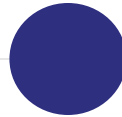


# WORKPLACE VIOLENCE – MANAGING THE RISK



**Donna Vanderpool, MBA, JD**

Director of Risk Management  
Professional Risk Management Services (PRMS)

North Carolina Psychiatric Association  
September 2023

***I have no relationships with  
ineligible companies to disclose***

# AGENDA

- The issue – overview
- Risk management – general advice
  - › Planning
  - › Evaluating
  - › Terminating
- Targeted workplace violence
  - › Against physicians
    - Stalking
    - Homicide
  - › Against others in the office
- Random violence in the workplace

# Patient Violence Against Health Care Professionals

Mar 3, 2011

Robert I. Simon, MD

## Psychiatric Times

Psychiatric Times Vol 28 No 2

Volume 28 Issue 2



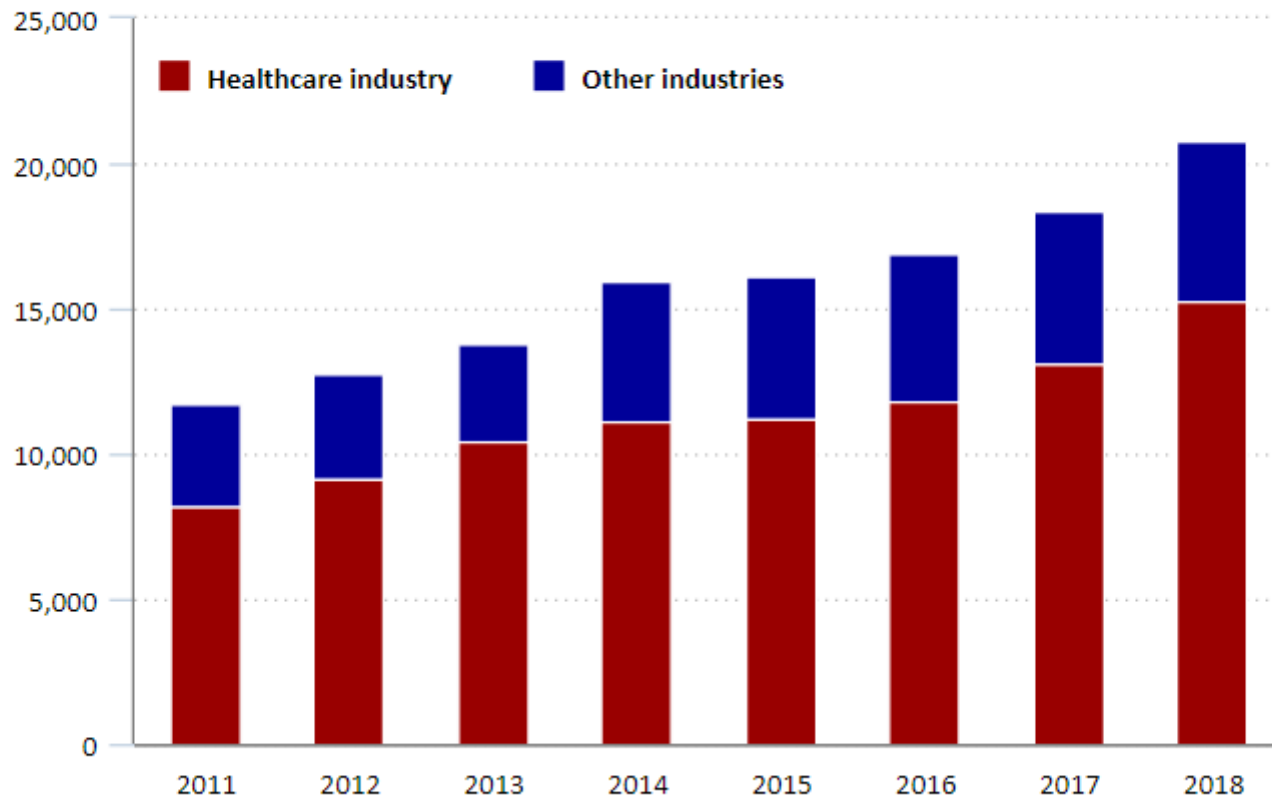
*Every case of patient violence against clinicians provides lessons to be learned in safety management. Here: some key points that can enhance physician safety and help minimize the risks.*

*"No physician, however conscientious or careful, can tell what day or hour he may not be the object of some undeserved attack, malicious accusation, blackmail or suit for damages . . ."*

Assaults Upon Medical Men. *JAMA*. 1892;18:399-400.

It is contrary to clinical experience that a patient would want to harm a physician or allied professional who is trying to help. Nonetheless, clinicians inevitably encounter disgruntled, angry, and deranged patients. The reasons for violence inflicted against clinicians are many and varied. Violence is a function of the dynamic interaction between a specific individual and a specific situation for a given period. Patients who feel they have been physically and/or psychologically injured are at increased risk for committing violence against clinicians, especially if their complaints are dismissed. Fear and helplessness are risk factors for patient violence, especially when painful intrusive procedures are used.

