opportunities that could avert escalation to violence.

Action Green Today

Today, Mr. Green continues to receive medical treatment with a different provider within our

system, which allowed him a fresh start. The new provider and his colleagues were made fully aware of Mr. Green having brought a gun into the clinic. Mr. Green must travel to a further location equipped with a metal detector in order to receive medical care. To date, he has been compliant. The alternative – dismissing him from care and banning him from our premises – may have worked out fine. But then again, maybe not.

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[1]Matthew B. Stanbrook MD, PhD, "Gun Control: A Health Issue for Which Physicians Rightfully Advocate," *Canadian Medical Association Journal*, 191(16): E434-E435 (April 23 2019).

[2]Tweet by NRA November 8, 2018. For further discussion, see D Taichman, SS Bornstein, C Laine, "Firearm Injury Prevention: AFFIRMing that Doctors Are in Our Lanes," *Annals of Internal Medicine* (2018).

[3]Jennifer de Pinto, Election 2018: "Voters Supported Stricter Gun Policy, but it wasn't Priority for Most," CBS News, November 9, 2018 (Election 2018 exit polling showing 6 in 10 favored stricter gun control, but only 1 in 10 voters said it was a voting priority).

[4]Sam Lee, chairman of Gun Control Australia, quoted in *The New York Times*, "Mass Shooting in Australia Leaves a Tiny Community in Shock and Grief," May 12, 2018.

[5]The December 14, 2012 mass shooting at Sandy Hook Elementary School in Newtown, CT left 20 children and 6 teachers and staff dead.

[6]Reid Wilson, "Seven Years After Sandy Hook, the Politics of Guns has Changed," *The Hill*, December 14, 2019.

[7]Therese Postel, former policy associate at The Century Foundation, "The Assault Weapons Ban: Did it Curtail Mass Shootings?" CRIMINAL JUSTICE COMMENTARY, The Century Foundation, January 11, 2013.

[8]Jurgen Brauer, Chief Economist at Small Arms Analytics & Forecasting (SAAF), a politically unaffiliated research consultancy focusing on the global small arms and ammunition markets, "U.S. Firearms Sales: 2020 Sales Continue at Record Pace" November 2, 2020.

[9]Brauer, "U.S. Firearms Sales: 2020 Sales Continue at Record Pace" November 2, 2020.

[10]Brauer, as quoted by Fox News, "Gun Sales Year-to-Date Surpass Previous Annual Record High by Nearly 2 Million, Statistics Show," November 2, 2020.

[11]Associated Press, "Gun sales hit high in January, continuing 2020 surge," February 4, 2021. https://abcnews.go.com/Politics/wireStory/gun-sales-hit-high-january-continuing-2020-surge-75693468

[12]Mark Oliva is a spokesperson for The National Shooting Sports Foundation (NSSF), a gun industry trade group. Oliva made the comment in an email to reporter Stephanie Pagones at Fox News.

[13]John Donohue is C Wendell and Edith M Carlsmith Professor of Law at Stanford University, "Ban Guns, End Shootings? How Evidence Stacks Up Around the World," *CNN's The Circuit*, August 27, 2015.

[14]For a discussion of healthcare-unique challenges when responding to active shooter incidents, see Daniel L. Schwerin, Jeff Thurman, Scott Goldstein, "Active Shooter Response," StatPearls Publishing LLC, September 23, 2020.

[15]The American Society for Health Care Engineering and the International Association for Security & Safety (IAHSS) 2018 Hospital Security Survey https://www.hfmmagazine.com/articles/3519-hospital-security-survey

[16]For a comprehensive discussion of threat assessment in healthcare, see e.g., Sarah J. Henkel, "Threat Assessment Strategies to Mitigate Violence in Healthcare" IAHSS-F RS-19-02 November 11, 2019.

[17]IAHSS as cited in 2018 Hospital Security Survey, *supra* (xi).

[18]"Risk Assessment Guideline Elements