Crime and its relationship to the University Medical Center

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CRIME AND ITS RELATIONSHIP TO THE UNIVERSITY MEDICAL CENTER

by

Paul D. Shapiro

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in Criminal Justice

Department of Criminal Justice
University of Nevada, Las Vegas
May 1997
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ABSTRACT

This study explores the relationship between crime and violence and the University Medical Center of Southern Nevada. An investigation was conducted to determine how crime and violence affects the medical center from an economic, security, staff and organizational response perspective.

Nursing staff and security officer interviews, supplemented with security department incident reports, suggest a perception problem exists. Nurses interviewed believe a major cost of crime and violence at the medical center is the perceived threat to their personal safety by gang members and patients under the influence of drugs or alcohol. Security officer interviews and data from incident reports suggest the major cost of crime and violence at the hospital center has to do with minor property offenses and not threats or assaults against staff. Additionally, nursing attitudes and compassion levels seem to be negatively affected from treating large numbers of patients whom they feel are deserving of their injuries.
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From March of 1985 to July of 1995, I worked on an ambulance in New York City. As a New York State and nationally registered paramedic, I estimate that over that ten year period, I responded to between fifteen or sixteen thousand “911” emergency calls.

A subtle transformation occurred as I evolved from a rookie medic to an experienced veteran. My views concerning people, health care, society, crime, violence, good, evil, life and death slowly changed. There wasn’t one individual event that caused this transformation. For a while, the good shifts I had depended on the misfortune of others. For me to have an exciting productive day required someone else to get shot, stabbed, hit by a truck or incur some equally traumatic medical emergency. At times it was easy to rationalize other’s misfortunes: they were gang members, and as such were expected to get shot; of course she had a heart attack. she weighed three hundred pounds and smoked like a chimney; and homeless people who live in the subways are occasionally going to get run over by trains.

There were times when we knew about the new trends, locations or personnel involved in illegal activity before the police did. After a few people overdosed (and did not respond to traditional treatment) in the same back alley, behind the same bar. during the same midnight shift, the paramedics in midtown Manhattan knew there was a new type of powerful heroin hitting the streets.
We knew when the homeless shelters were open. We knew when the psychiatric facilities had released inpatients. We knew when the methadone clinics closed. We knew when the city's social service unit cleaned out the subways.

I saw the best and the worst of the city.

But I changed. I might not have known it then. But I know it now.

Anyone who witnesses the death and destruction that we paramedics did on a regular basis has to change. Whether one acknowledges those changes or not, it's certain that they occur. One may become more careful as one does their job, or radically less so. Maybe you become more compassionate with patients, or decidedly colder. Perhaps one becomes more open and forthright in their relationships, or become withdrawn and introspective. I do not believe there is a mold or pattern that emergency workers can be pigeon holed into. But I do know that we all adapt to our environment. It's our nature. The bottom line is we try to do our jobs as best we can.

It's what we do.

I dedicate this thesis to those people who do their best to pick up the pieces.
ACKNOWLEDGEMENTS

I am greatly indebted to many people for their contributions to this project. I would like to thank my graduate committee chairman, Randall Shelden, for his encouragement, patience and excellent guidance. Considering how weird and bizarre things had gotten, I can’t thank him enough for seeing this project through. The fact that he didn’t once try to kill me during the previous year is a tribute to his professionalism. I also appreciate the assistance and input of the other members of my committee: Josephe Albini, Kriss Drass and Andrea Fontana.

I must thank a number of people from the University Medical Center of Southern Nevada: Mike Parker and Ron Kirk from the security department; and Dennis Morris and Christie Elrod from fiscal services.

A special thanks to my two “gatekeepers” who know who they are.

I would also like to thank Richard McCorkle who was the best interim thesis chair a student could have. This project is as much his as anyone’s.

And finally, a very special word of thanks must also go out to Marsha Green from the office of sponsored projects. Thank you again.

Without everyone’s efforts and time consuming support, this thesis might never have come to be.
CHAPTER 1

INTRODUCTION

In 1993, there were 92.8 million visits to the emergency rooms of non-federal, short stay hospitals in the United States (Statistical Abstract of the U.S. 1995:129). As a major entry point into the hospital, the emergency department (E.D.*), and its personnel, are subjected to the increased risk of assaults, shootings and a host of other serious security problems. The 1991 issue of the Journal of Healthcare Protection Management, the publication of the International Association for Healthcare Security and Safety (IAHSS), showed that violent incidents continue to increase in the hospital setting, particularly in the E.D.s (Hagland 1992).

In a one year study by the IAHSS, violent assaults in selected hospitals increased 25% from 1,435 reported incidents in 1988 to 1,789 reported incidents in 1989 (Hagland 1992:30). In a 1990 IAHSS follow up study, 335 responding hospitals reported 2,293 assaults (nearly 7 per hospital), the majority occurring in the emergency department (Lang 1993:37). Former Labor Department Secretary Robert Reich has pointed out that health and social services employees endured a dramatically higher incidence of fatal assaults than many other occupations. From 1980 to 1990, 18 RNs and 88 other health care workers were killed in job-related

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* Emergency Department (E.D.) and Emergency Room (E.R.) are frequently interchanged.
homicides (Brider 1996:169). A 1993 Occupational Safety and Health Administration (OSHA) report, citing Bureau of Labor Statistics data, showed that health care and social service workers had the highest incidence of assault injuries in any workplace (Brienza 1996:77). The majority of the nonfatal workplace assaults that occurred in health and social service facilities were primarily attacks by patients on nursing staff (Brider 1996).

The presence of security officers is not an absolute deterrent to violence in the hospital setting. As one nurse reported, "security guards can’t always be nearby when we’re treating patients. Even if there were enough guards to go around, a patient’s right to privacy demands that we be alone with him" (Kinkle 1993:23). Moreover, security officers are often the targets of that violence. According to Barry Feinstein, president of the Teamsters Local 237 which represents the security police officers patrolling New York City’s 16 public hospitals, “in the course of a year, as many as one-third of our people will miss work because they’ve been shot, knifed, struck with lead pipes, or otherwise physically beaten” (Johnsson 1990:56).

**Understanding E.D. Violence**

It appears generally accepted in the literature that violent behavior in the E.D. stems from two major sources; increases in urban crime in general, and gangs and drugs in particular (Hagland 1992:30). Violence is also believed to be the result of the stress and anger created by long waits for treatment (Keep & Gilbert 1995; Simonowitz 1994).
“Long hospital delays clearly contribute to the strong potential for violence in our waiting room,” says Dr. Robert Hockberger, chairman of the department of emergency medicine at Los Angeles Country Harbor-UCLA Medical Center. “We’ve gone from 80,000 patients in 1982 to 120,000 in 1991, but the E.D. itself and our staffing are essentially the same” (Hagland 1992:31). And as emergency room nurse Vicki Sweet from Hoag Memorial Hospital in Newport Beach reported, “the waits are getting longer. And people here have a drive-thru mentality; they think an E.R. can operate like a fast-food restaurant” (AJN 1993:92).

