



# VIOLENCE



## AGAINST EMS PRACTITIONERS

2019 **NATIONAL SURVEY**

*How safe are EMS practitioners – and what  
are EMS agencies doing to protect them?*

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The survey is a project of NAEMT's EMS Workforce Committee. NAEMT extends a sincere thank you to committee members for contributing their insights and expertise.

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# INTRODUCTION

From physical assaults to verbal abuse, violence is a significant occupational hazard for EMS practitioners.

In April 2019, a man revived by naloxone attacked the New York City medics who administered it, sending one to the hospital with head injuries. In June, a paramedic in San Diego was hospitalized after he was beaten and kicked by the family of a woman being placed on a 72-hour mental health hold. In July, a psychiatric patient stabbed a Boston EMT who was treating her and sprayed the other EMT with pepper spray as he tried to intervene.

The most horrendous incidents can result in line-of-duty deaths. In March 2017, a psychiatric patient ran over and killed Yadira Arroyo, a mother of five, with her own ambulance in Bronx, New York. And in May 2019, two firefighters were shot – one fatally – responding to a medical emergency on a bus in Appleton, Wisconsin.

Hardly a day goes by without a headline telling the story of an EMS practitioner attacked by a patient or family members. Even more common are the incidents that don't make the news – the push, punch, or kick from an angry or disoriented patient. On top of that is the verbal abuse – threats of violence, intimidation and harassment – that many EMS practitioners would never consider reporting.

**“The assault resulted in me herniating two cervical vertebrae and losing my job.”** – Survey respondent



## Health and safety impacts

While EMS practitioners may feel they need to accept some violence as part of the job, research has shown that it can negatively affect their physical and mental health. A comprehensive review of studies on the impact of workplace violence on healthcare providers concluded that physical and verbal assaults are major health and safety issues for healthcare workers. Injuries, if severe, can lead to long-term disability and job loss.<sup>1</sup>

There are also psychological impacts. Healthcare workers exposed to violence may experience symptoms of post-traumatic stress disorder and depression. Common emotions include anger, sadness, fear and disgust.

To better understand how violence impacts EMS practitioners and what EMS agencies are doing to protect their crews, the National Association of Emergency Medical Technicians (NAEMT) conducted a national survey of our members. The survey asked about:

- The types of violence experienced.
- The impact of violence on perceptions of safety on the job.
- Practitioner knowledge and use of violence reporting systems.
- Agency policies and policies to prevent violence.
- Practitioner wishes for violence prevention and protection training and education.

The results are presented in this report.

## About the Survey

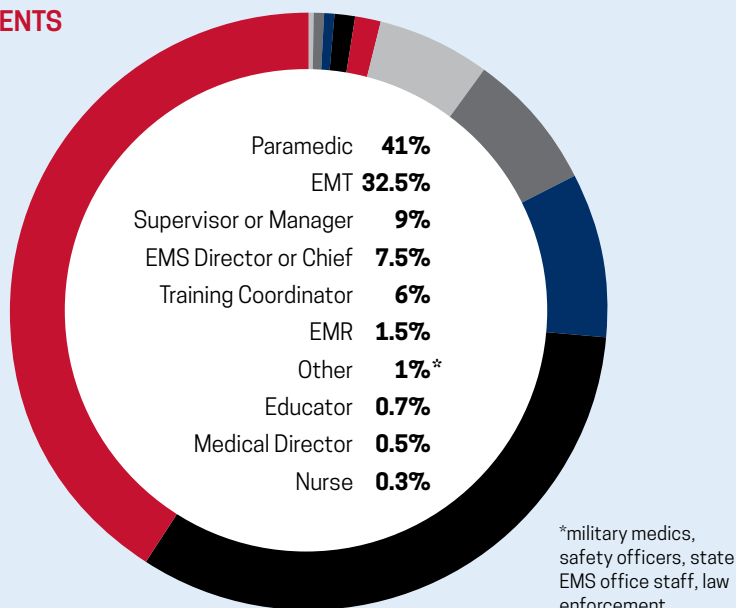
This survey was developed by the members of NAEMT's EMS Workforce Committee. The survey was comprised of 38 questions and was distributed electronically in February and March 2019 to more than 37,000 NAEMT members in the United States, including emergency medical responders (EMRs), EMTs, paramedics, training coordinators, EMS managers at all levels, and medical directors. We received 2,171 responses from all 50 states and the District of Columbia.

1. Lanctôt, N. & Guay, S. The Aftermath of Workplace Violence among Healthcare Workers: A Systematic Literature Review of the Consequences. *Aggression and Violent Behavior* 19, no. 5 (2014): 492-501. doi:10.1016/j.avb.2014.07.010

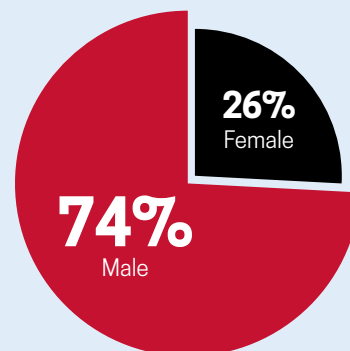
# DEMOGRAPHICS OF RESPONDENTS

Survey respondents worked for all types of EMS delivery models, from large urban departments to small volunteer agencies in super rural areas. Call volumes also ran the gamut, from over 100,000 calls annually to super rural areas with less than 100 calls annually.