**Chart 2. Number of nonfatal workplace violence injuries and illnesses with days away from work, 2011-18**



# VIOLENCE IN HEALTHCARE

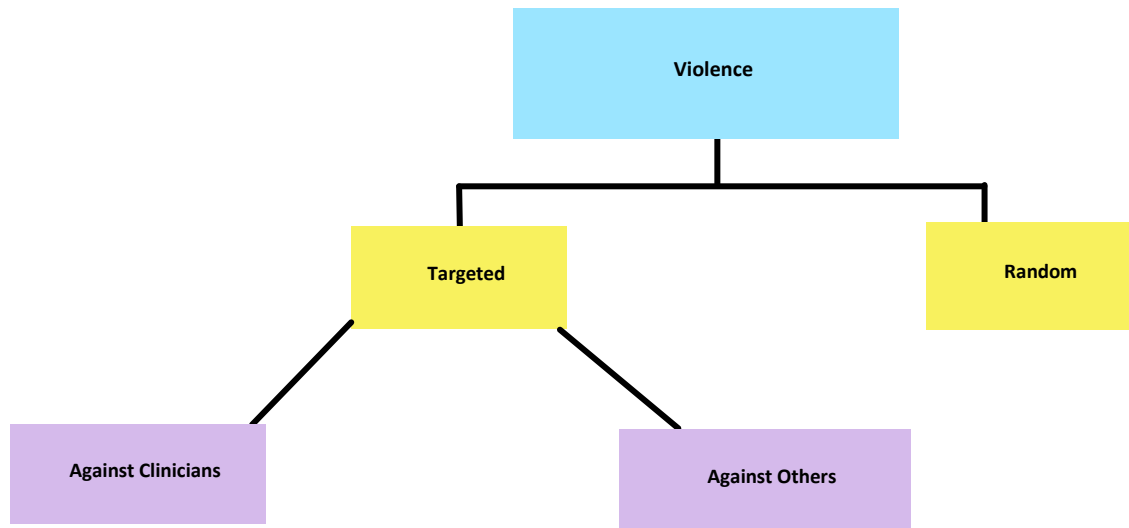
2018 stats (US Bureau of Labor, 2020):

- › Highest rate of injuries – 5x more common than in private industry
- › Healthcare workers –
  - 73% of all non-fatal workplace injuries
  - 4% of all workplace homicides

# VIOLENCE IN HEALTHCARE

- Is under-reported
  - › “do no harm”
  - › Part of the job
  - › Unintentional, so unavoidable
- 40-50% of psychiatric residents will be physically attacked by a patient during their 4-year training program (Anderson and West, 2011)

# Workplace Violence In Healthcare





# FEDERAL LAW

- Bills
  - › Workplace Violence Prevention for Health Care and Social Services Workers Act
  - › Safety from Violence for Healthcare Employees Act
- OSHA

## Table of Contents

Overview of the Guidelines .....	1
<b>Violence in the Workplace: The Impact of Workplace Violence on Healthcare and Social Service Workers .....</b>	<b>2</b>
Risk Factors: Identifying and Assessing Workplace Violence Hazards .....	3
<b>Violence Prevention Programs. ....</b>	<b>5</b>
1. Management Commitment and Worker Participation .....	6
2. Worksite Analysis and Hazard Identification .....	8
3. Hazard Prevention and Control .....	12
4. Safety and Health Training. ....	24
5. Recordkeeping and Program Evaluation .....	27
<b>Workplace Violence Program Checklists .....</b>	<b>30</b>
<b>Bibliography .....</b>	<b>40</b>
<b>Workers' Rights .....</b>	<b>46</b>
<b>OSHA Assistance, Services and Programs .....</b>	<b>46</b>
<b>NIOSH Health Hazard Evaluation Program .....</b>	<b>50</b>
<b>OSHA Regional Offices .....</b>	<b>51</b>
<b>How to Contact OSHA. ....</b>	<b>53</b>



## Request for Information and Stakeholder Meeting: Preventing Workplace Violence in Healthcare and Social Assistance

The Occupational Safety and Health Administration sought comments on a potential standard to prevent workplace violence in healthcare and social assistance settings.

**The comment period closed on April 6, 2017.**

On December 7, the Occupational Safety and Health Administration published a Request for Information (RFI) to solicit information on a potential standard to prevent workplace violence in healthcare and social assistance settings. The RFI also solicits more detailed information on topics such as effective strategies for reducing incidents of violence in various healthcare and social assistance settings. Comments and materials may be submitted electronically to [www.regulations.gov](http://www.regulations.gov), the Federal eRulemaking Portal, or via mail, facsimile or hand delivery. Read the Request for Information for submission details. The submission deadline was April 6, 2017.

OSHA held a public meeting on Jan. 10 for interested parties to comment on the need for a standard to prevent workplace violence in healthcare and social assistance. This meeting was intended to supplement written comments by allowing workers to tell of their personal experiences with workplace violence as well as allowing for discussion among stakeholders.

# NC law helps protect health care staff

Attacking hospital worker could result in felony charges as of Dec. 1



Graziella Steele  
Writer

Published  
Nov. 3, 2015



Beginning Dec. 1, anyone who attacks a hospital worker on hospital premises may face felony charges.

The new law, [House Bill 560](#), was passed this summer by the North Carolina General Assembly and signed into law by Gov. Pat McCrory. It extends protections to all health care workers beyond the emergency room.

# R<sup>3</sup> Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 30, June 18, 2021

Published for Joint Commission–accredited organizations and interested health care professionals, *R<sup>3</sup> Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R<sup>3</sup> Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R<sup>3</sup> Report* may be reproduced if credited to The Joint Commission. Sign up for [email delivery](#).

## Workplace Violence Prevention Standards

Effective January 1, 2022, new and revised workplace violence prevention standards will apply to all Joint Commission-accredited hospitals and critical access hospitals. According to US Bureau of Labor Statistics data, the incidence of violence–related health care worker injuries has steadily increased for at least a decade. [Incidence data](#) reveal that in 2018 health care and social service workers were five times more likely to experience workplace violence than all other workers—comprising 73% of all nonfatal workplace injuries and illnesses requiring days away from work. However, workplace violence is underreported, indicating that the actual rates may be much higher. Exposure to workplace violence can impair effective patient care and lead to psychological distress, job dissatisfaction, absenteeism, high turnover, and higher costs.

The high incidence of workplace violence prompted the creation of new accreditation requirements. The new and revised Joint Commission standards provide a framework to guide hospitals in developing effective workplace violence prevention systems, including leadership oversight, policies and procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence.

The accreditation manual's Glossary now defines workplace violence as "An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."