Responding to E.D. Violence

It is difficult to eliminate violence from an E.D., especially when the environment outside the hospital is violent. Even an E.D. that has taken preventative measures will experience an occasional incident (Keep & Gilbert 1995). There have been responses by hospitals attempting to reduce the dangers to their employees. Some common sense tactics include removing all potential weapons from the E.D. waiting room such as glass bottles, movable chairs, non-mounted phones and objects with sharp or hard surfaces. Personalized safety precautions for staff, such as avoiding certain types of hairstyle, clothing or jewelry that could allow a potential attacker to easily grab, pull or control the staff member have been advised. Some hospitals have taken considerably more drastic measures. White Memorial Hospital in Los Angeles, following a gang related shooting, physically relocated the E.D. away from the street to an area inside the radiology department (Hagland 1992).
To keep violent people from getting to the staff in the first place. California Occupational Safety and Health Administration (OSHA) officials recommend bullet proof glass in the triage, admitting, and other reception areas. Additional recommendations include: locked or key-coded doors inside the E.D. to limit access to treatment areas, closed circuit TV monitors to survey concealed or problem areas, and metal detectors to screen for weapons in the E.D.s and psychiatric facilities (Simonowitz 1994:62). Audubon Humana Hospital in Louisville, Kentucky, has gone one step further by using biometrics to solve a security problem in their laboratories. This biometric technology uses a sensor to “recognize” a person’s voice and allow access to secured areas (Moran 1990). While some of these recommendations may seem excessive and expensive, it is important to note that in 1993 a Chicago psychiatric hospital where nurses and attendants had been beaten by patients became the first health care facility to be cited by OSHA for not protecting employees from violence (Simonowitz 1994:62).

There are, however, difficult practical issues to be considered when attempting to increase security. Metal detectors and x-ray machines, for example, require the hiring and training of specialized personnel to operate the new equipment. The hospital would then also need better trained and more heavily armed security officers capable of disarming armed visitors. Dr. Frank Lavoie and colleagues found that, after the installation of a metal detector in one teaching hospital emergency department, there were over 300 incidents of persons carrying weapons within the first month (Lavoie, Carter, Danzl & Berg 1988). Lavoie’s findings would not come as a surprise to emergency room nurses in California. In a 1992 survey of 103 E.D.
nurse managers from inner city, urban and rural hospitals across that state found that in the previous year more than half of all emergency departments reported incidents that involved weapons brought into the department by patients or visitors. The most common weapons were knives and loaded guns (Keep & Gilbert 1992:436). One OSHA guideline pointed to a study showing that as many as one-fourth of hospital patients, their friends or family members may be carrying a weapon (Huff 1997).

The Care of Crime Victims

Unlike most private health care facilities, municipal hospital emergency departments and the specialized emergency units designed specifically for trauma patients, called trauma centers, cannot choose which patients they will or will not admit. And as trauma centers around the country continue to close (between 1983 and 1989, 66 centers were closed [Skolnick 1992:2994]), the burden placed upon the remaining centers multiplies. The existing emergency departments remain the primary sources of health care for victims of violent crime, the poor and uninsured (Sklar 1994).

During the 1992 Los Angeles riots, hospitals treating large numbers of riot victims suffered substantial financial loss since most of the patients had no health insurance, public or private. Peter Bastone, executive vice president and administrator of Daniel Freeman Memorial Hospital reported, “in addition to the one million dollars lost from the fact that 80% of the patients treated had no insurance, elective surgeries (a hospital money maker) were canceled and some in the region are
now reluctant to come to Daniel Freeman because they think it’s in a dangerous neighborhood” (Hudson 1992:25).

Riots and other mass scale disturbances aside, the day-to-day violence in American society is placing a tremendous strain on hospitals and the health care system. According to the federal Center for Disease Control and Prevention, by the year 2003, gunfire will have surpassed auto accidents as the leading cause of injury death in the United States. As of 1996, in seven states it already has (Headden 1996:31; Kizer, Vassar, Harry & Layton 1995:1768). In 1991, the most common cause of death for African American males 15 to 24 years of age was gunshot wounds (Cornwell, Jacobs & Walker 1995:1788). For every patient who dies from a gunshot wound (there were 39,720 in 1994) three others are injured seriously enough to be hospitalized (Headden 1996:37). Gunshot patients are far more expensive to care for than victims of other kinds of crime. A “typical” stab wound cost $6,446 to treat (Headden 1996:34), while the “average” gunshot case costs around $15,000 to $20,000 (Headden 1996:34; Wagner 1990:24). Since 4 out of 5 gunshot victims, are on public assistance or uninsured, unlike car crash victims who are frequently insured, taxpayers bear the brunt of medical costs that have soared nearly nine-fold in the past ten years to a staggering $4.5 billion a year (Headden 1996:34).

Additionally, the greater use of semi-automatic weapons has increased the intensity of these injuries. According to Dr. John Barrett the trauma director of Chicago’s Cook County Hospital, “in 1982, only 5% of the patients admitted for gunshot wounds had been shot more than once. By 1991, that proportion had risen to 25%” (Skolnick 1992:2994). It should not come as a surprise that the military has
been sending their surgical residents to train at trauma centers around the country. The Medical Shock Trauma Acute Resuscitation Unit (MedStar) in Washington, D.C., provides the new Army and Navy physicians with outstanding training. “From the military point of view, the trauma cases (gunshot and stab wounds) that the residents and fellows see while they are in the MedStar program are the best approximations we can get to military combat” says Colonel Juan D’Avis, chief of surgery at Walter Reed Hospital (Marwick 1991:1047).

Estimates vary regarding the exact figures concerning the medical costs of violence. Four billion dollars seems to be a somewhat consistent figure regarding the expense of caring for gunshot victims (Chafee 1992:20; Headden 1996:31; Kizer et al. 1995:1768). One estimate of the medical and mental health costs stemming from violent crimes like murder, rape, assault, and robbery total approximately $11 billion each year (Collins 1994:40). There are some reports that estimate the overall costs of violent victimization to be much greater. According to researchers from the University of California at San Francisco and the National Public Services Research Institute in Landover, Maryland, “the cost of treating a crime-related physical injury averages $41,000, and all the injury causing crimes that occur in a year in the country ultimately cost $202 billion in medical fees, psychological costs, and productivity losses over the victim’s lifetimes” (Buss 1994:17).