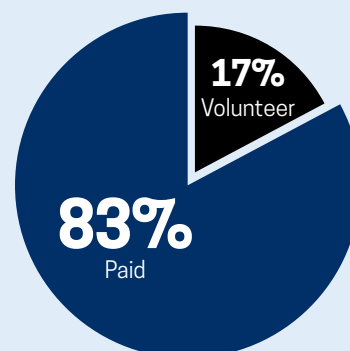
## RESPONDENTS



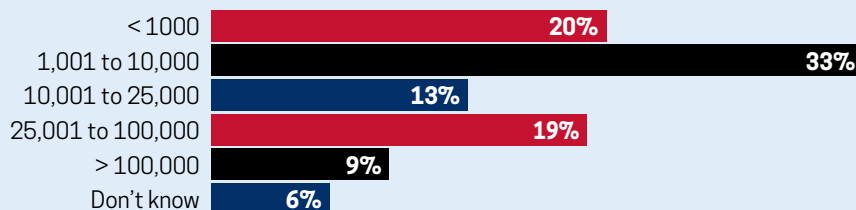
## MALE VS. FEMALE



## PAID VS. VOLUNTEER



## CALL VOLUME



## GEOGRAPHIC AREA



# INCIDENCE OF PHYSICAL & VERBAL ASSAULTS

Research in workers in healthcare settings has shown that healthcare workers are more likely to be victims of violence on the job than other professions. According to the Occupational Health and Safety Administration (OSHA), about 75% of nearly 25,000 workplace assaults reported annually occurred in healthcare and social service settings.<sup>2</sup> While violence against healthcare workers occurs in all settings, hospital emergency departments and inpatient psychiatric facilities are the most common sites.<sup>3</sup> EMS has significant contact with both groups of patients. These encounters often occur in homes, at other sites in the community, or in the back of an ambulance. In some situations, police may be on scene to assist. In others, EMS crews are on their own to deal with the situation.

## Frequency of violence

A few studies have looked at the frequency and type of work-related violence in EMS specifically. A study published in 2018 in *Prehospital Disaster Medicine* found U.S. EMS personnel are 22 times more likely to be injured due to workplace violence than other occupations.<sup>4</sup> A 2002 study published in *Prehospital Emergency Care* on self-reported violence in a large California EMS system found 8.5% of EMS patient encounters involved some sort of violence, with 53% directed against practitioners and 47% against others on scene. About 21% of the violence was verbal only, 49% physical and 30% both.<sup>5</sup>

In 2014, a survey of 221 EMS practitioners in a busy urban system in New England found that 80% reported a physical assault at some point during their careers.<sup>6</sup> Among those assaulted, 40% sought medical care and 49% reported the assault to police. About 68% reported that they feared for their personal safety while at work. The longer they were on the job, the more likely they were to have been assaulted on the job. The study found no statistically significant difference between the likelihood of males vs. females being assaulted.

## Men vs. women in research

Other research has also found that men and women are equally at risk of being assaulted on the job. A study published in 2016 in

the *American Journal of Industrial Medicine* found that paramedics had higher odds of patient-initiated violence than firefighters, and women reported being struck more often than men. However, women were also more likely to be paramedics than firefighters.<sup>7</sup>

## Men vs. women: NAEMT survey

As with other research, the NAEMT survey did not find major differences in the rate of assaults on men compared to women, although slightly more men reported having been assaulted than women.

**69% of men reported having been physically assaulted, compared to 62% of women.**

**92% of male EMS practitioners reported verbal assaults, compared to 88% of women.**

Nor were there major differences among delivery models in the likelihood of being assaulted, although hospital-based EMS practitioners were somewhat more likely than other delivery models to say they had been physically assaulted. Because violence prevention has gotten significant attention in hospitals in recent years, hospital-based EMS practitioners may be more likely to have received training or information on recognizing and reporting assaults.

**2 in 3 survey respondents (67%) reported having been physically assaulted while practicing EMS.**

**Nearly all (91%) respondents reported having been verbally assaulted while practicing EMS.**

2. Occupational Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers (OSHA, 3148-O4R). Washington, DC: OSHA, 2015.

3. Sentinel Event Alert. The Joint Commission. Issue 59, April 17, 2018. [https://www.jointcommission.org/assets/1/18/SEA\\_59\\_Workplace\\_violence\\_4\\_13\\_18\\_FINAL.pdf](https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf)

4. Maguire, B.J., Browne, M., O'Neill, B.J., Dealy, M.T., Clare, D., O'Meara, P. (2018). International Survey of Violence Against EMS Personnel: Physical Violence Report. *Prehospital Disaster Medicine*, Oct; 33(5):526-531. doi: 10.1017/S1049023X18000870.

5. Grange, J. & Corbett, S. (2002). Violence Against Emergency Medical Services Personnel. *Prehospital Emergency Care*, 6:2, 186-190, doi: 10.1080/10903120290938526

6. Furin, M., Eliseo, L. J., Langlois, B., Fernandez, W. G., Mitchell, P., & Dyer, K. S. (2015). Self-Reported Provider Safety in an Urban Emergency Medical System. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*, 16(3). doi: 10.5811/westjem.2015.2.24124

7. Taylor J., Barnes B., Davis A., Wright J., Widman S., LeVasseur M., "Expecting the unexpected. A mixed methods study of violence to EMS responders in an urban fire department." *American Journal of Industrial Medicine*. 2016 Feb; 59(2): 150-163. Published online 2016 Jan 4. doi: 10.1002/ajim.22550



## Assaults leading to injuries

In 2016, 3,500 EMS practitioners sustained serious enough injuries from work-related violence that they visited hospital emergency departments, according to the CDC's National Institute for Occupational Safety and Health (NIOSH). Violent incidents accounted for 16% of all injuries serious enough to seek medical care in the ED.<sup>8</sup>

## Barriers to collecting violence data

But collecting data on workplace violence against EMS practitioners is difficult. One reason is that there is disagreement among healthcare workers on what constitutes violence, and the tools used to measure violence differ from study to study.

In addition, studies on violence are almost always voluntary, which raises the possibility of selection bias, meaning that participants may be more or less likely to have experienced violence than a typical EMS practitioner. Another difficulty in gathering accurate violence statistics from studies is that they are also retrospective, and rely on people's memories of events.

## What is workplace violence? A definition from NIOSH

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty."

The U.S. Department of Labor defines workplace violence as an action (verbal, written, or physical aggression) which is intended to control or cause, or is capable of causing, death or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior toward authority, intimidating or harassing behavior, and threats.<sup>9</sup>

62% of survey respondents said they feel safe while practicing EMS.

Women were somewhat less likely to feel safe than men, with 57% saying they felt safe on the job compared to 64% of men.

## EMS Uniforms



Two-thirds of survey respondents (67%) believe their uniform clearly differentiates them as an EMS practitioner. One-third (33%) don't.