### Engagement with stakeholders, customers, and experts

In addition to an extensive literature review and public field review, The Joint Commission sought expert guidance from the following groups:

- Technical Advisory Panel (TAP) of practicing clinicians from health care and academic organizations, professional associations, and healthcare and government sectors.
- Standards Review Panel (SRP) of representatives from organizations or professional associations who provided a "boots on the ground" point of view and insights into the practical application of the proposed standards.

The prepublication version of the workplace violence prevention standards will be available online until December 31, 2021. After January 1, 2022, please access the new requirements in the E-dition or standards manual.

## Environment of Care

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# Workplace Violence Prevention Resources

This website provides a valuable source of information from The Joint Commission enterprise and other organizations related to the topic of workplace violence in healthcare.



[Workplace Violence Prevention Resources](#)   [Workplace Violence Prevention Compendium of Resources](#)

[Information on Joint Commission Standards](#)   [From the Field](#)   [File a Patient Safety Complaint](#)

## Workplace Violence Prevention Resources

This page provides links to materials developed by The Joint Commission as well as government resources and those from professional associations (such as the American Nurses Association and the American Hospital Association) and related organizations. The tabs below organize the resources according to source: From The Joint Commission, Federal Resources, State Resources, Professional Associations, and Other Resources. We

<https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/>

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  - › Evaluating
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  - › Against physicians
    - Stalking
    - Homicide
  - › Against others in the office
- Random violence in the workplace



# RISK MANAGEMENT ADVICE

## Key Strategies

- Take patient violence directed at you / staff seriously
- Workplace safety planning
- Assess violence risk
- Termination



# RISK MANAGEMENT ADVICE

## General Office Safety Planning

- Ensure you are able to exit quickly
  - › Patient is not between you and the exit
- Ensure items that could be used as weapons are out of reach
- Ensure there is a method to notify others if you need help
- Avoid seeing patients alone
  - › Particularly at night
  - › Particularly new patients

# Violence Prevention in the Healthcare Workplace

Initial assessment by:

Date:

In consultation with:

Date of previous  
assessment:

## ECRI Institute's INsight® Survey

ECRI Institute's assessment tools provide a multidisciplinary perspective for identifying and managing risks related to this topic and other healthcare services. This web-based tool provides an easy-to-use, unbiased method to survey staff ranging from frontline nurses to organizational leaders. The tool generates reports, benchmarking data, and recommendations. [www.ecri.org/INsight](http://www.ecri.org/INsight)

Violence is a concern for everyone in a healthcare facility. If a facility is considered to be at risk for violence or experiences a violent event, its workers may not function effectively, its reputation may suffer, workers' compensation costs may increase, and patients may go elsewhere for treatment. The Occupational Safety and Health Administration (OSHA) defines workplace violence as "any threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site" (OSHA "Workplace Violence"). Accrediting agencies, including Joint Commission and DNV, require accredited entities to assess the risk of workplace violence and take steps to address it, and the Centers for Medicare and Medicaid Services requires that healthcare organizations provide a safe setting for patients and ensure that they are not subjected to any form of abuse or harassment. Additionally, in 2015, OSHA released updated voluntary guidelines for preventing violence in healthcare (OSHA "Guidelines").

Risk assessment provides a critical foundation for targeting violence prevention efforts. This self-assessment questionnaire (SAQ) is designed to help risk managers determine their facility's violence risk level and identify improvements or additions needed in their organization's violence prevention programs. Regardless of an organization's risk level, *Healthcare Risk Control (HRC)* recommends that risk managers complete this SAQ in its entirety, as it may help an organization identify areas in which violence prevention policies or procedures need to be developed or revised. For example, all healthcare workers, including physicians and volunteers, should know what to do if a violent incident does occur and how to report such an incident. *HRC* includes nonemployees in the definition of healthcare worker for two reasons: first, security is everyone's concern; second, anyone can be either a victim or an assailant. Facility policymakers should determine whether a reason exists to distinguish between employee and nonemployee healthcare workers.

## Caring for Our Caregivers



### Preventing Workplace Violence: A Road Map for Healthcare Facilities

December 2015



<https://www.osha.gov/sites/default/files/OSHA3827.pdf>

## Table of Contents

Overview of the Guidelines .....	1
<b>Violence in the Workplace: The Impact of Workplace Violence on Healthcare and Social Service Workers .....</b>	<b>2</b>
Risk Factors: Identifying and Assessing Workplace Violence Hazards .....	3
<b>Violence Prevention Programs. ....</b>	<b>5</b>
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2. Worksite Analysis and Hazard Identification .....	8
3. Hazard Prevention and Control .....	12
4. Safety and Health Training. ....	24
5. Recordkeeping and Program Evaluation .....	27
<b>Workplace Violence Program Checklists .....</b>	<b>30</b>
<b>Bibliography .....</b>	<b>40</b>
<b>Workers' Rights .....</b>	<b>46</b>
<b>OSHA Assistance, Services and Programs .....</b>	<b>46</b>
<b>NIOSH Health Hazard Evaluation Program .....</b>	<b>50</b>
<b>OSHA Regional Offices .....</b>	<b>51</b>
<b>How to Contact OSHA. ....</b>	<b>53</b>

## Resource Document on Psychiatric Violence Risk Assessment

**Alec Buchanan, M.D., Ph.D. [chair]**

**Renee Binder, M.D.**

**Michael Norko, M.D.**

**Marvin Swartz, M.D.**

Approved by the Joint Reference Committee, October 2011

"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." — *APA Operations Manual*.

### Table of Contents

1. Introduction.....	1
2. The changing context of violence risk assessment in psychiatry.....	1
3. The process of violence risk assessment.....	2
4. The accuracy of risk assessment.....	5
5. The ethics of risk assessment.....	7
6. Conclusions.....	8
7. References.....	8

## 1 Introduction

The APA published a Task Force report, "Clinical Aspects of the Violent Individual," in 1974 (1). Since then, the assessment of violence risk by psychiatrists has assumed increased prominence (2, 3). At the same time, significant changes have taken place both in the contexts in which psychiatrists assess risk and in the techniques that help them do so.