Whether one accepts the $202 billion figure or not, there is little disagreement that trauma care for victims of gunshot wounds is extremely expensive. Moreover, many of the patients are not covered by insurance (Skolnick 1992). Two thirds of the gunshot wound patients in a Sacramento County, California study did not have
insurance (Kizer et al. 1995:1771). According to Dr. Markovchick, director of emergency medical services for Denver Health and Hospital, "90% of [our] penetrating trauma patients are uninsured and the hospital doesn’t recover anything" (Wagner 1990:26).

Parkland Hospital in Dallas, Texas, where President John F. Kennedy was taken following his gunshot injuries, expected to lose $23 million in 1992 chiefly from unreimbursed trauma care. Overall, trauma care is running nearly $300 million a year in uncompensated funds in Texas alone (Dworetzky 1992:28).

While the bulk of the crime analysis of health care focuses on medical costs, patient payments, government reimbursement, and insurance coverage, little is known about other ways in which violence and crime affects the day-to-day operations of a hospital. This thesis is an exploratory case study of the University Medical Center of Southern Nevada (UMC). As such, research questions will be put forth which will examine and identify relationships between crime and violence and the operations of UMC. Among the questions to be addressed are:

- How has crime and violence affected UMC economically?
  (A) Is crime and violence affecting UMC’s economic well being?
  (B) How has UMC’s expenditures changed in response to crime and violence?

- How has UMC’s operating procedures changed in response to crime and violence?

- How has crime and violence affected UMC’s personnel?

- What are the hidden costs of crime and violence on UMC?
Data from a single case study cannot provide a definitive answer to the question of how crime and violence affects hospital operations. However, this study can suggest new avenues for future research about this important topic.
CHAPTER 2

LITERATURE REVIEW

This chapter will discuss the literature which addresses the subjects of crime and violence and their relationship to hospitals. The first section is a brief overview of some basic sociological literature. This literature, from many of the preeminent sociological theorists, contains information briefly covering such topics as the effectiveness of organizations, organizational relationships, employee stress, and status passages. The basic sociological concepts found in this literature are easily related to the specifics of the present case study.

The second section explores the issue of violence and economics, which also includes the topic of cost shifting. The economic issues surrounding health care and violence are predominantly found in the physician targeted medical journals. The Journal of the American Medical Association and The New England Journal of Medicine focus almost exclusively on the expenses of providing medical care, actual costs of said care, and reimbursement issues for the hospitals, physicians and society.

The third section examines some of the specific issues regarding health care workers and their workplace security. Safety issues are almost always found in the nursing and health care related publications. The American Journal of Nursing, Journal of Emergency Nursing, and Hospitals, seem to focus on the human aspects of
violence in the hospital setting; primarily, the increase in assaults against health care professionals, the risks and factors associated with hospital violence, and the growing concern about employee safety.

The final section provides some history and practical knowledge important for an understanding of hospitals and trauma centers. Since most victims of gunshot or stabbing injuries are transported to trauma centers (specialized units within a hospital), a section of literature regarding their history and dynamics is appropriate.

A. NURSING STRESS AND IDENTITY

Georgopoulos and Tannenbaum (1957) point out that many factors are relevant in determining an organization's effectiveness. Among these, morale, member satisfaction, turnover, absenteeism and market fluctuations are all contributing factors to efficiency and effectiveness. Therefore, the authors define organizational effectiveness as, “the extent to which an organization as a social system, given certain resources and means, fulfills its objectives without incapacitating its means and resources and without placing undue strain upon its members” (Georgopoulos & Tannenbaum 1957:535-536).

Such strain, when applied to nurses working in a hospital setting, can prompt serious organizational inefficiency. Strain on nursing staff can be manifested in a variety of ways. Hiscott and Connop (1990) discovered a strong relationship between shift length, rotating shifts, and working round-the-clock hours with nursing dissatisfaction which contributed to job turnover. Ling (1992) reported that in addition to rotating shifts, the unpredictability of patient volume, the wide array of
medical problems and the high acuity of patient illness and injury also contribute to high levels of nursing stress. Fang and Baba (1993:25) concluded that stress, identified as "an emotional response to stimuli that may have dysfunctional, psychological, behavioral, and/or physiological consequences," clearly plays a role in the job dissatisfaction rates of nurses. Additionally, the authors determined that increases in role ambiguity, role conflict and role overload provide a significant predictor of turnover intentions.

Hospitals, like other complex organizations have a variety of interactants doing various types of work, which must be articulated through arrangements. Corbin and Strauss (1993) reported that the work a nursing staff must do in hospitals requires coordinated and cooperative arrangements with physicians and other departments (such as pharmacy, housekeeping, dietary and laboratories). According to the authors, these arrangements are usually worked out within or between departments through a series of interactional strategies that usually but not always involve negotiation and persuasion. Additionally, "when these arrangements breakdown the work may be delayed, suffer in quality, and sometimes not get done at all" (Corbin & Strauss 1993:74).

The relationship between hospital staff and hospital security department was explored by Winfree and Williams (1985). Not surprisingly, of all hospital employees, nurses had the greatest contact with the security department, and the majority of those contacts took place in the emergency departments and waiting rooms. Furthermore, nurses were identified as the predominant "at risk" group inside the hospital. This "at risk" status further compounds on-the-job stress. Nudelman
(1995:62) concluded, "employees threatened or harmed by workplace violence
become less productive or simply leave for a safer workplace."

The decrease in workplace productivity is identified as a primary symptom of
workplace burnout. According to John-Henry Pfifferling, the director of the Center
for Professional Well-Being in Durham, North Carolina,

burnout occurs incrementally, as unrealistic expectations clash with
reality. People lose the joy they had in their work, and are slowly nibbled
to death. Those who are burning out are too depleted to give of
themselves in a creative fashion. So beyond the loss to the individual,
the organization and society pay a heavy price, losing providers too

Eastburg, Williamson, Gorsuch & Ridley (1994) report that a personality
construct that has been related to nurse stress is identified as "personality hardiness."
It is hypothesized that a group of attitudes, beliefs, and behavioral tendencies exists
which "tend to insulate individuals from the ill-health effects of high degree of life

It is reported by Gilmore and Barnett (1992:538) that, "patients drain the
nurses, who often have to displace their aggressive feelings away from the patients
onto the systems or administration that appear never to support them adequately in
their difficult work." While this researcher does not question Gilmore and Barnett's
reporting of nurse's feelings of inadequate support from supervisors and
administrators, it is possible that their findings of nurses diverting aggression away
from patients onto administrators was too idealistic. There is considerable literature
to suggest that nurses, as well as other health care providers, consistently provide less
then admirable care depending upon their particular prejudices or clientele. Howard
and Strauss (1975) show that inherent worth, uniqueness as an individual, wholeness of person, freedom of action, and equality of status all reflect different levels of care by health workers and the health-care system in accordance with the biases of the rest of the social order. Roth (1972) showed that the perception of social worth on staff evaluations of patients who came to the hospital for emergency services reflected the concepts of social worth common in the larger society. Furthermore, according to Howard & Strauss (1975:178), “patients labeled as drunks are more consistently treated as undeserving than any other category of patient.”

