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When Patients Become Attackers

Protecting EMTs and paramedics from violence on the job takes on added urgency

ON FEB. 8, 2014, ROGER LANE, a paramedic for Wake County EMS in Raleigh, N.C., responded to a 911 call for a 28-year-old man with chest pain.

When Lane and his partner arrived, the man was lying in a shopping center parking lot, handcuffed and screaming, with police all around. He had been involved in a road rage type altercation in which he had followed another vehicle driven by a man and his daughter, repeatedly rammed that vehicle, then followed the girl into a store before he was subdued.

Lane squatted down, leaned in and tried to calm the man. "We're the medics. We're hear to help you," Lane said.

Suddenly, the man flipped over and kicked Lane and his partner with his heavy boots in the face, neck and back. "It happened so fast. It didn't take long for law enforcement to get back over there, but he already broke me and my partner to pieces," Lane said.

From intentional assaults to injuries caused by unruly or dangerous patient or bystander behavior, EMS practitioners face the very real threat of being a victim of violence. Among the most horrific of the recent reports: in October, two Detroit EMTs nearly died after being viciously stabbed and slashed with a boxcutter in the face and hands while answering a call for a woman with an ankle injury outside a homeless shelter. Both were left with disfiguring wounds.

Whether the incidence of violence has increased, or if word simply spreads faster and wider because of social media, is not clear, as no national data on this issue is collected. But what is clear is that a heightened awareness about the threat is leading many in EMS to question how much risk is acceptable — and what individuals, agencies and the profession as a whole can do to protect practitioners from being attacked or maimed while serving their communities.

"Finally we've come to a point that this isn't something people should be trying to deal with themselves," said Robert Luckritz, an NAEMT board member and director of Jersey City Medical Center EMS. "This is something we need to be looking at more closely as an industry and how we can better tackle this."

In the attack, Lane's partner suffered a severe shoulder injury that required surgery and kept her off the job for seven months. Lane, 59, will likely never return. The assault fractured the bones in his neck, knocked a tooth loose and dislocated his jaw. He's had one surgery and doctors have told him to expect more.


Roger Lane receives support from fellow EMS colleagues.

And the physical injuries aren't his only wounds. Lane has developed post-traumatic stress disorder and depression. "In medic school, you're told to be careful. You're taught the concept of scene safety. Put your gloves on, make sure the scene is safe," Lane says. "But there is no scenario in paramedic school that teaches you how to get out of a violent situation."

Threats can be as unnerving as actual incidents

In summer 2014, days after a 23-year-old Jersey City rookie police officer was ambushed and killed execution style, Jersey City Medical Center EMS received a chilling memo. A "reliable source" had informed police that gang members

CONTINUED ON 10

INSIDE

When Patients... CONTINUED FROM COVER

were seeking to kill other police officers or EMS practitioners because of their close relationship with law enforcement.

"It was terrifying," recalled Luckritz, whose agency, Jersey City Medical Center EMS, provides 911 medical response to the 14.5 square mile city of 300,000 just outside New York City. "My colleagues and fellow managers sat down and said, 'What do we do? We can't just stop providing EMS. But how do we ensure our staff is protected?'"

EMS crews were issued bulletproof vests and body armor. For the next several months in the heart of the city's most violent area, police and an EMS supervisor were present for every response.

Though they are no longer operating under such heightened security, the experience left Jersey City EMS grappling with difficult questions about what equipment, training and protocols they need to best protect responders, and how to help employees who struggled with feeling helpless to save the life of the young police officer.

"Most EMS agencies have a policy, 'Don't enter a scene unless it's safe,'" Luckritz says. "But can we realistically expect that if it's one of our own who is injured?"

And standard policies also don't account for how quickly circumstances in the field can change, said Skip Kirkwood, director of Durham County (NC) EMS.

"There is a myth in EMS that you arrive on scene, you determine if the scene is safe and if it's not, you leave," Kirkwood said. "That is a completely flawed approach to the subject because a scene that is safe one minute can be completely violent the next."

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Skip Kirkwood, Director, Durham County (NC) EMS

"He wanted to … kill us."

On the afternoon of April 10, 2013, five firefighter-EMTs and paramedics from Gwinnett County Fire outside Atlanta responded to a 911 call for chest pain. When they entered the home, they found the lights off, and the caller sitting up in bed, partially covered by a blanket.

Firefighters had put the blood pressure cuff on and were preparing the 12-lead, when the man lifted back the covers, revealing a gun.

One of the firefighters hit an emergency button on his radio, alerting dispatchers. For the next four hours, the man held the firefighters hostage.

"He said he had family problems. He had financial problems …," recalled one firefighter in a report issued after the event.

"My personal opinion is he wanted to board the house up, kill us, set the house on fire," said another.

During the standoff, the firefighters tried to build a rapport with him by cracking jokes and offering to make coffee. They wrestled with whether to sit tight and try to keep him calm, or take their chances and tackle him.

The standoff ended when SWAT officers tossed a concussion grenade into the residence, and then shot and killed the man. One police officer was shot in the wrist. The firefighters escaped with minor injuries, and were soon able to return to the job, said Tommy Rutledge, Gwinnett Fire's public information officer.

"It was a traumatic event for each of them, but for the most part they are doing fine," Rutledge said. "But it's never far from our minds. When we go on medical calls now, we're thinking, 'Are the lights on? Where is the patient? Are their hands hidden? Is there something that is a signal to cause us to think this call is something different?'"

