**Testimony of**
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**Hearing on “Caring for the Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence.”**

**U.S. House Of Representatives**
**Committee Education & Labor**
**Subcommittee on Workforce Protections**
**February 27, 2019**

Good afternoon Chairman Courtney and Members of the House Workplace Protections Subcommittee.

My name is Jane Lipscomb.  Thank you for this opportunity to present my views on the compelling need to protect frontline workers under the Workplace Violence Prevention for Health Care and Social Service Workers Act.

My training is as a nurse and epidemiologist. I have spent my career- including the past two decades as a Professor of Nursing and Medicine at the University of Maryland - researching and addressing the epidemic of occupational health and safety hazards facing our nation’s health care and social service workforce.  Health care workers face higher on-on-job injury and illness rates than workers in mining, manufacturing and construction - yet fail to garner the attention commensurate with this statistic.

Of the range of hazards faced by health care and social service workers, few issues have received less attention than the hazard of workplace violence.  This is despite the fact that this workforce experiences a higher number of non-fatal assaults than any other worker group. And let me be clear, I am not talking about the random acts of violence that get much media attention. I am referring to the systemic acts of violence that occur every day in these workplaces that are predictable and therefore preventable. The good news is that we know how to prevent much of this type of violence.

Health care workers want to provide the compassionate and professional care that patients deserve, but such care is compromised when steps to prevent workplace violence are not taken by their employers.

In the course of my work I have conducted federally-funded research into how to prevent workplace violence in hospitals and other high-risk settings.  In addition, I have consulted with numerous state and federal agencies on how to advance workplace violence prevention.

Quite frankly I have too much firsthand experience working with victims of workplace violence, or in the case of workers who were murdered by patients in their care, their bereaved families.  In many of these cases, these highly skilled individuals were working alone with very dangerous patients in the community.

Judie Scanlon was a registered nurse who was killed by a patient while conducting a home visit in Buffalo NY; Dr. Wayne Fenton and Nicole Castro, both from MD, Marty Smith from Seattle, and Stephanie Moulton from outside Boston - the accounts of those health care workers murdered on-the-job are especially tragic.

Fortunately, the vast majority of assaults on health care and social service workers are non-fatal. The risk of workplace violence that I am most concerned about arises from exposure to individual patients, their family members and visitors, who sometimes are violent, in combination with a lack of sufficiently strong violence prevention programs. Patients, especially those in hospital and residential settings are often traumatized by the experience, in pain and may have altered cognition due to their illness or treatment, including prescription and illicit drugs. They may not "intend" to assault their caregiver, but regardless of intent, an employee is still injured (often both physically and emotionally).

While I believe that patient rights and confidentiality are important and must be respected, health care and social service institutions also need to recognize that workers in these facilities have a legal and moral right to come home safely at the end of the day. My experience and research show that both concerns can be reconciled and HR 1309 does that.

My first encounter with a victim of workplace violence occurred while I was working at UCSF in Northern California. Two physicians from Napa, CA (one who lost his sight in one eye and another who suffered a punctured lung) requested to meet with me after reading a journal article I had published in 1992, describing workplace violence as an occupational hazard amendable to public health interventions. At the time, workplace violence was considered a criminal justice issue and handled as such. Since meeting with the Napa State Hospital physicians, I have heard personal testimony from hundreds of workers who have dedicated their lives to caring for the health of the public, yet suffered serious and even career-ending assaults.

Today, workplace violence is one of the most dangerous occupational hazards facing health care workers. This is in part because of the lack of attention to the prevalence and severity of workers' injuries, but also because of the failure to recognize workplace violence as a public health problem amenable to an occupational health approach to prevention, as well as the view that working with individuals with cognitive impairment, mental illness or a tendency towards violent acts "is part of the job" [1] [2].

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[1] Lipscomb, J.A., Rosenstock, L. (1997). Healthcare workers: Protecting those who protect our health. *Infection Control Hospital Epidemiology,* 18: 397-399.

[2] Lipscomb, J.A., London, M. (2015). Not Part of the Job: How to Take a Stand Against Violence in the Work Setting. American Nurses Association. Silver Spring Maryland.

I am here to testify that workplace violence prevention plans, tailored to the specific risk, workplace and employee population work. By contrast voluntary guidelines, such as those that were first published by OSHA in 1996, and updated in 2015, do not protect the vast majority of employees, because they fail to incentivize employers to act voluntarily to address this hazard. I can attest to that fact because the vast majority to health care workers who I have spoken with report that they do not have a workplace violence prevention plan or that they have a "paper plan" that does little to nothing to protect them from the ongoing risk of violence.