It is apparent that some nurses deviate from one of their basic ethical tenets; that is, “to deliver care in a nonjudgmental and nondiscriminatory manner that is sensitive to client diversity” (ANA 1991:15). Assuming that not all nurses violate these tenets, those who do would be considered a deviant subgroup of nurses. Many deviant groups have a self-justifying rationale. According to Becker (1963), these justifications “furnish the individual with reasons that appear sound for continuing the line of activity that he [sic] has begun” (Becker 1963:39). Furthermore, Becker believes that many kinds of deviant activity spring from motives which are socially learned. Becker goes on to say, “whether a person takes this step or not depends not so much on what he does as on what other people do, on whether or not they enforce the rule he has violated” (Becker 1963:31). Finally, it is noted that when a person makes a definite move into an organized deviant group, or when he or she realizes and accepts the fact that they have already done so, it has a powerful impact on their conceptions of themselves.
These conceptions may involve a status passage. According to Glaser and Strauss (1971:2), “such passages [status passages] may entail movement into a different part of a social structure; or a loss or gain of privilege, influence, or power, and a changed identity and sense of self, as well as changed behavior.” Glaser and Strauss identify twelve properties which may characterize a status passage. Selected characteristics relating specifically to this study include:

- The passage may be considered in some measure desirable or undesirable by the person making the passage or by other relevant parties.
- The passage may be inevitable.
- The person who goes through the passage may do so alone, collectively, or in aggregate with any number of other persons.
- It follows that when people go through a passage collectively, or in aggregate, they may not be aware that they are all going through it together or at least not aware of all aspects of their similar passages.
- The clarity of the signs of passage, for the various parties, may vary from great to negligible clarity. In other words the signs are not always so clear to the person (Glaser & Strauss 1971:4-5).

Glaser and Strauss, and Becker’s theories regarding self conceptions and status changes, which are traditionally applied to deviance, can also be applied to children living in violent environments. It is reported that many psychotherapists think that children exposed to violence develop the same symptoms as “shell-shocked” soldiers in wartime. Psychiatrists first started using the diagnosis post traumatic stress syndrome (PTSS) to describe the circumstances of Vietnam veterans who were unable to adjust when they returned home (Prothrow-Stith 1993:68). It was
initially believed that children trapped in violent circumstances may also exhibit the
symptoms of PTSS. Recently mental health providers have begun to see signs of
PTSS in crime victims, in the victims of terrorist attacks, and in children chronically
exposed to violence in their homes and communities (Prothrow-Stith 1993:68).

It would not be unreasonable to conclude that emergency and trauma
department nurses, who are chronically exposed to victims of crime and violence,
who work in the most uncontrolled and dangerous settings of the hospital, may
experience their own versions of post traumatic stress syndrome.

B. VIOLENCE AND ECONOMICS

A great deal of research has focused on the cost and expense of providing
medical care for victims of violence. These costs are then compared to the actual
payment for services that patients are charged, and the amount of reimbursement, both
direct and indirect, that the hospital receives for this emergency treatment.

Firearm injuries are an extremely expensive type of injury to treat, and most
victims are non or under insured (Headden 1996:34; Skolnick 1992:2994; Wagner
1990:23). Hospitals may lose money treating the firearm and stabbing victims of
violence. But these costs can be more than offset, if the majority of their patients
have insurance, through a strategy known as “cost shifting”. Cost shifting is the
process of overcharging hospital patients who can pay or have insurance to
compensate for those who cannot. If there were a question regarding the legality of
such measures, a ruling by the United States Court of Appeal for the Third Circuit
ruled that states may legally shift the hospital costs of caring for people without insurance onto those who have insurance (NY Times 1993).

In an excellent example of cost shifting Kizer, Vassar, Harry, and Layton (1995) reported on a three year study of the University of California, Davis Medical Center (UCDMC). Those researchers showed that, though the trauma center was losing money on two out of three patients treated for gunshot injuries, the institution’s pricing structure was such that firearm-related wounds, as an aggregate, contributed nearly $4.4 million to the hospital’s net income. The UCDMC achieves a net income by increasing charges above costs at 3.8 times greater than the actual cost of providing the care, to that minority of patients who have insurance, to compensate for the majority who do not (Kizer et al. 1995). It was determined that hospitals in the early 1980s added an average of 10% to privately insured patients’ bills to cover the cost of under-compensated care. By the early 1990s the economic research firm of Browne, Bortz & Coddington calculated this to add-on was approaching 70% (Hopkins 1992).

A similar study of the costs related to firearm injuries by Martin, Hunt and Hulley (1988) concentrated more on the relationship between public and private payer sources. Their study found that public sources paid 85.6% of the costs, while private payer sources paid only 14.4%. The authors urged legislators to restrict the availability of firearms, since they believed that the issue is not simply one of individual rights, since taxpayers pay most of the cost associated with firearm injuries. The impact of firearm injuries has been well-documented (Wagner 1990; Skolnick 1992; and Chafee 1992). The increase costs of hospitalization, the proliferation of handguns on the streets, and the high cost of violence are believed
responsible for the closing of 90 trauma centers since 1985. Additionally, firearm, stabbing, and drug related violence and economic effects on inner city trauma centers was examined. Skolnick (1992) predicts that Congress may have to come to the aid of some trauma centers that are in financial straits. The lack of reimbursement from most victims of violence, and ways that some states have been trying to support their trauma systems have also been explored. The Governor of Maryland in 1992 proposed an $8 surcharge on all vehicle registrations to save one of the nation’s best trauma systems. Other possibilities include proposals regarding the levying of a “gun tax” on firearm manufacturers (Skolnick 1992). It is stressed that unlike most of the major killers (heart disease, stroke) that show up later in life, trauma injuries primarily affect younger people, causing more years of potential life lost.

The effects of trauma center closings on remaining trauma centers has been examined (Larkin 1989; Laskowski-Jones 1993; Hopkins 1992). The effect on Chicago’s trauma system when the University of Chicago hospitals pulled out of the city’s trauma network has been clearly documented. Trauma admissions quadrupled at nearby Michael Reese Hospital and Medical Center. For the three months following the University of Chicago pullout, trauma care loses at Michael Reese totaled $400,000; which also threatened to pull out of the network if bailout funds were not obtained (Larkin 1989:22-23).