Although violence risk assessment has become more prominent in the last 40 years, assessing the various forms of clinical risk has always been integral to psychiatry. It is a necessary part of providing safe and effective outpatient

are practiced in a diverse array of settings, including emergency rooms, hospital consultation services and outpatient clinics. Like other aspects of psychiatric practice, risk assessment is a potential source of legal liability.

Psychiatric risk assessments are also used by courts to help them make a range of important decisions, including the involuntary commitment of patients to hospitals and those concerning child custody. In criminal cases, psychiatric judgments inform decisions concerning the placement of mentally disordered defendants prior to trial and the sentences the same defendants receive if convicted (4). Often, as with civil commitment proceedings and the appointment of a conservator, psychiatrists have to provide evidence on risk while continuing to provide care to the patient. As with other aspects of risk assessment in legal settings, the needs of courts can present ethical challenges to clinicians which are different from those encountered in other areas of psychiatric practice.

This document reviews the changes that have occurred since 1974 in the context in which psychiatric risk assessment is conducted, the processes by which risk is assessed, the accuracy that can be expected of psychiatrists seeking to assess risk and the ethics of risk assessment. The general principles outlined here are intended to provide a background to the detailed descriptions of risk assessment and management covering particular patient groups, such as children and adolescents, and particular areas of psychiatric practice, such as psychiatric report writing (5), that have been published since 1974.

## 2 The Changing Context of Violence Risk Assessment in Psychiatry

Temporal trends in the locus of psychiatric care in the United States have had a profound effect on the context of and demands on violence risk assessment (6). When most psychiatric care was provided in closed psychiatric institutions, much of the focus of violence risk assessment was on the risk of release of patients, risk of increasing freedom to leave restricted settings or the risk of violence perpetration

***TERMINATION ≠ ABANDONMENT***

Once a provider has established a treatment relationship with a patient, the duty of care exists, and the provider is legally and ethically obligated to continue treating the patient until the relationship has been properly terminated

# ABANDONMENT

## **1891** New York Case – discusses liability for abandonment

“When a physician engages, as here, to attend a patient without limitation of time, he cannot cease his visits except, first, with the consent of the patient, or secondly upon giving the patient timely notice so that he may employ another doctor; or thirdly, when the condition of the patient is such as no longer to require medical treatment – and of that condition the physician must judge at his peril. Here it is not shown that the plaintiff was no longer in need of medical attention; so that the defendant had no right to discontinue his attendance, unless either the plaintiff consented or he gave her proper notice; and if he left her without such consent or such notice he was guilty of grave professional negligence.”

*Becker v. Janinski*, 15 NYS 675, 1891



# TERMINATION PROCESS

- 1) Provide the patient reasonable notice and time to find alternative treatment
- 2) Educate the patient about treatment recommendations
- 3) Assist the patient with finding alternative treatment
- 4) Provide records, as requested by the patient
- 5) Send a follow-up termination letter

# TERMINATION PROCESS

## Providing notice is the key

“[after a review of abandonment cases] It will be noted that each case uniformly holds there is actionable abandonment only in the *absence of reasonable notice or of providing an adequate medical attendant...*”

*Lee v. Dewbre*, 362 S.W.2d 900, 1962

# TERMINATION PROCESS

- Educate the patient about treatment recommendations, medications, etc.
- Assist the patient with finding alternative treatment – referral resources
- Provide records, as requested by the patient
- Send follow-up termination letter
  - › Remember: the provider has to prove the treatment relationship was terminated

# Resources & Information

## Resources & Information Overview

### Professional Resources

#### PA Resources

#### Online Services

#### Laws, Rules and Position Statements

#### Special Topics

#### Publications

- **Forum Newsletter**
  - Articles
  - Notices
- Disciplinary Reports
- Annual Reports
- Glossary/Disciplinary  
Definitions
- Brochures

NCMB

Jun  
30  
2022

## On the podcast: Avoid these common mistakes when releasing patients from your care

Jun 30, 2022 | Newsletter: May-June 2022 Digital Forum |  
comments | Print Friendly Version | Share this item



The May episode of NCMB's podcast, MedBoard Matters, focuses on the difficult and delicate topic of dismissing patients from a medical practice. NCMB receives calls from patients on a weekly basis indicating that a practice has released them from care without providing appropriate refill prescriptions or fulfilling other professional obligations to patients.

The podcast reviews NCMB's position on a clinician's professional obligations when ending the clinician-patient relationship and discusses common missteps that can result in frustration, confusion, patient harm or even an investigation into possible patient abandonment.

Listen now to make sure you are handling patient dismissals appropriately and make sure to share the information with your front office staff!

On the podcast: Avoid these common mistakes when releasing patients from your care ([ncmedboard.org](http://ncmedboard.org))

## FROM THE BOARD PODCAST

“ physicians do have the right to choose their patients, and can, in fact, end the clinician-patient relationship at any time for just about any reason”

# Resources & Information

## Resources & Information Overview

### Professional Resources

[PA Resources](#)

[Online Services](#)

**Laws, Rules and Position  
Statements**

- [Laws](#)
- [Rules](#)
- **[Position Statements](#)**

[Special Topics](#)

[Publications](#)

[NC PHP](#)

[Look Up a Licensee](#)

## Consumer Resources


[FAQs](#)

[Multimedia](#)

## Position Statements

[← Back to List](#)

### 2.1.1: The Licensee-Patient Relationship

 Adopted: Jul 1995 | Amended: Jan 2021 |  
 [Print Friendly Version](#) |  [Share this item](#)

A licensee's first responsibility is to his or her patients. Having assumed care of a patient, the licensee's responsibility is to provide competent, compassionate, and economically prudent care within the standards of acceptable medical practice and to make treatment decisions that are in the best interest of the patient. It is the Board's position that it is unethical for a licensee to allow financial incentives or other interests to adversely affect or influence his or her medical judgment or patient care. Patient advocacy is a fundamental element of the licensee-patient relationship and should not be altered by the health care system or setting in which a licensee practices. All licensees should exercise their best professional judgement when making patient care decisions. Patient welfare must always take priority over economic or other interests. Licensees who hold administrative leadership positions should foster policies that support the licensee-patient relationship and enhance the quality of patient care.