Uniforms serve as a way to differentiate a profession, and as a marker of authority (think: law enforcement blue) or rank and skill (think: a doctor's white coat.) While nearly all EMS agencies require EMTs and paramedics to wear uniforms, the style and color of those uniforms vary from agency to agency.

In the U.S., EMS uniforms may be dark blue or navy, sometimes paired with a white or light blue shirt. Tan, gray, green and black are also common. Shirts may be button down collared shirts, polos or T-shirts. Some uniforms incorporate clip-on ties and badges. EMS lacks an instantly recognizable uniform, and some uniforms have the potential to be mistaken for law enforcement.

EMS practitioners working for fire departments were somewhat less likely than other EMS delivery models to feel confident their uniforms clearly differentiated them. About 62% of fire-based EMS practitioners said their uniforms clearly differentiated them, compared to 73% of EMS practitioners working for private nonprofit or private for-profit EMS agencies.

8. National Institute for Occupational Safety and Health (NIOSH). Emergency Medical Services Injury Data, 2016. <https://www.cdc.gov/niosh/topics/ems/data.html>

9. Sentinel Event Alert. The Joint Commission. Issue 59, April 17, 2018. [https://www.jointcommission.org/assets/1/18/SEA\\_59\\_Workplace\\_violence\\_4\\_13\\_18\\_FINAL.pdf](https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf)

# SAFETY CULTURE



77% of survey respondents said their EMS agency practices a culture of safety.

23% said their agency doesn't.

Currently, there are no national guidelines or recommendations on how to prevent violence in EMS; what attitudes, habits, policies or procedures are needed to create a culture of safety within an EMS organization; or what sorts of incidents should be reported.

Despite this, three in four respondents (77%) believe their agency practices a culture of safety; 76% agreed that their EMS agency values the safety of practitioners, while only 7% disagreed. 15% neither agreed nor disagreed.

Safety culture refers to a collection of core values that provide a frame of reference for leadership and workers, and influence shared beliefs, practices, rituals, norms and behaviors related to safety, according to the Strategy for a National EMS Culture of Safety.<sup>10</sup>

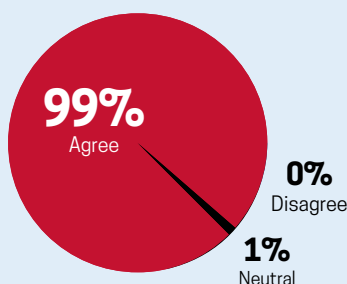
Thus far, discussions around developing a culture of safety within EMS have largely focused on preventing injuries to EMS practitioners due to motor vehicle accidents through safe driving behaviors, and preventing back or repetitive use injuries through safe patient handling techniques. More recently, mental health and wellness have emerged as major concerns, with more EMS leaders stressing the importance of speaking out and seeking help to deal with the psychological stress that can come with responding to members of the community who have been seriously injured, killed or victims of abuse or violence themselves.

Scene safety is a part of many EMS training and education programs. EMS practitioners are often taught to keep in mind that any scene has the potential to turn violent. Situational awareness encourages the use all of the senses to look for clues as to whether or not a scene could be hazardous. EMS practitioners are also instructed to call for law enforcement before entering a home or a scene they determine might be dangerous.

But beyond that, what constitutes a culture of safety related to violence against EMS practitioners has yet to be defined.

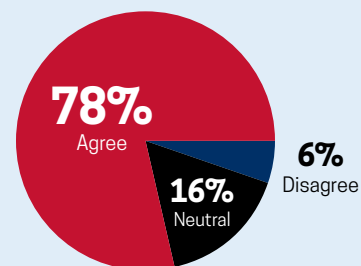
EMS practitioners are confident that they make safety a priority...

I make safety a priority when practicing EMS.



But somewhat less confident in how much of a priority safety is to their EMS colleagues.

My EMS colleagues make safety a priority when practicing EMS.



The survey found some differences in safety perceptions among personnel at various delivery models. About 82% of fire-based EMS respondents said their agency values the safety of EMS practitioners. County (public) EMS came in at 79%, hospital-based was 78%, private nonprofit was 74%. Among respondents from public utility and private for-profit EMS agencies, just 70% said their agency made safety a priority.

10. Strategy for a National EMS Culture of Safety, Oct. 10, 2013. <https://www.ems.gov/pdf/Strategy-for-a-National-EMS-Culture-of-Safety-10-03-13.pdf>

## POLICIES & PROCEDURES

Policies and procedures are ways in which EMS agencies can clearly spell out the responsibilities of EMS practitioners, and the agency's responsibility to their employees. Policies and procedures set expectations for how the agency will respond to violence, outline the steps to take so that incidents are investigated and reported, and let employees know that violence against them is not condoned.

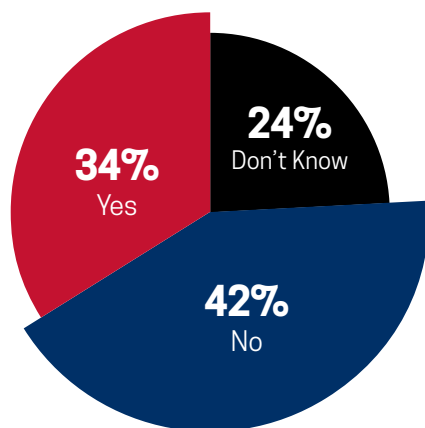
Although the majority of respondents said that they and their colleagues make safety a priority (and that their agency practices a culture of safety), far fewer said their EMS agency has written policies and procedures on violence against EMS practitioners. Policies also must be widely disseminated so that people are aware of them.

Requiring assault reporting, and ensuring that employees know how to make these reports, is an essential aspect of a violence prevention plan. Managers and supervisors also need to know what steps to take when they receive a report of an assault. Employees must also know that they will not face retaliation from managers or co-workers for reporting violence.

One goal of investigations should be to look for ways to reduce similar incidents from happening again. Investigations may be done by teams of EMS staff, including managers, HR, and the legal department, to determine whether law enforcement should be notified.