While patient care issues and finances are explored in many studies, there are lesser examined economic factors that one needs to be aware of. Administrative costs, costs for upgrading communication equipment, and for creating a 911 system must be considered. Additional expenses to upgrade staff, facilities, and equipment...
are all associated with the high cost of trauma centers (Laskowski-Jones 1993). The massive costs to establish and maintain these centers encourages hospitals to find additional ways to compensate themselves for non paying patients. Because Medicaid and Medicare provides paltry reimbursement, doctors are discouraged from treating the poor and the elderly. According to a 1992 Health Insurance Association of America survey, Medicaid reimburses doctors an average of just 55% of what private insurance pays for the same service. As Hopkins (1992:75) describes in detail, in some cases these payments are considerably lower: 37% for tonsillectomies, 29% for coronary bypass surgery, and a pathetic 15% of the going rate for obstetrical services, including delivery. As of 1992, only five states nationwide reimburse hospitals enough to cover the cost of caring for Medicaid patients (Hopkins 1992:75). The lack of private medical care forces these patients to utilize emergency departments as their primary care medical provider. It stands to reason that occasional care in the emergency room is better than no care at all. In this regard the emergency department has become increasingly important to the urban poor who are increasingly unable to access private medical services (Steinbrook 1996:657).

Spencer (1994) confirmed Hopkin’s and Steinbrook’s findings. Spencer reminds us that people who have no health insurance not only receive care, but receive the most expensive care, that delivered in the emergency rooms. Citing from the Congressional Budget Office, the author also points out the deficiencies in Medicaid and Medicare reimbursement rates.

The disproportionate reimbursement rates for victims of violence continues to affect trauma center viability. Firearm victims, who are among the most expensive
type of patient to treat, are also some of the most underinsured. Since the government (i.e., taxpayers) pays approximately 86 percent of the medical bills for gunshot violence, many observers recommend that developing a system to compensate hospitals for these additional costs may be worthwhile to preserve access to care for disadvantaged patients and to ensure the financial viability of the institutions that serve the disadvantaged and poor (Martin, Hunt & Hulley 1988:3048; Stern, Weissman & Epstein 1991:2338).

C. HOSPITAL SAFETY ISSUES

Issues regarding hospital safety seem to be mostly ignored by the two major physician targeted journals. There are virtually no safety or security related articles published in either the Journal of the American Medical Association, or The New England Journal of Medicine.

By contrast, studies regarding hospital safety and on-the-job violence seem to be promoted by the nursing associations and their publications: the American Journal of Nursing, Nursing and RN. There may be a very logical reason for the discrepancy in safety and security articles between the predominantly male physician journals and the predominantly female nursing publications. Women are traditionally more concerned for their personal safety than men. In addition, most hospital employees are women. And to some extent, men are less likely to admit to being scared, feeling unsafe, or of even being assaulted by a patient, or coworker. There is evidence that many E.D. employees feel that some degree of violence is part of their jobs, and that reporting it would be a sign of weakness (Nursing 1993; Lenehan 1991).
A number of books have been published specifically on the subject of hospitals and safety. Most of these books are targeted for hospital administrators or directors of hospital security departments. There are, however, more general works that are continually cited in the healthcare, safety and security literature.

Turner (1984) focused on the role of administrators in medical facilities. He emphasized the administrator's responsibility for development of a viable security program. He stressed that hospitals are at a particular risk of crime, because they operate 24 hours a day, employ a high percentage of women, and have helpless "customers." Pascal (1977), while somewhat outdated given today's increase in gang, drug and weapons problems, is still frequently utilized for basic safety and self protection recommendations. Pascal advises that the onus is upon the employer to rid the place of employment from hazards that may adversely affect the general safety and well-being of the employees. Further he stresses, to protect the safety of employees, extraneous information such as home address, telephone number or social security number, should not be included on any visible hospital identification card.

Colling (1992) writes on many of the modern problems facing today's hospitals. While the book is filled with facts and economic figures highlighting security department needs, Colling is careful to emphasize that it's impossible to compare the protection budget of one organization to that of another - even though the organizations may be similar in terms of size, type and environmental setting. Although, no two hospitals are exactly the same, there is a consensus that violence in the emergency department has escalated and is now a much greater problem than had been in the past.
There are a number of relevant articles on emergency department and hospital safety. These articles, written primarily by nurses, are specifically geared towards identifying problems and reducing violence in the hospital setting. Mahoney (1991), reminds the reader that emergency nurses are at a higher risk for victimization than either the general public or other hospital workers. A survey of California emergency department nurses conducted by Keep and Gilbert (1992) focused on violent episodes and incidents inside their E.D.'s. One of their findings was the frequency of dangerous weapons, specifically knives and loaded firearms, being brought into their emergency departments. In another Keep and Gilbert (1995) article, an E.D. safety checklist assessing the potential danger in specific situations is presented. Examples of safety problems included: the number of uncontrolled entrances in the E.D.; isolated or unmonitored areas where staff might be assaulted; inadequate means to call for help and not enough security guards. They also provide many pointers for reducing the risks associated in working in an emergency department: knowing where all the exits in a particular room are; knowing if there are potential weapons in the room; keeping a safe distance from a potentially violent patient and knowing how to summon help if an emergency should arise. Kurlowicz (1990) noted that summoning help is easier when the E.D. has an established protocol. Panic buttons, telephone codes, autodialers, or a radio/intercom system are all valuable for summoning help in an emergency.

Additional workplace and security issues are discussed by Kinkle (1993), Simonowitz (1994) and Hagland (1992). Each author details workplace safety issues including: treating violent patients, security lapses, communication strategies, and
techniques for dealing with violent occurrences. According to these authors, many violent occurrences are tied to the spread of gang and drug activity. Two anonymously authored articles in Nursing (1993) and The American Journal of Nursing, (1993) respectively, cite additional factors that lead to emergency department violence. These factors, in addition to gang and drug problems, cite inflexible hospital rules and policies, inadequate staffing, seclusion of patients or families, invasion of personal space and extended emergency department waiting times.

Security issues have become more and more prevalent in the literature. And while Brider (1996) chronicled the dramatically higher rate of fatal assaults on health and social service employees between 1980 and 1990, the tasks and intervention the hospital security officers are authorized to perform have also been changing. While some hospitals have been expanding the security officer's role, other facilities rely on the local police for the more serious interventions. Winfree and Williams (1985) write on the relationship between the hospital and its security force. In addition to the day-to-day interaction of the staff members, they detail some of the problems of policing a public hospital. For example, public hospitals, unlike corporations and many private institutions, must remain largely open to all people. Ingress and egress is generally unrestricted, except in certain locations or at specific time.