# REASONS FOR TERMINATION

- Ineffective treatment
- Patient does not pay
  - › Does not justify abandonment – still need to give notice
- Patient fires you
  - › Send confirmation letter
- Patient stops coming in
  - › Formally terminate

# REASONS FOR TERMINATION

- Insurer no longer authorizes treatment
- Patient does not adhere to treatment plan
  - › May justify termination – but not abandonment
- Patient is abusive / violent
  - › May justify termination – but not abandonment
  - › May need to modify termination process for safety





# REASONS FOR TERMINATION

## Abusive patients – notice is still required

Discussing a dialysis provider's termination of an abusive and dangerous patient –

“The court found that Dr. Weaver had given sufficient notice to Brenda, and that Dr. Weaver was not responsible for Brenda being refused dialysis by any other [provider]. Dr. Weaver had discharged all obligations imposed by the patient-physician relationship with Brenda...Dr. Weaver supplied Brenda with a list of the names and telephone numbers of all dialysis providers in San Francisco and the East Bay, and it is apparent from the record that nothing would have pleased him more than to find an alternative facility for her, but there is no evidence that there is anything further he could have done....There exists no basis in law or in equity to saddle [the physician] with a continuing sole obligation for Brenda's welfare.”

# SPECIAL TERMINATION ISSUES

## Transferring care

- **Can transfer care directly to another provider**
  - › No notice is required since patient will be under immediate care of new provider – no abandonment
- **Can terminate while patient is hospitalized – care is transferred to hospital**
  - › Let attending know you will not be available upon discharge
  - › May want to follow-up with faxed confirmation of discussion
  - › May discuss with patient, if appropriate

# SPECIAL TERMINATION ISSUES

## Patients in crisis

- **Termination by the provider**
  - › Not appropriate to terminate with a patient in crisis
  - › Continue to treat until the patient is hospitalized for the crisis is resolved
- **Termination by the patient**
  - › Provider should not automatically accept the decision and assume they are free of any duty to patient
  - › Evaluate patient's understanding
  - › If you accept termination, confirm by letter (unless contraindicated)

# TERMINATION

*Understand your employer's position on  
termination of treatment relationships*

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- Random violence in the workplace

December 3, 1999

## Stalked Psychiatrist Turns Fears Into Valuable Lessons for Others

Psychiatrist Doreen Orion, M.D., was just out of residency in Arizona when she admitted a woman with schizophrenia and suicidal ideation to a hospital where she was working. After treating her for two weeks, Orion discharged her to the care of her previous psychiatrist. Now, and a move to another state later, the woman is, to Orion's extreme distress, still an integral part of the psychiatrist's life, having stalked her and made her life a nightmare come true.

A host of therapeutic and legal attempts to end the stalking, including jail terms, has all failed to deter the woman from her obsession with Orion.

"My story is a primer on what not to do" when faced with a stalker, Orion told a ballroom full of forensic psychiatrists at the annual meeting of the American Academy of Psychiatry and the Law (AAPL) in Baltimore in October.

The stalking began the day after the patient, whom Orion calls Fran, was discharged. The next day Orion found a note on her car that read in part, "I am surprised at your interest in me. . . . If you don't respond, I will understand." Orion did not in fact respond, explaining the naïveté, she really believed that Fran would understand and leave her alone.

Fran, however, kept sending cards and calling, revealing that she had made an effort to learn intimate details of Orion's personal life. Several weeks later, she accosted the psychiatrist in the hospital parking lot.

"I was very frightened," Orion explained, "but I told her calmly, 'Don't contact me again. I'm not your psychiatrist.' " Orion believed this direct rejection would succeed. She was wrong.

It was at that point that Orion, who is a forensic psychiatrist and on the faculty of the University of Colorado psychiatry department, contacted Fran's previous psychiatrist. That psychiatrist informed Orion that this behavior was a pattern Fran had exhibited in the past, a crucial fact which Orion wishes the other psychiatrist had informed her earlier. That psychiatrist "reassured" her that the stalking would soon stop and did not pose a threat of harm, but Orion said if she had known of this pattern while she was treating Fran, she would have immediately referred her to a male psychiatrist.

It turned out, Orion explained that Fran is one of that small subset of stalkers—about 10 percent—who suffer from erotomania, a delusion that another person is in love with them. "What they lack in numbers, they make up in persistence," she told those at the AAPL meeting.

Orion has since become an expert in erotomania and has written the book *I Know You Really Love Me: A Psychiatrist's Journal of Erotomania, Stalking, and Obsessive Love* about her experiences as a victim who also happens to be a mental health expert.

### Delusional Belief System

She pointed out that erotomanics usually "fixate on someone society deems to be desirable," such as a celebrity, doctor, or professor. Their delusion about the victim's attraction to them centers on the belief that "if this person loves me, I can't be so bad," Orion said. Their belief is virtually unshakable since they are easily able to rationalize any attempt at dissuading them from their obsession.

Fran, for example, is convinced that Orion's husband, also a psychiatrist, is possessive and jealous and is the main obstacle keeping her and Orion apart. These people also believe that the relationship they think they have with their victim "is universally approved of, and that others are helping them" cement their bond, Orion pointed out. They commonly "embellish innocent symbols" with meaning. Sometimes they are convinced that even the criminal justice system's involvement is sending the message that it wants the relationship to succeed.

In addition, she noted, stalkers with erotomania often avoid face-to-face contact with their victims, relying instead on constant phone calls, letters, and following at a distance. Orion's stalker subjected her to all of these—and still does—but also schemes to have direct contact.