Though firefighters are now issued body armor and helmets, few wear them with any regularity, Rutledge said. They have undergone some additional training in active shooter and situational awareness. Yet in reviewing the incident after the fact, the firefighters themselves said there wasn't anything about the scene that triggered suspicion.

"There was nothing there out of the ordinary that we don't see four, five, six times a day … We just responded to a call where someone was laying in their bed and said they had chest pain," said one firefighter.

Is some violence predictable?

Figuring out if there are certain situations or types of patients that are more likely to turn violent is one of the aims of Emerg (emerg.org), a new organization in which member agencies will work together to address patient and practitioner safety.

Beyond the headline-grabbing incidents like those in Detroit and near Atlanta, statistics suggest that violence happens with alarming frequency, and that predicting even a portion of the events could help EMS prepare, said Matt Womble, Emerg executive director.

A 2002 study published in *Prehospital Emergency Care* on self-reported violence found 8.5 percent of EMS patient

encounters involved some sort of violence, with 53 percent directed against practitioners and 47 percent against others on scene. About 21 percent of the violence was verbal only, 49 percent physical and 30 percent both.

A 2005 NAEMT survey found that about half of respondents (52%) reported having been assaulted by a patient.

In 2012, the online EMS Voluntary Event Notification Tool (E.V.E.N.T.) began collecting anonymous reports of violence along with other safety-related incidents. "Last month for the first time we received more violence reports than patient or provider safety reports," Womble said.

One challenge with studying violence is that there is no agreed upon definition of it, Womble said. Few would disagree that spitting, biting and hitting constitutes violence. But how about verbal abuse and threats? What about a hypoglycemic patient who becomes aggressive? How about the same behavior from an intoxicated patient?

"When reporting violence, it's human nature to look at intent: did they intend to hurt me?" Womble said. "Our goal needs to be to protect our providers from anything that negatively affects them."

In rural Pennsylvania, one group is especially worrisome: psychiatric patients in need of lengthy inter-facility transport from community hospitals to in-patient mental health facilities.

During one Mutual Aid Ambulance Service transport in Westmoreland County, Pa., a psychiatric patient jumped out of an ambulance when it stopped at a red light and threw himself off a bridge, said Bill Groft, director of operations for Mutual Aid. A neighboring EMS agency had a psych patient try to leap out of the ambulance while it was going 65 mph — and take the EMT with him.

Groft's agency and others tried to work with hospitals and mental health staff to increase the use of restraints, but met with resistance. "We respond to many inter-facility mental health calls without a problem. It's that one in 1,000 that there is a problem," Groft said. "I know of several EMS agencies that will not do inter-facility mental health transports from sunset to sunrise. They're traveling long distances at night in rural areas, and they feel it's too dangerous."

No single solution

With the kinds of violent or dangerous situations EMS practitioners face so varied, all agree that addressing the problem will take a multi-pronged approach.

Forty-two states have laws that stiffen penalties for assaults on EMS practitioners, according to NAEMT research. Though these laws may not deter criminals, it does send a signal to the EMS profession, to law enforcement and to the criminal justice system that violence against EMS practitioners is unacceptable, Groft said.

Kirkwood advocates for EMS-specific self-defense training for all practitioners. In Durham County, about half of Kirkwood's 160 employees have gone through a course called Escaping Violent Encounters for EMS and Fire, created by DT4EMS (dt4ems.com).

"Police tactics don't work for EMS because it's the wrong endpoint," Kirkwood said. "What we do not want is a bunch of paramedics on top of a patient on the ground. What we want is the medic away from the violence."

NAEMT's EMS Safety Course covers all aspects of workplace safety, including risk assessment and situational awareness. Making one decision that a scene is safe is not using situational awareness, said Mike Szczygiel, chair of the NAEMT Safety Commitee. Situational awareness is an ongoing process of using visual, auditory and other cues to determine changes in the environment. "We must use the same level of intensity to monitor the safety of scenes that we use to monitor the clinical condition of our patients," he said.

And then there is the mental and emotional component of violence, and how to ensure EMS practitioners develop the resilience to maintain their emotional and psychological wellbeing, Luckritz said.

One step in that process is for EMS to let go of the idea that being assaulted on the job is either a badge of honor or something to laugh off, Kirkwood said. "In many organizations, if a medic gets beat up on the job, they get teased and harassed. The attitude is, 'If you were a street-smart medic you would have kicked his ass or hit him over the head with an oxygen tank.' That is bravado by people who don't know what they're talking about," Kirkwood says. "The management will discourage them from pressing charges, or management won't give them time off to go to court. They are in denial. That has got to stop."

In October, Roger Lane's attacker, Remy Gagnon, was sentenced to 6 to 17 months in jail. Gagnon's attorney claimed his client was a drug addict with mental health issues who believed that the girl in the car was being kidnapped and he was trying to help.

On the day of the sentencing, the courtroom was packed with Lane's EMS colleagues, who embraced him in the hallway after it was over. "It was more support than I ever asked for or hoped for," Lane said.

Unable to work and still dealing with the physical and emotional fallout from the assault, Lane hopes his experience will serve as a wake up call to the profession. "You know that thing you talk about in medic school, scene safety? The scene is never safe," he said. "We've got to do a better job of protecting ourselves, and taking care of ourselves."