The issue of whether hospital security officer should be armed with firearms is examined by Johnsson (1990). While many hospital administrators present mixed views, most agree that the conditions outside the hospital will ultimately determine the level of force needed inside the hospital. Conditions outside the hospital do
influence the conduct inside the facility. Today the staff inside the hospital, especially the emergency room staff, need to be acutely aware of the conditions and the environment outside their facility. Lang (1993) discussed the importance of familiarizing the hospital staff with gangs and their insignia. Since gangs frequently come to the hospital with wounded members, it behooves medical personnel to recognize potential trouble before it starts.

Broad safety issues relating specifically to hospitals and the general populous have become prevalent in day to day society. When dramatic events occur, especially well publicized ones, our fears become compounded and acute. It was during a study of the 1992 Los Angeles riots that Hudson (1992) examined how hospitals survived and made best efforts to treat the riot victims. Financial repercussions were also examined since many of the riot victims were non or under insured. Other serious health and safety issues were investigated by Simolowe (1993). Her analysis focused on the various shootings and violent incidents, (such as the 1993 McDonald’s shooting spree in Kenosha, Wisconsin) that have impacted American’s views of their physical safety. Included in this general article is a report that incidents of violence against health-care workers have increased dramatically.

D. THE HISTORY AND EVOLUTION OF TRAUMA CENTERS

The emergency medical services (EMS), as we know it, began in 1966 with the enactment of the Highway Safety Act, which prompted the Department of Transportation to require the development of programs targeting highway injuries (Routh 1995:541). One such program, the Emergency Medical Services System Act
of 1973, enabled several states to use federal funds to develop trauma systems. Unfortunately, these early efforts were severely hampered when federal support was not extended in the early 1980s. Although great strides were made in developing guidelines for optimal trauma care delivery, many early trauma systems lost momentum because of state and local budget crises (Bazzoli, Madura, Cooper, MacKenzie & Maier 1995:395).

In the late 1980s, as the increase of violent injuries and the closing of trauma centers continued, the federal government began to make an effort to reestablish its economic ties to trauma care. In the "Trauma Care Systems Planning and Development Act of 1990", Congress acknowledged that physical trauma in the United States resulted in an aggregate annual cost of $180 billion in medical expenses, insurance, lost wages and property damage. So the legislature's authorization of $60 million to be appropriated for fiscal year 1991, with repeat allocations for 1992 and 1993, (while a start) seemed fairly inconsequential. Sixty million allocated, for an estimated cost of $180 billion, is only a tiny fraction (.03%) of the estimated annual cost of trauma (Public Law 101-590).

Trauma centers can be independent and self contained emergency departments (as part of a regular hospital) designed exclusively to treat serious traumatic injuries. Or, trauma units can consist of specialized personnel who, when activated, respond to the hospital’s regular emergency room to treat traumatic injury patients. Trauma centers are designated by specific levels. Level I and Level II centers typically provide comprehensive care to the most severely injured. Additionally, Level I centers are more involved in research, education and systems leadership activities.
Level III facilities are responsible for stabilization, preliminary diagnosis and preparation for transport of severely injured patients to Level I or II facilities for definitive care (Bazzoli et al. 1995:397).

While patient choice of hospitals is, for the most part, respected by pre-hospital emergency ambulance personnel, hospital selection for trauma patients is not. Fire department and ambulance crews are bound by protocol to transport trauma patients to trauma centers. Unless extreme circumstances are present, the trauma patients will be transported to these specialized facilities. There is little question that trauma centers reduce mortality. Studies show that severely injured patients have improved chances for survival if they are treated by these specialized trauma units. These centers usually provide better care and have higher patient survival rates than other hospitals even though they deal with the more seriously injured (Bazzoli et al. 1995:395; Giacopassi & Sparger 1992:251; Doerner 1988:173). Some studies show that mortality can be reduced by as much as 70 percent if the intervention takes place within the “golden hour” (the hour immediately following the injury) (Dworetzy 1992:28).

Progress in the development of trauma systems in the United States is examined by Bazzoli, Madura, Cooper, MacKenzie and Maier (1995). The authors provide a strong overview of the trauma systems that have been developed, their history and evolution. Bazzoli et al. concluded that while state and regional organizations have accomplished a great deal, they still have substantial work ahead in developing comprehensive trauma systems. According to Dr. Gregory Henry, associate professor, Department of Surgery, University of Michigan Medical Center,
Ann Arbor, "a lot of trauma services are based on municipal concepts, such as paying a fire department for its standby ability, but a half-dozen trauma centers aren't needed in our medium-sized cities" (Montague 1993:40).

The most common deficiency in these established systems was the failure to limit the number of designated trauma centers based on community need. This lack of community need, or over-extension of unnecessary trauma centers, affirm the conclusions of Narad and Smiley's (1992). The authors focused on the twenty two California trauma centers that have dropped their trauma center designation since 1982. They claim that at least one third of them should never have been designated a trauma center in the first place. And while Narad and Smiley are critical of California's trauma system, they wholeheartedly endorse the concept of trauma centers. They even go so far as to recommend that some centers in geographically desirable locations, but with non-lucrative patient mixes, receive direct subsidies to maintain the solvency of their trauma programs. A blunt/penetrating injury ratio of 4:1 has been defined as a healthy mix financially for the viability of most trauma programs (Laskowski-Jones 1993:123).

Most trauma systems have an open designation process in which all interested hospitals are able to obtain the designation as a trauma center, provided the hospital meets rigid standards and requirements set by the Committee on Trauma of the American College of Surgeons. To gain this specialized designation, a hospital must have a surgeon and other specialists in-house or available within specific times, thus minimizing the time to surgery (Narad & Smiley 1992:563). Start up costs for establishing a trauma center vary according to existing resources and geographic area.
In 1989, the range of start up costs for 12 level II trauma centers in Florida averaged $800,000 dollars (Mendeloff & Cayten 1991). Interestingly, the start up costs of a Level I trauma center are approximately $400,000 less than for Level II centers. This is explained by the following: Level I centers are usually upgraded from existing Level II institutions in large teaching hospitals. Level II centers are usually upgraded from community hospitals, and require a larger initial influx of expensive personnel and resources.

It is possible that a large number of hospitals initially obtained trauma center status in an effort to raise the prestige of their facility, as well as to protect their market share. Both the hospital’s public and professional image can be enhanced with the addition of a trauma service (Stein 1989). It is reasoned that emergency patients might bypass community hospitals in favor of a trauma center (Larkin 1989:24; Garza 1990). There is some evidence that the designation creates a “halo effect” implying to some potential patients that the hospital has been found to be a center of excellence in one area, and may be in other areas as well. The flip side is the negative image of the hospital that many (perspective patients) maintain, since they believe that trauma centers treat primarily drug-related patients, gang members and homeless persons (Narad & Smiley 1992:564).
CHAPTER 3

METHODOLOGY

Data for this thesis was derived from two primary sources: secondary data analysis and face-to-face and telephone interviews.