Evidence that workplace violence prevention plans are feasible and work includes research from Wayne State University, the Veteran Health Administration and others, as well as my own.

My research focused on the feasibility and impact of OSHA's Guidelines using a non-experimental intervention design focused on three state-run in-patient psychiatric hospitals in New York State. This research provided evidence for the feasibility and positive impact of comprehensive violence prevention program in the in-patient mental health workplace[3] (Lipscomb, 2006).

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[3] Lipscomb, J., McPhaul, K., Rosen, J., Geiger Brown, J., Choi, M., Soeken, K., Vignola, V., Wagoner, D., Foley, J., Porter, P. (2006). Violence prevention in the mental health setting: the New York state experience. *Canadian Journal of Nursing Research,* 38(4).

Evidence from a randomized, controlled intervention study (the "gold standard" in research methods), published in 2017 by researchers at Wayne State University, demonstrates that a data-driven, worksite-based intervention based on the OSHA Guidelines was effective in decreasing the risk of patient-to-worker violence-related injuries by 60%, 24 months following the intervention[4] (Arnetz, 2017).

I believe that when OSHA finally passes a standard, that health care and social assistance employers will greatly benefit from the regulation. Evidence of the prevalence of the problem and the inadequacy of current voluntary measures are clearly delineated in the 2016 GAO study and report. A 2017 report from the American Hospital Association entitled "Cost of community violence to hospitals and health systems" estimates that in 2016, the proactive and reactive violence response efforts cost U.S. hospitals and health systems approximately $2.7 billion. The largest category of costs was associated with the safety of hospital patients, visitors, and employees[5].

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[4] Arnetz, J.E., Hamblin, L., Russell, J., Upfal, M.J., Luborsky, M., Janisse, J., Essenmacher, L. (2017). Preventing patient-to-worker violence in hospitals: Outcome of a randomized controlled intervention. *J Occup Environ Med*. 59(1) 18-27.

[5] Van Den Bos, J., Creten, N., Davenport, S., Roberts, M., (2017). Milliman Research Report – Cost of community violence to hospitals and health systems: Report for the American Hospital Association.

HR 1309  and a future OSHA standard will focus on employee health and safety, but a well-recognized benefit of such a regulation will be enhanced safety for patients receiving care in hospitals and other covered workplaces.   This is especially true in the mental health and social assistance setting, where patients frequent experience assaults perpetrated by other patients.

Here I would like to emphasize that worker and patient safety are inextricably linked.   When there is an insufficient number of staff to meet patient needs, they act out not only towards caregivers, but also other patients.  Ask anyone who has a family member or friend who required in-patient mental health services.

Finally, I would like to address workplace violence protection afforded by (Section 5(a)(1) of the Occupational Safety and Health Act), OSHA's General Duty Clause.  Currently, when an employer fails to address the problem voluntarily, the GDC is the only tool employees have to advance workplace violence prevention in their workplace. The GDC is a cumbersome and ineffective means of seeking protection; requiring a very high burden of proof in order to issue such a citation.   In the small number of cases where OSHA has cited an employer, the employer may contest the citation, requiring the DOL and the company to expend resources fighting the citation, rather than investing in preventing the hazard. Because of employer challenges and subsequent legal review, the few workers who have risked filing an OSHA complaint have to wait months to years before

OSHA is able to mandate common senses changes to a workplace via an OSHA citation.

A violation under Section 5(a)(1) states the "employer did not furnish to each of its employees a workplace that is free from recognized hazards that are causing or likely to cause death or serious physical harm." Such cases end up in a hearing before an administrative law judge (ALJ). In the two cases where the ALJ's decision upheld the citations, including the Integra case, the employer has appealed the decision to the OSHA Review Commission, resulting in more costs and delays. It is my fear that an adverse ruling in either of these appeals will seriously compromise OSHA's ability to enforce future workplace violence protections. Also of note, in one of the recently heard cases, the defense attorney argued that under the GDC, an employer does know when they have met OSHA's criteria for an adequate workplace violence prevention program. I believe that the promulgation of an OSHA standard addressing workplace violence in these industry sectors would provide the specific guidance that is lacking in the use of the GDC.

I am grateful that this committee is finally recognizing violence towards health care and social assistance workers as a major public health problem. Fortunately, there is much that can be done to prevent or minimize the hazard and passage of HR will facilitate such prevention.

H.R. 1309 is a relatively modest and straightforward piece of legislation that would do much to stem this workplace violence epidemic that has been perpetrated on this hardworking and committed workforce for far too long.  I urge this subcommittee to act on this important bill.

Thank you and I would be happy to respond to any questions.