"It is a very adolescent way of relating," she said, adding that erotomaniac stalkers rarely sustain friendships or romantic relationships and frequently are unemployed or working in menial jobs. Fifty percent of all stalkers, Orion also explained, have a mental illness, substance abuse disorder, or criminal history. "They are not just the boy-next-door types," and they can turn violent.

### Stalking Escalates

<https://psychnews.org/pnews/99-12-03/stalked.htm>

# STALKING BY PATIENT

- “Repeated infliction on another of unwanted communications, unwanted contacts, and a myriad of other harassing behaviors, in a manner that causes reasonable fear and distress”
  - Can be:
    - › Brief, intense periods
    - › Episodes that last beyond two weeks
  - Predominant motives:
    - › Anger / resentment
    - › Infatuation
- (Pathe and Meloy, 2013)



# STALKING BY PATIENT

Risk management / safety advice (Kaplan, 2006):

- When working with a new patient, set limits early.
- Minimize risk by:
  - › Using a work or post office address rather than home address in directories of professional or community organizations
  - › Removing yourself from online search engines
  - › Not disclosing personal information to patients or having family pictures in the office
- Carry out a risk assessment
- If you are the target of criminal behavior of a current patient, attempt to terminate the care in a professional way

# STALKING BY PATIENT

- Pay close attention to how your behavior could unwittingly reinforce the patient's pursuit
- Let colleagues know you are being harassed and/or stalked and alert others in the building in which you work
- Carefully document all incidents
- Retain any evidence

(Kaplan, 2006)

# STALKING BY PATIENT

- Get advice from experts in stalking behavior
- Contact police, but be mindful of confidentiality
- Seek help for the psychological consequences

(Kaplan, 2006)

- My additional advice: Contact your risk manager for guidance!

# STALKING BY PATIENT

“It has appeared to me for several years that the worst response for a stalking victim is to initiate direct contact with the threatening person. Regardless of what is said or the affect that is exchanged, the act itself becomes an intermittent positive reinforcement, and causes a significant increase in pursuit behavior. In a recent analysis of data on women who stalk, we found that initiating contact with the stalker by the victim increased subsequent pursuit in 68% of the cases.”

(Meloy, 2002)

## APA Resource Document

### Resource Document on Stalking, Intrusive Behaviors and Related Phenomena by Patients

Approved by the Joint Reference Committee, October 2019

"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." -- *APA Operations Manual*.

Prepared by the Council on Psychiatry and Law

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#### I) Introduction and Disclaimer

The doctor-patient relationship should ideally be a collaborative and mutually respectful one. In some instances, however, patients may engage in behaviors that can engender concern and even fear in the psychiatrist involved. When these behaviors are repeated, unwanted, and distressing, we might colloquially refer to them as "stalking." In the midst of a stalking episode, it may be difficult for the psychiatrist to know how to proceed, what steps to consider to protect oneself and what choices to consider to manage the patient-physician relationship. In this document we provide practical guidance for psychiatrists who may face these situations in the course of their work with patients. It was drafted via the consensus of individuals whose practices intersect at the interface of law and psychiatry and represents a range of voices and recommendations. It provides general guidance and is not considered dispositive for any particular response to specific situations. Individual circumstances may require courses of action that differ from those noted in this document.


#### A) Definitions

The *Violence Against Women Act* of 2005 (Amendment, Stat.108 1902 et seq) defines the phenomenon of stalking as:

"engaging in a course of conduct directed at a specific person that would cause a reasonable person to (A) fear for his or her safety or the safety of others; (B) suffer substantial emotional distress."

From a more clinical perspective, Mullen, Pathe, & Purcell (2000) [hereafter Mullen et al.] define stalking as follows:

# My Patient, My Stalker Empathy as a Dual-Edged Sword: A Cautionary Tale

Sharon K. Farber , Ph.D.

**Published Online:** 30 Apr 2018 | <https://doi.org/10.1176/appi.psychotherapy.2015.69.3.331>

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## Abstract

Success in psychotherapy is correlated with the “fit” between patient and therapist, a factor related to attachment. For psychotherapists of any orientation, empathy and building the bond of attachment is our stock-in-trade. When empathy builds the bond of attachment with someone starved for connection, a therapist may inadvertently set him-or herself up to become a victim of a stalker. Because individuals who stalk others suffer from severe attachment disorders, their hunger for attachment motivates them to shadow psychotherapists, which makes being stalked a very real occupational hazard for psychotherapists.

This was a painful discovery for me. I was stalked for 11 months, leaving me with post-traumatic stress disorder. After recovering, I deconstructed the experience to understand how and why it happened, and discovered that it was my empathy and compassion that contributed to and maintained the stalking. What I learned from the forensic literature provided the knowledge and confidence needed to end the stalking. In this paper recommendations are made about how to prevent stalking and to halt it if it does happens.

# AGENDA

- The issue – overview
- Risk management – general advice
  - › Planning
  - › Evaluating
  - › Terminating
- Targeted workplace violence
  - › Against physicians
    - Stalking
    - Homicide
  - › Against others in the office
- Random violence in the workplace

# Surgeon shot to death in suburban Memphis clinic

JULY 12, 2023 / 6:34 AM / CBS/AP



An orthopedic surgeon was fatally shot inside a clinic in a suburb of Memphis Tuesday and a suspect was arrested minutes later, police said.

Collierville Police Chief Dale Lane said Dr. Benjamin Mauck was shot and killed by a patient in the Campbell Clinic, [CBS Memphis affiliate WREG-TV reports](#). "It's bad, it's horrific, it's terrible and our thoughts and prayers are with the family," Lane said.

He told reporters the shooting was a one-on-one encounter in an exam room. The suspect hasn't been identified.

The suspect had reportedly been at the clinic for several hours before the shooting, Lane said.





## Patient Admits Killing Psychiatrist, Police Say

By Cameron W. Barr, Ernesto Londoño and Dan Morse  
Washington Post Staff Writers  
Tuesday, September 5, 2006

A 19-year-old North Potomac man told detectives that he killed a psychiatrist with his fists during a hastily arranged appointment Sunday in which they discussed the man's treatment for schizophrenia, according to Montgomery County police.