### Does your EMS agency have written policies and procedures on violence against EMS practitioners?



### Reviewing policies & procedures

Among those who were aware of their agency's policies, 93% said those policies were provided to them. Among those who receive the policies, 36% were provided a

printed copy, 39% were sent an electronic copy, 14% were provided with classroom training, 8% were offered online training, 1% were provided the information in multiple formats and 1% said they knew where to find the policies if needed but they were not given a copy.

EMS agencies vary in how often they review their policies and procedures related to violence and violence prevention. Of those respondents who reported having policies at their agencies, about half (49%) said policies and procedures are reviewed annually. 9% review the policies and procedures twice a year; 10% quarterly; 6% post-incident; 1% review only with new hires; 7% said their agency never reviews the policies and procedures, and 17% don't know. About 1% provided different intervals ranging from every five years to "on occasion."



**“Verbal abuse and threatening words and body language are common occurrences in EMS.” –**

Survey respondent

### What do the policies & procedures cover?

Of respondents who said their agency has policies and procedures on violence, 81% of agencies require all acts of violence to be reported, compared to 9% that don't. (The remaining 10% didn't know).

Fewer agencies take an across-the-board team approach to reviewing acts of violence. About 37% said that all acts of violence must be referred to a review committee, while 35% do not require all violent acts to be referred to a review committee; 28% didn't know.

### Policies on handling verbal confrontations

Verbal assaults are the most common form of workplace violence faced by EMS practitioners. Because no physical injuries occur, verbal abuse or threats are often brushed off and accepted as part of the job.

But verbal abuse from volatile patients can cause EMS practitioners to fear for their safety. The practitioner cannot know whether the verbal confrontation will escalate to a physical assault – will the patient's outburst stop at yelling, threatening, intimidation or insulting, or will the patient become angrier and lash out physically?

Of those respondents who said their EMS agency has written policies on violence against EMS practitioners, 68% reported that their EMS agency has a policy on how to handle a verbal confrontation; 21% have no policy, and 11% didn't know.

### Policies on body armor

Recently, there have been numerous news reports of fire and EMS agencies issuing or requiring body armor for responders<sup>11</sup>.

In May 2019, Detroit Fire and EMS established a policy requiring EMS and fire personnel to wear stab-resistant vests during medical calls<sup>12</sup>. Cleveland EMS has a similar policy – medics are required to wear body armor at all times, except inside the station or hospital.<sup>13</sup>

Some EMS agencies require the use of body armor such as ballistic vests and helmets in certain situations. For example, in Broward County, Fla., fire and EMS personnel are required to wear department-issued body armor when responding to incidents involving guns or other weapons.<sup>14</sup> Other EMS agencies, such as Allina Health in Minneapolis, Minn., give EMS personnel an allowance toward buying body armor and to use their discretion in determining if or when to wear it.

But the majority of EMS agencies do not have body armor policies or procedures. According to the survey, even among respondents reporting their EMS agency has written violence policies, only about one in three (32%) said their EMS agency has a policy on wearing body armor on duty; 61% don't have a policy, and 7% didn't know.

### Policies on firearms

In the last few years, several states, including Ohio, Kansas and Florida, have passed legislation allowing first responders, including firefighters and EMS personnel, to carry concealed weapons on duty in certain circumstances. Similar legislation has been proposed in multiple other states. Yet even in those states that allow EMTs and paramedics to carry guns, many EMS agencies continue to have policies prohibiting it.

According to the survey, among agencies with written violence policies, 61% do not have policies on firearms; 32% do have a policy (the survey did not ask whether the policy prohibits or allows firearms, only if the agency had a policy); 7% don't know.



11. Friese, G. Jan. 15, 2016. "Body armor for EMS: Is it time for every medic to wear a ballistic vest?" <https://www.ems1.com/body-armor/articles/50209048-Body-armor-for-EMS-Is-it-time-for-every-medical-to-wear-a-ballistic-vest/>

12. Detroit Fire and EMS now required to wear body armor. WXYZ Detroit. May 7, 2019. Retrieved from <https://www.wxyz.com/news/region/detroit/detroit-fire-and-ems-now-required-to-wear-body-armor>

13. Danylko, R. Jan. 6, 2016. "Bulletproof vests now mandatory for all Cleveland EMS responses (video)." Retrieved from <https://www.cleveland.com/metro/2016/01/bulletproof-vests-now-mandatory.html>

14. Barszewski, L. Sept. 19, 2017. "Fla. firefighter-paramedics getting body armor, helmets." Retrieved from <https://www.ems1.com/ems-products/Body-Armor/articles/323907048-Fla-firefighter-paramedics-getting-body-armor-helmets/>

# TRAINING

There are many potential underlying causes or triggers for violence against EMS practitioners.

Assaults can be premeditated and intended to do harm, potentially even targeting EMS. Practitioners may encounter people who become aggressive when they are angry and stressed, or they perceive EMS should be doing something more to help their critically ill loved one. In other cases, EMS may respond to a scene that is already violent – such as domestic violence or other crime scene.

Mental illness and substance use, especially when combined, can also be factors in aggression toward EMS. And certain medical conditions, such as dementia, can cause people to lash out who never would otherwise.

EMS practitioners can receive education and training on dealing with violence in its many forms either from their EMS agency, or through a continuing education course, either online or in person.

## EMS practitioners reported that their EMS agency provided training for:

EMS safety	<b>51%</b>
Agitated delirium	<b>36%</b>
Violence and the altered mental state	<b>34%</b>
Violent and unruly patients	<b>31%</b>
Abnormal psychology	<b>20%</b>
Domestic violence	<b>26%</b>
Verbal de-escalation	<b>23%</b>
Gang awareness	<b>14%</b>

## EMS practitioners reported taking a continuing education course for:

	CLASSROOM	VIRTUAL
EMS safety	<b>37%</b>	<b>17%</b>
Agitated delirium	<b>36%</b>	<b>16%</b>
Violence and the altered mental state	<b>36%</b>	<b>16%</b>
Violent and unruly patients	<b>34%</b>	<b>14%</b>
Abnormal psychology	<b>38%</b>	<b>14%</b>
Domestic violence	<b>34%</b>	<b>14%</b>
Verbal de-escalation	<b>32%</b>	<b>12%</b>
Gang awareness	<b>24%</b>	<b>9%</b>

53% of respondents agree that they have received adequate training to respond to EMS calls where violence may occur.