A. SECONDARY DATA SOURCES

Much of the secondary data on UMC and its relationship to crime and violence came primarily from governmental publications. Hospitals in Nevada are required to file reports to the Nevada State Health Department on a wide variety of matters. The Nevada Annual Trauma Report and the Fiscal Year End Summary Utilization Report published by the Department of Human Resources of the Nevada State Health Department, from the years 1992 to 1996 provided much of the UMC statistical data. Incident report data from the UMC security department was furnished by the security director. Additional hospital fiscal data was provided by the UMC controllers office.

B. INTERVIEWS

Human subject data were gathered during private and confidential interviews. A loosely followed interview guide was utilized (see appendix B). While spontaneous conversation with interviewees was the ultimate goal, it was essential to
cover a predetermined set of topics for the sake of consistency. Question specific probes were designed to touch upon a number of issues with each subject. The specific issues included in the interview guide focused on the subject's on-the-job experience with: crime, violence, gangs, and safety issues. The subject's attitudes and opinions regarding the various types of patients they treat were also explored.

Since questionnaire items can be biased negatively or positively (Babbie 1990:131), the researcher attempted to keep the questions and probes as simple, straightforward and neutral as possible. By attempting to triangulate data sources (Miles & Huberman 1994:263) he believes that quality data was valid and reliable. When one interviewee described something unique, and to that point unmentioned by other subjects, the researcher would incorporate that topic into the future interviews. While that tactic enabled the interviews to continually evolve, due to time and agreement constraints the author was not able to return and re-interview previously interviewed subjects.

Certain ethical issues in human subject interviews arose. First and foremost, the author's responsibility for protecting the anonymity of his subjects was paramount. In addition to assuring potential subjects of complete confidentiality, the author was careful not to place the subjects in any positions that might be compromising. If the research would discover anything that, upon release, could potentially harm the subject the researcher was careful to additionally disguise the subject's identity. The author was extremely careful not to bring harm to the hospital or any of his subjects.
The author began his field research with an exploratory attitude to determine its feasibility. This process began when he applied for permission from the University of Nevada, Las Vegas's "Human Subjects" Review Board (see appendix A). After receiving authorization from the university to conduct research interviews, he contacted the public relations department at the University Medical Center. During this initial interview he described the nature of the project and what he hoped to ascertain from the research. After receiving a genuinely warm reception from the director of public relations towards this research project he was introduced to the department of trauma services.

The researcher's initial goal was to obtain maximum access to the hospital and staff, which would allow ample time to interview and observe several different hospital employees. Over the next two months the author worked his way up the trauma services chain of command at UMC. Unfortunately access to the trauma unit and its personnel during their working hours was denied.

Nevertheless, the author's enthusiasm to continue with the project remained. Through personal friendships with people in the medical field, this researcher was able to contact two nurses who worked in two different critical care units at UMC. After explaining this research project (and problem) both nurses (not known to each other) agreed not only to be interviewed, but to act as "gatekeepers" (Berg:1995:107) and assist him in contacting other critical care nurses. Because of these new time and access constraints, the author believed it was now necessary to limit the scope of the study to the opinions and impressions of nurses. While the initial strategy included interviews with physicians and a broader group of hospital employees, this minor
setback in no way nullified this study's worth. Nurses are the predominant employee
group at UMC (Fiscal Year End Summary Report 1995) and their presence is
essential throughout the hospital. Limiting the scope of the medical staff interviews
exclusively to nurses was not a disadvantage and in fact may have provided additional
focus. Through these two subjects the author was able to access, snowball style (Berg
1995) seven additional nurses from the critical care units, and one non-critical care
floor nurse. While not a representative cross section of UMC nurses, this small
sample is capable of providing accurate and useful information regarding the critical
care nurse's experiences with crime and violence. Critical care nurses from the
following units were interviewed: the trauma E.D., general E.D., trauma Intensive
Care Unit (ICU), neurological ICU, and medical ICU.

C. SAMPLING PROCEDURES

As an exploratory study (Babbie 1990:53) no attempt was made to select a
representative sample of nurses. Rather the nurses interviewed were encouraged to
speak freely about their views and attitudes towards crime and violence. It is
important to note that as an exploratory study this paper is unable to categorically
satisfy all the aforementioned research questions. Nevertheless, this study does raise
new questions, which hopefully can be followed up in a more detailed and controlled
study.

A pilot interview was first conducted. This sample interview was conducted
with two nurses at a different Clark County hospital. The subjects indicated to the
researcher that they basically enjoyed the interview. They expressed interest in the
questions and the subject. A few format and content suggestions were offered and subsequently incorporated into the study.

The interviews with nurses took an average of about thirty minutes. Interviews were conducted at various locations including: two different Starbucks Coffee Shops, restaurants, bars and the hospital's cafeteria. Two interviews were held over the phone. The shortest interview was approximately fifteen minutes. The longest interview took just over one hour. During this time the author took extensive notes. Following the interviews he re-wrote his notes in their entirety, substituting pseudonyms for the subject's real names. Interviews with the UMC director of security: four security officers and two Las Metropolitan Police Department officers who were assigned to UMC were conducted. These interviews took place at the hospital, when it was convenient for the subjects, as not to interfere with their jobs.

Following the completion of the nursing (N=10) and security department (N=5) interviews, the researcher examined certain job-specific questions and the subject's responses. Taking into consideration the small sample, the author was able to quantify certain distinctive findings.

The researcher assured the subjects that their responses would be held in the strictest of confidence. He also assumed the expenses when the interviews were conducted in food or drinking establishments. When the interviews were conducted over the phone, the author placed the call.
CHAPTER 4

THE UNIVERSITY MEDICAL CENTER

A. UMC HISTORY

The hospital now known as the University Medical Center opened in 1931, before the cities of Boulder City, North Las Vegas or Henderson even existed. At first, the fledgling hospital contained just twenty beds and was staffed by one doctor and one nurse (Anderson 1985).

During the Hoover Dam’s construction, Las Vegas's population began its boom. As the need arose, the small hospital, renamed the Clark County Indigent Hospital grew. As the demand for medical care continued to increase, the hospital began receiving paying patients as well as the indigent. In 1940, the hospital’s first board of trustees was elected and, in an effort to accurately reflect its new mission, changed its name to the Clark County General Hospital.