Police charged the patient, Vitali A. Davydov, with first-degree murder yesterday in the killing of Wayne S. Fenton, 53, a prominent psychiatrist who served as associate director of the National Institute of Mental Health. He maintained a private practice in Bethesda, treating severely mentally ill patients mostly on weekday evenings and weekends.

Near Fenton's house yesterday on Parkedge Drive in Rockville, small groups of neighbors gathered and remembered their friend. "This is a tremendous loss for his family and his colleagues and his patients," said Roger Rothman, who lives next door.

He said neighbors liked walking by Fenton's house and listening to him sing as he played old-time Southern blues on his guitar. He played songs from the greats, like Robert Johnson. "He was very good," Rothman said.

Tim Moran, Fenton's brother-in-law, said Fenton was trying to help out another doctor in treating Davydov. "This young man was not a regular patient of his," Moran said. "He was having an episode of some sort."

Advertisement

Fenton developed research programs at NIMH that were designed to help schizophrenics deal with day-to-day life.



Vitali A. Davydov, 19, above, is charged with killing psychiatrist Wayne S. Fenton, 53. (Ricky Carioti - Twp)

### TOOLBOX

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# Patient Kills Psychiatrist in Murder-Suicide

A psychiatrist is murdered every 2 to 3 years in the U.S., says researcher.

By: ALYSSA NEWCOMB  
July 25, 2011, 2:48 PM



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July 25, 2011 -- Dr. Mark Lawrence, a Virginia psychiatrist who was killed by a patient in a murder-suicide Friday, was remembered by his colleagues as a gifted psychiatrist and mentor to hundreds of therapists.

"He helped people focus on their own strengths. It was such a hopeful vision," said Dr. Cynthia Margolies, who worked with Lawrence at [the Center for Healing and Imagery](#), a school Lawrence founded 27 years ago to provide continuing education to therapists.

Barbara Newman, 62, shot Lawrence, 71, when she showed up at his home office in McLean Friday afternoon for her appointment. Newman then turned the gun on herself.

CRIME >

## Police: Kansas psychiatrist stabbed to death by his patient

SEPTEMBER 15, 2017 / 3:52 PM / CBS/AP



**WICHITA, Kan.** - A psychiatrist was stabbed to death in an alley behind his holistic practice in Kansas and a man identified as one of his patients has been arrested in the killing, police said Thursday.

Dr. Achutha Reddy, 57, was killed in the attack Wednesday evening at the Holistic Psychiatry Services clinic in Wichita. Police Lt. Todd Ojile said the suspect in custody was Reddy's client, but that authorities do not know what prompted the attack.

CBS affiliate KWCH reports records show 21-year-old Umar Dutt was arrested Wednesday on a first-degree murder charge and is being held at the Sedgwick County Jail on a \$1 million bond.

Ojile said investigators expect the case to be presented to the district attorney's office on Friday.

Police said the suspect and Reddy had been seen entering the clinic together earlier in the day. The suspect left and later returned, and the two entered an office together. The office manager heard a disturbance, found the client assaulting the doctor and tried to intervene, allowing Reddy to flee the building. The suspect followed Reddy into the alley where the doctor was stabbed multiple times, Ojile said.

[Police: Kansas psychiatrist Dr. Achutha Reddy stabbed to death by his patient - CBS News](#)

# Police: Tulsa gunman targeted surgeon he blamed for pain

A gunman who [killed his surgeon and three other people](#) at a Tulsa medical office blamed the doctor for his continuing pain after a recent back operation and bought an AR-style rifle just hours before the rampage, police said Thursday.

The patient called the clinic repeatedly complaining of pain and specifically targeted the doctor who performed the surgery, then killed himself as police arrived, Tulsa Police Chief Wendell Franklin said.

That physician, Dr. Preston Phillips, was killed Wednesday, along with Dr. Stephanie Husen, receptionist Amanda Glenn and visitor William Love, police said. The attack occurred on the campus of Saint Francis Health System in Tulsa. The chief identified the shooter as Michael Louis, 45, of Muskogee, Oklahoma.

# PHYSICIAN HOMICIDES – TAKE AWAY POINTS

- Be aware of unusual patient behavior
- Take threats seriously
- Use caution when working alone
  - › Especially at night
- Screen for new patients
  - › Are they appropriate for your practice?
- Have adequate building security
- Be extra careful in home offices

# PSYCHIATRISTS MURDERED BY PATIENTS

Study of homicides of mental health workers by patients, 1981 - 2014 (Knable, 2017):

- 10 out of 33 were psychiatrists
- Of the psychiatrist murders:
  - › Patient's diagnosis:
    - Schizophrenia – 60%
    - Bipolar disorder – 10%
    - None listed – 30%
  - › Location of murder:
    - Hospital – 40%
    - Private office – 40%
    - Office in a clinic – 20%
  - › Method:
    - Gunshot – 70%
    - Beating – 30%

# PSYCHIATRISTS MURDERED BY PATIENTS

Risk management / safety advice (Knable, 2017):

- Develop the capacity to assess the danger level of patients in a prescreening interview before the first appointment
- Take special care with evening or weekend appointments or in other situations in which additional office personnel are not present

# PSYCHIATRISTS MURDERED BY PATIENTS

Risk management / safety advice (Knable, 2017):

- For patients that have a history of violent acts or poor impulse control, see the patient along with family members or with colleagues
- Have a security barrier between the waiting room and the consulting room so that patients cannot easily “barge in”
- Sit behind a desk rather than in a more traditional psychotherapeutic environment



# PSYCHIATRISTS MURDERED BY PATIENTS

Risk management / safety advice (Knable, 2017):

- Have an escape route
- If feasible, have an emergency alert system
- Home visits to patients with a history of violence or involuntary treatment should be made by teams
- For patients who become threatening, obtain consultation sooner rather than later
- For direct threats of violence or threats that occur outside of an office or institutional setting, law enforcement should be informed