25% disagreed.  
22% neither agreed nor disagreed.

## What is verbal de-escalation?

Verbal de-escalation is the use of communication, listening and other non-physical skills to calm and reassure agitated or angry patients. The goal of verbal de-escalation is to prevent a physical confrontation by recognizing danger signs that conflict is brewing and defusing the situation. There are four objectives:

- Ensure the safety of the patient, responders and bystanders.
- Help the patient manage his or her emotions and regain control of his or her behavior.
- Avoid the use of restraints when possible.
- Avoid actions that escalate agitation.<sup>15</sup>

There is widespread support for greater use of verbal de-escalation throughout healthcare, however there are no agreed upon guidelines or training for EMS practitioners. “A review of the literature indicates that scientific studies and medical writings on verbal de-escalation are few and lack descriptions of specific techniques and efficacy,” according to the American Association for Emergency Psychiatry Project Beta De-escalation Workgroup. In 2012, the group developed the 10 domains of de-escalation for use in emergency situations that could be used as a basis for education and training in this area.<sup>16</sup>

Another analysis of workplace violence training programs for healthcare workers found that the only element included in every program was de-escalation of potentially violent situations.<sup>17</sup> Elements addressed in nearly all of the other programs included: train the trainer approach, de-escalation practice, evasion and extrication with practice, restraints and holds, and the team approach.

Elements addressed by less than half of the programs included: facility-specific workplace violence policies and risk assessment, the four types of violence, predatory violence, pharmacology, legal issues, working alone, multicultural information, worker post-event monitoring, and evaluating program effectiveness with supporting references. All of these are topics for EMS agencies to consider when implementing workplace violence prevention programs.

**“Most situations can be avoided with proper dialogue with the would-be aggressor. Simply walking away helps also. Often times, I see members of our profession escalate the situation.” – Survey respondent**

About 4% of respondents said they had taken training courses covering other safety-related topics, including: active shooters, sexual assault, suicidal patients and crisis intervention team training.

Several mentioned specific courses, including: NAEMT's Tactical Emergency Casualty Care (TECC), Defensive Tactics for Escaping, Mitigating, Surviving (DT4EMS), Management of Aggressive Behavior (MOAB), and martial arts or other self-defense sources.

Among those who hadn't received training in the safety topics listed above (agitated delirium, violence and the altered mental state, violent and unruly patients, verbal de-escalation, gang awareness, and so on), almost all responders were interested in additional training in those areas.

### **EMS practitioners want more training in a range of topics related to preventing and responding to violence on the job.**

Asked what topics they thought would best address violence issues encountered in the field, survey respondents said:

Violent and unruly patients	<b>78%</b>
Verbal de-escalation	<b>74%</b>
Violence and the altered mental state	<b>72%</b>
Self-defense	<b>71%</b>
EMS safety	<b>64%</b>
Domestic violence	<b>64%</b>
Agitated delirium	<b>55%</b>
Abnormal psychology	<b>53%</b>
Gang awareness	<b>38%</b>

Other suggestions include concealed weapon identification and location, weapons training, active shooters, suicide attempt, hostage situations, explosive devices, motivational interviewing, mental health first aid for first responders, resilience training for first responders, managing bystanders and family interference, defensive tactics specific for EMS, and human trafficking/child abuse victim recognition.

## **Should EMS practitioners learn self-defense?**

The goal of self-defense courses is to help EMS practitioners avoid becoming a victim of violence by teaching means of escaping an attacker, and protecting the body to minimize injury if attacked. Training varies widely from program to program – factors such as the length of the course, the experience of the trainer, and the amount of time allotted to practicing skills can impact how much people learn.

There is no consensus on whether self-defense courses help make EMS safer, which types of self-defense courses are most effective, or how much training an EMS practitioner should need. There is also very little evidence-based research on what type of self-defense training is optimal, or even if it works.

Self-defense courses gained popularity in the '70s and '80s as a way to empower women to defend themselves against sexual assault. Most studies about self-defense have been about whether resistance strategies reduce the chance of a “completed rape” without exposing a woman to additional physical injury. There is some evidence that physical resistance can help prevent an assault,<sup>18</sup> and that self-defense training can help reduce non-consensual sexual contact.<sup>19</sup>

15. Richmond, J., Berlin, J., Fishkind, A., Holloman, G., Zeller, S., Wilson, M., Rifai MA, Ng A. (2012). Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine*, 13(1), 17-25. doi:10.5811/westjem.2011.9.6864

16. Richmond, J., Berlin, J., Fishkind, A., Holloman, G., Zeller, S., Wilson, M., Rifai MA, Ng A. (2012). Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine*, 13(1), 17-25. doi:10.5811/westjem.2011.9.6864

17. Arbury, S., Zankowski, D., Lipscomb, J., & Hodgson, M. (2017). Workplace Violence Training Programs for Health Care Workers: An Analysis of Program Elements. *Workplace Health & Safety*, 65(6), 266-272. doi: 10.1177/2165079916671534

18. Rheingold, A. & Kilpatrick, D. “Self-Defense Training: A Brief Review.” National Violence Against Women Prevention Research Center, Medical University of South Carolina. <https://mainweb-v.musc.edu/vawprevention/research/self-defense.html>

19. Healy, M. June 15, 2015. “Women’s program shown to reduce rapes by nearly half.” *Washington Post*. Retrieved from [https://www.washingtonpost.com/national/health-science/showing-women-how-to-resist-sexual-aggression-reduced-chances-of-rape/2015/06/15/3935ba14-1067-11e5-9726-49d6fa26a8c6\\_story.html?utm\\_term=.4ee08ad01312](https://www.washingtonpost.com/national/health-science/showing-women-how-to-resist-sexual-aggression-reduced-chances-of-rape/2015/06/15/3935ba14-1067-11e5-9726-49d6fa26a8c6_story.html?utm_term=.4ee08ad01312)

# REPORTING VIOLENCE

Research has shown that violence against healthcare workers is “an underreported, ubiquitous and persistent problem that has been tolerated and largely ignored.”<sup>20</sup>

In the NAEMT survey, the majority of EMS practitioners (84%) said they report *any* act of violence to their EMS agency. (Only 16% said they don’t report all acts of violence.)

