



The Hartford Consensus: Survey of the Public and Healthcare Professionals on Active Shooter Events in Hospitals

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From news reports, it is readily apparent that active shooter events in the US have been occurring more frequently. A study by Texas State University and the Federal Bureau of Investigation (FBI) examined active shooter events in the US for the years 2000 through 2013.¹ In the years from 2000 through 2006, there was an average of 6.4 active shooter events per year. For the years 2007 through 2013, the average was 16.4 events per year. The FBI defines an active shooter event as one where one or more persons actively engage in killing or attempting to kill people in a populated area.² All public places appear to be vulnerable. This includes hospitals. Of the 160 active shooter events meeting the FBI's definition, for the years 2000 to 2013, four, or 2.5% of the total, occurred in healthcare facilities. A study of shooting events on hospital properties for the years 2000 to 2011, including those not meeting the definition of the FBI for an active shooter event, found 154 incidents where at least 1 person was injured.³ An examination of the steady increase in hospital-based shootings reveals that the attacks have become more complex, involve more weapons, and target more individuals.⁴

Although hospitals share vulnerability with other public places, what makes hospitals different is the vulnerability of patients. Patients might be unable to flee to safety or understand commands for safety because of states induced by medical conditions, procedures, or treatments. The most profound examples of patients who are vulnerable are those completely anesthetized and completely dependent on operating room (OR) or ICU personnel and equipment for their very existence. Similarly, those undergoing cardiopulmonary or trauma resuscitation are completely dependent on the team intervening to save their lives. In these situations, minutes left unattended by medical personnel could, and most likely, mean death.

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Active shooter situations in hospitals present not only unique challenges, but challenges that can be more dire and more distressing than events in other settings.⁵

Although there are guidelines for planning responses for active shooter events in hospitals, it has been recognized that there is no single answer; how healthcare professionals should respond is an intensely personal decision.⁵ The typical direction to “run, hide, fight”—meaning to first leave the area if possible, second to stay if necessary but hide, and lastly to fight the attacker—has different implications for healthcare professionals, as their individual actions have meaning and consequences for those in their care. Although it is recognized that a healthcare professional's decision for action during an active shooter event is a personal decision, the consequences can go well beyond the personal realm.

The Hartford Consensus, the result of the Joint Committee to Create a National Policy to Increase Survivability in Intentional Mass Casualty and Active Shooter Events sponsored by the American College of Surgeons (ACS), has issued recommendations to achieve this goal.⁶⁻⁹ The guiding principle of the Hartford Consensus is that no one should die from uncontrolled bleeding from any cause. The general public is viewed as critical to stopping bleeding and the concept of the public as immediate responders is strongly encouraged. The ACS, working through the Hartford Consensus, adopted the effort to educate the public about bleeding control as an important outreach effort. The Hartford Consensus continues to be concerned about bleeding control. However, an additional focus now is the obligations of hospital staff, particularly doctors and nurses, in an active shooter event in a hospital setting.

It is not known what the general public would expect their healthcare professionals to do if they were patients in a hospital in an active shooter situation. Would they expect their caregivers to continue to give care despite threats to personal safety? Similarly, it is not known how healthcare professionals, particularly doctors and nurses, perceive their obligations to patient care in a threatening active shooter situation. The purpose of this project was to query the general public and healthcare

Abbreviations and Acronyms

ACS	= American College of Surgeons
EAST	= Eastern Association for the Surgery of Trauma
FBI	= Federal Bureau of Investigation
OR	= operating room

professionals about these aspects of active shooter events in hospitals.

Issues to be addressed included:

1. What do the public and healthcare professionals believe the level of risk is for an active shooter event in a hospital?
2. How prepared do the public and healthcare professionals believe hospitals are to respond to an active shooter event?
3. What do the public and healthcare professionals believe the obligations of doctors and nurses are to patients in an active shooter situation in a hospital?
4. What level of personal risk do the public and healthcare professionals believe doctors and nurses should accept to protect patients in an active shooter situation in a hospital?
5. Do the public and healthcare professionals believe that doctors and nurses should be required to try to save the lives of patients in an active shooter attack even at the risk of their own lives?

METHODS

Langer Research Associates was retained to conduct a national survey of the public about active shooter events in hospitals and, more specifically, to determine what the public believes the responsibility of doctors and nurses are to protect patients in such events. Ideas for the survey questions were generated by the authors. These were shared with Langer Research Associates, who assisted with clarifying the ideas and then generating questions to obtain pertinent information to fulfill the purpose of the project via a telephone survey. The final questionnaire had 10 questions, with 1 sub-question about the intensity of a response option. The standard survey demographic questions were included. The interview questions are presented in [Table 1](#).

The public survey was conducted by landline and cell phone interviews March 1 to 5, 2017. Sampling, data collection, and tabulation were performed by Social Science Research Solutions. Sampling was designed to be representative of the adult population in the US. Random-digit-dialing of landline households and randomly generated cell phone numbers were used to

Table 1. Content of Survey Questions and Response Options

1. Level of risk at a public school, shopping center, public airport, hospital—Very high, high, moderate, low, very low
2. Current level of preparedness of each site—Very, somewhat, not so, not at all
3. Importance of being prepared at each site—Extremely, very, somewhat, not so, not at all
4. Do doctors and nurses have a special duty like police officers and firefighters to protect patients who cannot get out of harm's way from an active shooter—Special duty, beyond their duty
4a. Level of strength of response if said special duty, beyond their duty—Strongly, somewhat
5. Level of personal risk doctors and nurses should accept to protect patients who cannot get out of harm's way—Very high, high, moderate, low, none
6. If you were a patient unable to get out of harm's way would you expect doctors and nurses to put themselves at risk to protect you? Yes, no
7. Should doctors and nurses be required to try to save the lives of patients in an active shooter attack or should this be a personal choice? Required, personal choice
8. Have you been a patient in a hospital? Yes, no
9. How long ago was the last time you were a patient in a hospital? In the past 12 months, more than 12 months up to 5 years, more than 5 years ago
10. Have you ever stayed overnight as a patient in a hospital? Yes, no

All questions provided a "no opinion" option.

contact potential respondents. Data collection was conducted by trained and monitored interviewers. Once all of the data were gathered, the sample was weighted to create nationally representative and projectable estimates of the adult population aged 18 years and older. Specifically, the sample was post-stratified and balanced for key demographics, including age, sex, race, region, and education. This involved a procedure of iterative proportional fitting to match the sample to population parameters derived from the most recent March Supplement of the US Census Bureau's Current Population Survey.¹⁰ In addition, the sample was weighted to reflect the distribution of phone use in the general population. This includes examination of the probability of selection of a phone number, the probability of contact, and the probability of respondent selection.¹¹

The survey of the health professionals was programmed, hosted, and administered online by SSRS from March 9 to 19, 2017. The survey questions corresponded to those questions asked of the general public. They were modified by Langer Research Associates to make them appropriate for an online survey. Additionally, the professionals were asked for their discipline, work environment, whether they provide direct patient care,

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