# PSYCHIATRISTS MURDERED BY PATIENTS

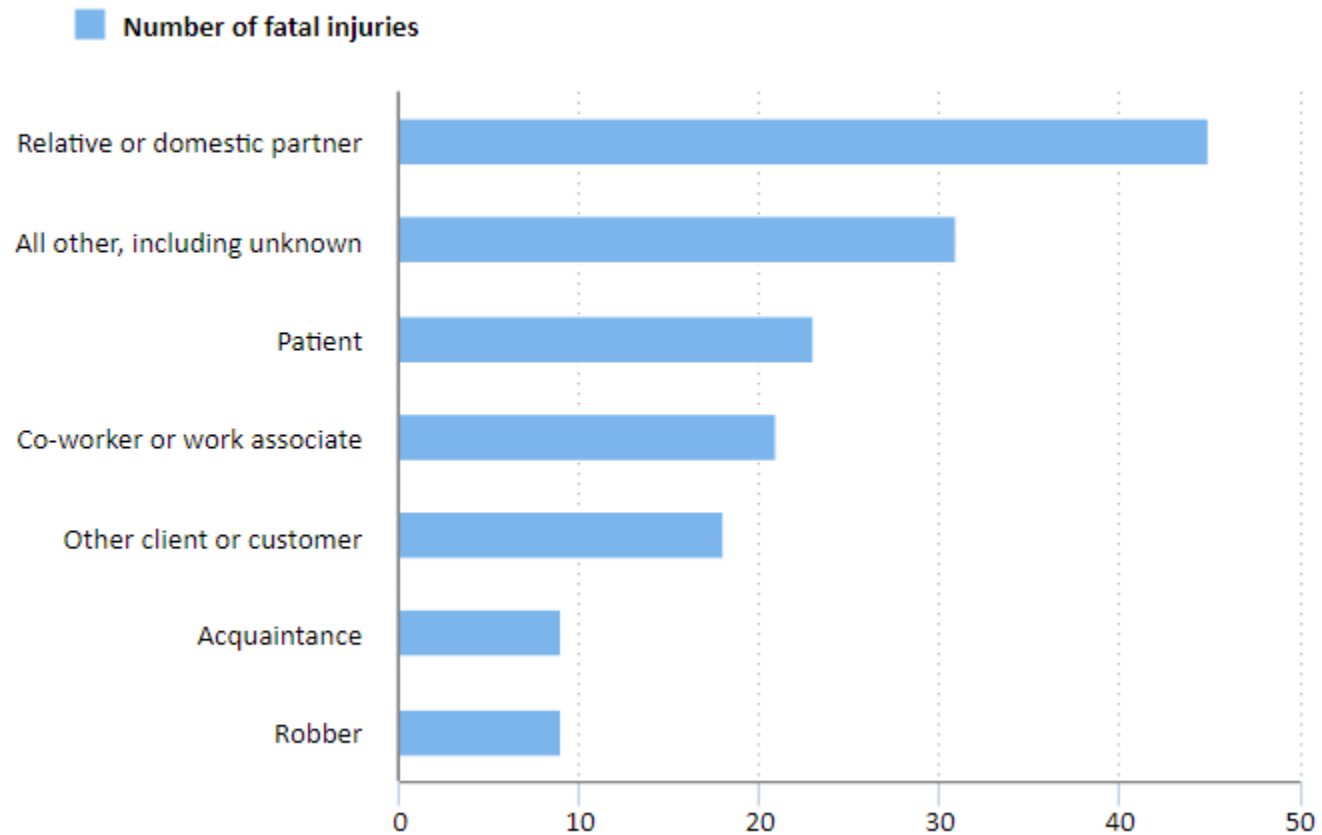
Risk management / safety advice (Knable, 2017):

- Evaluate the need for:
  - › Restraining order
  - › Criminal complaint
  - › Involuntary hospitalization
- My additional advice: Keeping yourself and your staff SAFE trumps patient confidentiality

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**Chart 3. Workplace homicides to healthcare workers, by assailant, 2011-18**



# TARGETED VIOLENCE AGAINST OTHERS IN OFFICE

- May be from:
  - › Patients
  - › Non-patients
- Training
- Termination of violent patients
- My advice: Your priority is to keep yourself and your staff SAFE

# RISK MANAGEMENT ADVICE

## Office Safety (Joshi, 2021)

- Install a security barrier between the waiting room and offices
- Restrict access to offices by using card readers, etc.
- Escort patients within office
- Install video cameras at entrances and exists
  - › Post notification signs
- Post signs saying concealed weapons are not allowed on premises

# RISK MANAGEMENT ADVICE

## Office Safety (Joshi, 2021)

- Install panic buttons in each office, at reception desk, and other areas (such as restrooms)
- Develop a code word / phrase allowing you to alert staff to trouble
- Designate a room where staff can gather and lock themselves in, if needed

# RISK MANAGEMENT ADVICE

## Personal Safety (Joshi, 2021)

- Position yourself so you can exit quickly
- Avoid having your back to the exit
- Avoid wearing attire that can be used against you or impede your escape
- Wear an audible alarm
- Avoiding posting personal information that is publicly available
- Avoid working alone
- Avoid going to car alone



# AGENDA

- The issue – overview
- Targeted workplace violence
  - › Against physicians
    - Risk management advice, including termination
    - Stalking
    - Homicide
  - › Against others in the office
- Random violence in the workplace

“The challenge for medical practitioners is to remain aware that some of their psychiatric patients do, in fact, pose a small risk of violence, while not losing sight of the larger prospective – that most people who are violent are not mentally ill and most people who are mentally ill are not violent.”

(Anderson and West, 2011)

# RISK MANAGEMENT ADVICE

## Key Strategies

- Take patient violence directed at you / staff seriously
- Workplace safety planning
- Assess violence risk
- Termination

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