- 52% had reported an act of violence against themselves, another EMS practitioner or been included in a colleague’s report.
- 43% had not.

Women were somewhat less likely than men to report violence to their agency (46% of women had reported a violent incident compared to 54% of men). Paramedics were more likely to have reported an act of violence than EMTs (60% compared to 36%). This could be because paramedics have more years on the job than EMTs and are more likely to have encountered violent patients.

When asked why some acts of violence are not reported, 313 respondents provided a variety of answers that can be grouped into several themes:

**Some incidents of violence are relatively minor and are not worth the paperwork and time it takes to report them.**

*“I’d kill a small forest if I reported every incidence of violence. I just report when an injury occurs.”*



*“If you reported every patient who was a bit aggressive you’d be doing nothing but filling out reports.”*

*“System is too busy to take a truck out of service to file a report.”*

*“Verbal violence happens with almost every [chronic inebriate] or psych patient. And physical violence happens with about every one in five psych calls. Too much to report.”*

*“There are too many to report. I’ve been grabbed and kicked, but not injured. If I reported it every time, I would be reporting it all day.”*

**Verbal abuse is commonplace and not seen as consequential enough to report.**

*“Verbal does not bother me and the occasional arm swinging is OK.”*

*“Because ‘verbal assault’ is not something I will ever report. Who cares? People talked mean to me. Whahhhh!”*

*“Verbal abuse happens daily. Bosses have enough to worry about without me taking issue with someone verbally abusing me.”*

20. Phillips, J.P. “Workplace Violence Against Health Care Workers in the United States.” *New England Journal of Medicine* 2016; 374:1661-1669 doi: 10.1056/NEJMra1501998



## Violence is expected and accepted as part of the job.

*"Violence can be expected from sick, disoriented patients."*

*"Some of the smaller things like the verbal abuse and people attempting to hit you are just a part of the job. If we were to report every time an elderly patient hit you or a psych patient hit you, the paperwork would be endless."*

*"We must accept there is an inherent risk involved with our career."*

## EMS practitioners are reluctant to report unintentional abuse from patients with dementia or patients who have disorders in which they are not fully aware of what they're doing. They differentiate between patients who are disoriented or confused vs. those who have an intent to harm.

*"Most acts of verbal assault against me are committed by patients with dementia or psychiatric illnesses and are so routine and minor that reporting them is more bother than just accepting them."*

*"Not everything classified as violence would I consider an intentional act against my partner and me."*

*"Most are minor, and hurt people defend themselves sometimes."*

*"If the violence was unintentional – altered mental status due to hypoglycemia – and no harm or insignificant harm is inflicted, I likely will not report."*

## EMS practitioners believe that even if they report violence, little will be done.

*"Within the past month I had a patient who was in law enforcement custody and altered due to intoxication. He clearly said he was going to kill me, told my partner he was going to kill her, and told the officer who rode in with us to the hospital that he was going to kill him. Did the officer charge him for it? No."*



*"The first time I was physically assaulted I had a patient's son shove me into a corner by connecting his forearm to my throat in the presence of an officer. The patient's son was angry I 'wasn't helping' his mother even though I was trying to talk her down from a panic attack. He intervened before assaulting me and attempted to put a spoon in her mouth (I found out after he thought she was going to 'swallow her tongue'). I put my hand on his shoulder and said 'hold on' when he tried to put the spoon in her mouth, so the officer refused to press charges since I touched him first. Go figure."*

*"There will be no repercussion to the assailant so it's truly a waste of time."*

## Reporting violence may be perceived as weakness.

*"There is to some degree a stigma to reporting it. There is no formal platform to easily report it, no standardized definitions."*

*"You will be viewed as a wuss."*

*"An altered mental status patient at times is not aware of their actions and under normal circumstances would not act in such a manner. Oftentimes the stigma associated with allowing yourself to be assaulted can be difficult for some and they do not want that spreading."*

*"Embarrassment about being on the receiving end of the acts. Possible criticism/ridicule from peers."*

## Fear of repercussion from the EMS employer.

*"The administration of my primary agency may choose to take disciplinary action against a crew who reports an incident."*

*"Excessive documentation and medical evaluations designed to shift blame onto myself and away from employer or the patient."*

*"Default assumption is that providers are at fault until proven otherwise."*

*"In the past violence against EMS personnel has been ignored. When personnel have reported violence against them, the organization has attempted to discredit our employees."*



# WHAT HAPPENS NEXT? AFTER A VIOLENCE REPORT

**“He spit Hep C at me, knew he was infected. I am fine.”** – Survey respondent

About 90% of respondents said when they reported a violent incident, it was reported to agency management. According to the survey results, not all of those incidents were reported to police – about 74% said the incident was reported to law enforcement. Fewer still resulted in charges or other legal action – 45% said charges were filed or legal action was taken.

When charges were filed, in 79% of cases, the defendant was found guilty.

Asked what judgment was rendered, 179 respondents wrote in a range of answers, including: jail time with credit for time served, suspended sentences, fines, probation, letter of apology and community service, anger management and drug treatment.

## Awareness of Violent Incident Report Systems Lagging

There are various industry efforts to collect data on violence through voluntary reporting. But knowledge of those reporting tools is limited.

18%

of respondents have heard of the EMS Voluntary Event Notification Tool (E.V.E.N.T.), which collects information on near-misses, patient safety events and violent incidents.

21%

had heard of the National Fire Fighting Near Miss Reporting System, managed by the International Association of Fire Chiefs (IAFC).

9%

were aware of Patient Safety Evaluation Systems, which can be implemented by EMS agencies, hospitals or other providers to track patient safety events, near misses or reports of unsafe conditions.

65%

had heard of none of these reporting systems.



**“She pulled a knife and tried to stab my partner. I stopped her.”**  
– Survey respondent

# LAWS TO PROTECT EMTS AND PARAMEDICS

Many states have passed legislation that seek to deter violence through tougher penalties for assaulting emergency responders, including firefighters, EMTs and paramedics.

Two examples: In 2016, Louisiana added first responders to the groups protected under the state's hate-crime laws. People convicted of intentionally assaulting police, firefighters or EMS face harsher penalties, as would someone convicted of targeting someone due to their ethnicity, religion, or sexual orientation. (Laws

that include police as a protected class under hate-crime statutes are sometimes referred to as "Blue Lives Matter" laws.)

In Vermont, legislators recently passed H. 321, which makes killing a firefighter or emergency medical provider an aggravated murder, which carries a sentence of life in prison.

Another type of law that EMS advocates are pushing for are statutes that require employers to create workplace violence prevention programs and provide services to those affected by violence. Since 2017, California OSHA's Workplace Violence Prevention in Health Care standard has required healthcare providers, including EMS, to implement a violent incident log, a workplace violence prevention plan, annual reviews of the plan and training for employees on the plan.<sup>21 22</sup>

Other states have implemented workplace violence prevention requirements but failed to specifically include EMS. The Illinois Health Care Violence Prevention

Act, which went into effect Jan. 1, 2019, requires hospitals and other healthcare providers to create violence prevention programs to protect nurses and other

healthcare workers, and provides whistleblower protections for workers who report assaults. The program must comply with the Occupational Safety and Health Association (OSHA) Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.<sup>23</sup> Dental hygienists, pharmacists, podiatrists and about a dozen other healthcare professionals

were specifically named as those protected by the law. There was discussion about including EMTs and paramedics on that list, but ultimately they were not named.

## Federal legislation

Similar to the California bill, the Workplace Violence Prevention for Health Care and Social Service Workers Act (S. 851 and H.R. 1309) was introduced in February 2019 in the House by Rep. Joe Courtney (D-CT) and in the Senate in March 2019 by Sen. Tammy Baldwin (D-WI). The bill requires OSHA to issue a Workplace Violence Prevention Standard mandating that employers develop

66% of survey respondents said they are fully aware of protections for EMS practitioners under the law.

34% said they are not.



comprehensive, workplace-specific plans to prevent violence.<sup>24</sup>

OSHA standards are rules that describe employer responsibilities in safeguarding the safety of employees. The violence prevention standard would set minimum requirements for employers' workplace violence prevention plans, including a violent-incident log and whistleblower protection for employees who report incidents to their employer and law enforcement.

NAEMT is advocating for the bill, which has the support of a broad range of organizations including the International Association of Fire Chiefs, International Association of Firefighters, American Nurses Association, the National Association of Social Workers, the American Association of Fire Fighters, the American Psychiatric Nurses Association, United Auto Workers, and the International Brotherhood of Teamsters. As of August 2019, the bill had 21 cosponsors in the Senate (all Democrats) and 208 cosponsors in the House (206 Democrats and two Republicans).

21. California Department of Industry Relations. Workplace Violence Prevention in Health Care. Retrieved from <https://www.dir.ca.gov/dosh/workplace-violence-prevention-in-healthcare.html>

22. National Nurses United. *California Workplace Violence Prevention in Healthcare Regulations*. Retrieved from <https://www.nationalnursesunited.org/california-workplace-violence-prevention-healthcare-regulations>

23. U.S. Occupational Safety and Health Administration. *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*. Retrieved from <https://www.osha.gov/Publications/OSHA3148.pdf>

24. Congressman Courtney Introduces Legislation to Reduce Violence Against Health Care and Social Service Workers. Feb. 21, 2019. Retrieved from <https://courtney.house.gov/media-center/press-releases/congressman-courtney-introduces-legislation-reduce-violence-against->

# HOW CAN WE STOP VIOLENCE?

Asked to share their thoughts on how to protect EMS practitioners from violence in the field, over 1,200 respondents shared ideas.

## Training and education in verbal de-escalation and self-defense.

Far and away the most common response was a request for additional training and education in verbal de-escalation. Many respondents also mentioned wanting more training in situational awareness, such as recognizing when a patient may become violent.

The second most common response was a recommendation for self-defense training. Several expressed frustration that training EMS to use physical self-defense techniques seems to be taboo among EMS management, or that management is more concerned that self-defense training could increase liability.

Several also said that the quality and length of the training matters. They said training should be in-person, hands-on, mandatory, held at regular intervals, and involve scenarios – a brief, online course wasn't enough.

Specific courses respondents recommended included: DT4EMS, Critical Intervention Team (CIT) training and NAEMT's EMS Safety course.

*"We need training beyond a one-hour online tutorial...Take pride in us and we can take pride in our companies!"*



**"Providing equipment and training is a necessity. It may be expensive but so is a lawsuit. We are not expendable!"** – Survey respondent

*"We must require hand-to-hand training while also requiring personnel to be physically fit as to avoid undue injury while training. In so many areas we're playing catch-up to other disciplines. Current events show the climate on the street no longer differentiates between EMS and law enforcement – medical providers should be given training and actual defensive tactics training to make safe decisions on the street."*

*"We need more active training for providers on how to de-escalate, restrain and manage all patients before they get violent."*

*"Verbal de-escalation and scene awareness I feel are the best strategies. I fear*

*that teaching medics self-defense classes might make them feel more confident than they should be and they might put themselves in bad situations. As an agency you have to make sure your employees know it is OK to not go into a scene they fear is unsafe or to leave a scene they feel is unsafe."*

*"First, I believe very strongly in the need for de-escalation training in the EMS field. Second, only after de-escalation training has been completed should we work on self-defense and physical restraint training. Unfortunately there have been several occasions during my career when a situation was intentionally or unintentionally escalated by an EMS colleague."*

### Greater availability of protective equipment and self-defense tools, including weapons.

Numerous respondents mentioned the need for greater availability of protective equipment, or protective equipment more in line with what law enforcement uses. Specific requests included: soft restraints, body armor/ballistics vests and chemical restraints.

Over 60 respondents (about 5%) called for arming medics or allowing them to carry a concealed weapon.

*"At night we do not have law enforcement backup. I believe we should be allowed to carry with proper training."*

*"I think that EMS professionals should be able to defend themselves in violent situations. I think training should be required at all agencies (initial & on-going). Firearms, tasers and batons should be an option (personal choice) for the EMS provider to carry if they so wish, so they may protect themselves and others if needed."*

*"EMS should work closer with law enforcement in learning techniques to deal with violence such as verbal de-escalation, self-defense training, and situational awareness. There should also be more available funding for ballistic protection for EMS providers. Lastly, there should be more openness and support for concealed carry."*

However, several noted their opposition to weapons on the ambulance and exasperation with EMS colleagues who do not realize that their gun may be turned against them or injure an innocent bystander.

*"Carrying a firearm is ridiculous! Firearms only make a situation more dangerous, not less."*

### Stiffer punishments.

Another theme was a call for stricter laws and stiffer punishments for those who attack EMS practitioners. Several expressed frustration that assaulters are not always held accountable. One respondent suggested that laws regarding violence against EMS should be posted on the ambulance as a deterrent.

*"EMS agencies and professionals should be regarded in the same protective classes as fire and police. Most incidents of violence towards EMS is viewed as a misdemeanor and not pursued at the same level [as an assault on police]."*

### More help from law enforcement.

Another common suggestion was the importance of working closely with police, and greater law enforcement presence on scene to prevent assaults. Several respondents said that police are present on every call in their jurisdiction. One specifically mentioned that the first unit dispatched for domestic violence should be police, not an ambulance. Another said psych patients should be transported in a police car. Others mentioned training with law enforcement or more information from law enforcement about people or homes that may pose a safety risk.

*"EMS is often asked to deal with patients that the police say need to go to the ER not jail. These patients are in handcuffs but are released from the handcuffs to ride with EMS."*

*"Have cops actually do their job on an assault rather than blowing it off. It would not be taken as lightly if it was another police officer who was treated the same way by a patient."*

*"We have good LEOs who will stop by calls to check safety even if it is a BLS call. Good working relationships with LEOs make a big difference."*



### Uniforms that clearly differentiate EMS from law enforcement.

EMS uniforms easily mistaken for law enforcement is another area of concern. Patches and other emblems don't seem to be enough for some members of the public to understand that they are being approached by a medical professional, not a police officer.

*"Get away from uniforms that look like police. Wear a golf shirt with no patches or a T-shirt all the time. The services care more about appearance than safety."*

*"While our uniforms identify us as EMS personnel, the public does not pay attention to the patches, medical equipment, and other identifiers. Other methods need to be designed that provide a professional looking uniform but clearly identify the wearer as an EMS professional."*



# CONCLUSION



EMS practitioners face threats to their safety on a daily basis as they answer calls for help in their community. Responding to emergency calls in homes and on the streets, and working with people who are in a mental health crisis, intoxicated or in emotional and physical pain, puts EMS practitioners at risk of violence. While some patients may be disoriented and unwittingly lash out at those trying to help them, other members of the public have an intent to harm.

Violent incidents against EMS practitioners have been documented in news reports and studies throughout the last decade, pointing to the need for stronger agency policies and better protection and training. A heightened awareness about the threat is leading many in EMS to question how much risk is acceptable – and what responsibility individuals, agencies and the profession as a whole have to protect practitioners from being assaulted while serving their communities.

Receiving over 2,200 responses, NAEMT's violence survey explored what has become a significant area of concern

for our nation's EMS practitioners. NAEMT's survey found EMS practitioners face the very real threat of being a victim of violence while performing their duty. According to survey respondents, verbal assaults and minor physical altercations are commonplace, and often go unreported. While a majority said they feel safe while practicing EMS and believe their agency and colleagues practice a culture of safety, only 34% of respondents reported that their EMS agency has written policies and procedures covering violence against practitioners.

EMS practitioners expressed strong interest in more training and education to deal with potentially violent situations in the field, particularly verbal de-escalation and self-defense tactics. In conversations outside of this survey, EMS managers have expressed concerns that teaching self-defense may blur the line between police and EMS, forcing providers to act as an arm of law enforcement rather than as medical professionals. Other concerns are that self-defense courses may give EMS professionals a false sense of security or cause EMS practitioners to take

unnecessary risks when the safest course of action is to exit the situation rather than engage in a confrontation. The cost of providing training is also a barrier.

EMS practitioners responding to this survey do not seem to share those concerns. The number one request for additional training was education in verbal de-escalation, including skills such as anticipating who might become violent and learning how to prevent a situation from escalating. Many respondents also expressed a desire for hands-on self-defense training, and additional protective gear. At the same time, EMS practitioners want to feel supported by their agency and EMS colleagues in walking away from situations that may be dangerous.

Many states have laws that stiffen penalties for assaults on EMS practitioners, and these laws are appreciated by EMS practitioners responding to the survey. Though these laws may not deter criminals, heightened penalties do send a signal to the EMS profession, to law enforcement and to the criminal justice system that violence against EMS practitioners is unacceptable. EMS practitioners also have strong interest in working more closely with law enforcement to deter assaults and provide protection from assault.

Every day throughout the United States, EMS responds to over 100,000 calls for help. The nature of the interactions means that some of these encounters will turn violent. EMS providers have made a decision to be there for patients all hours of the day and night, and in highly stressful situations. The personal safety of these dedicated men and women should be a high priority to EMS agencies, stakeholders and the communities they serve.



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Formed in 1975 and more than 72,000 members strong, the National Association of Emergency Medical Technicians (NAEMT) is the only national association representing the professional interests of all emergency and mobile healthcare practitioners, including emergency medical technicians, advanced emergency medical technicians, emergency medical responders, paramedics, advanced practice paramedics, critical care paramedics, flight paramedics, community paramedics, and mobile integrated healthcare practitioners. NAEMT members work in all sectors of EMS, including government agencies, fire departments, hospital-based ambulance services, private companies, industrial and special operations settings, and in the military.