Demands on the hospital continued to outpace its growth and by 1943 the hospital’s ownership was transferred to the Federal Works Administration. The FWA in turn spent nearly $450,000 on new construction for the hospital. At the conclusion of World II. Clark County bought the hospital back from the federal government for $182,000. (Pugh 1996). By the mid 1960s, the Southern Nevada Memorial Hospital (as it was now called) had grown to include the three story circular wing, an outpatient building and in 1968 a burn unit. In 1978 the six story medical education
center was built with a $4.5 million dollar federal grant. The seven story patient
tower was completed in 1979 with the addition of a new obstetrics unit and an
enlarged burn care unit. In 1986, the hospital’s name was again changed. to the
University Medical Center of Southern Nevada to better reflect its role as a teaching
institution and a medical center offering complete care (Coughlin 1986).

Prior to the University Medical Center obtaining its trauma center designation
in 1988, the majority of the gunshot and stab wound victims in the Las Vegas area
were being transported to UMC. This occurred partly due to UMC’s proximity to
North Las Vegas, the location of most of the area’s gangs, but also because of UMC’s
long history of treating poor, uninsured, and indigent people. As the nationwide push
towards improving trauma care continued, it was the University Medical Center’s
medical staff who pushed for the trauma center designation. “We were seeing most of
the trauma cases anyway,” one physician stated. “Since we were getting pretty good
at it [trauma] it seemed logical to put in for the designation.”

Initially the trauma center was part of the main emergency department. In
1990, two years following the official designation, construction of the free standing
trauma and pediatric center was completed.

B. UMC TODAY

Today, the University Medical Center is a very different organization than its
predecessor. Presently UMC is a bustling metropolitan medical center. Located
between West Charleston Boulevard and Goldring Avenue (South and North); and
Shadow Lane and Rancho Drive (East and West), encompassing three square blocks
are the four primary buildings that comprise the University Medical Center. In addition to having the busiest E.D. in Nevada, UMC's trauma center is fully staffed, 24 hours a day, 365 days a year with highly trained and skilled personnel. In addition to trauma center nurses and technicians, trauma team physicians and specialists are also on site 24 hours a day. A CAT Scan and angioplasty suite are available at all times, and a surgical team with an operating room (O.R.) is standing by. Following surgery, victims of trauma recover in UMC's specialized trauma intensive care unit (ICU).

In 1995, there were 647 registered nurses, 73 licensed practical nurses and 87 aides and orderlies employed at UMC (see Table 1).

### Table 1

<table>
<thead>
<tr>
<th></th>
<th>RNs</th>
<th>LPNs</th>
<th>TOTAL UMC STAFF</th>
<th>% NURSING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>528</td>
<td>96</td>
<td>2,187</td>
<td>29%*</td>
</tr>
<tr>
<td>1993</td>
<td>579</td>
<td>81</td>
<td>2,273</td>
<td>29%</td>
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<td>1994</td>
<td>605</td>
<td>77</td>
<td>2,224</td>
<td>31%</td>
</tr>
<tr>
<td>1995</td>
<td>647</td>
<td>73</td>
<td>2,259</td>
<td>32%</td>
</tr>
</tbody>
</table>

RNs: Registered Nurses  
LPNs: Licensed Practical Nurses

* All % nursing figures are rounded to nearest percent.

Those twenty beds, in 1931 have grown into a health care facility that had 19,822 admissions in 1995, resulting in an average daily census of 351 inpatients (Fiscal Year End Summary Report 1995). These admissions, while not the most for any Clark County hospital, are for the most part, the “sickest” of the Clark County patients. Using the only determinant available, average length of inpatient stay, UMC consistently treats patients who require longer hospitalizations (see Table 2).

Table 2

AVERAGE DAILY LENGTH OF INPATIENT STAY IN CLARK COUNTY HOSPITALS

<table>
<thead>
<tr>
<th>Year</th>
<th>UMC</th>
<th>SUNRISE</th>
<th>DESERT SPRINGS</th>
<th>ST. MARY’S REGIONAL</th>
<th>WASHOE MED CTR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>7.0*</td>
<td>6.5</td>
<td>5.8</td>
<td>5.5</td>
<td>5.8</td>
</tr>
<tr>
<td>1993</td>
<td>6.4</td>
<td>6.0</td>
<td>5.7</td>
<td>5.5</td>
<td>5.7</td>
</tr>
<tr>
<td>1994</td>
<td>6.1</td>
<td>5.7</td>
<td>5.7</td>
<td>5.4</td>
<td>5.5</td>
</tr>
<tr>
<td>1995</td>
<td>6.5</td>
<td>5.3</td>
<td>5.5</td>
<td>5.4</td>
<td>5.2</td>
</tr>
</tbody>
</table>

* All daily figures are rounded to nearest tenth of day.

It is interesting to note that the average inpatient stay for all Clark County hospitals is declining. Managed healthcare and subtle pressures on the staff to "move em out" may be responsible. The significant increase in the number of patients arriving at the hospital may account for additional nursing stress.

UMC's emergency department is the most active E.D. in Clark County receiving over 90,000 visits in 1995 (see Table 3). The second busiest emergency department in Clark County is Sunrise Hospital with nearly 50,000 E.D. visits. Those annual E.D. visits average out to nearly 250 patients a day (Table 4). Those visits breakdown to over 10 patients an hour, or one patient every six minutes. The 90,056 UMC emergency department visits reflects an 11% increase in E.D. visits since 1992.

Table 3

NUMBER OF YEARLY EMERGENCY DEPARTMENT VISITS
CLARK COUNTY HOSPITALS

<table>
<thead>
<tr>
<th></th>
<th>UMC</th>
<th>SUNRISE</th>
<th>DESERT SPRINGS</th>
<th>ST. ROSE DOMINICAN</th>
</tr>
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<tbody>
<tr>
<td>1992</td>
<td>80.767</td>
<td>49.369</td>
<td>31.815</td>
<td>19,209</td>
</tr>
<tr>
<td>1993</td>
<td>84.499</td>
<td>54.622</td>
<td>36,848</td>
<td>22,008</td>
</tr>
<tr>
<td>1994</td>
<td>89,275</td>
<td>59,150</td>
<td>39,572</td>
<td>22,225</td>
</tr>
<tr>
<td>1995</td>
<td>90,056</td>
<td>64,854</td>
<td>31,147</td>
<td>22,641</td>
</tr>
</tbody>
</table>

Table 4

DAILY AVERAGE NUMBER OF E.D. VISITS
CLARK COUNTY HOSPITALS

<table>
<thead>
<tr>
<th></th>
<th>UMC</th>
<th>SUNRISE</th>
<th>DESERT SPRINGS</th>
<th>ST. ROSE DOMINICAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>221*</td>
<td>135</td>
<td>87</td>
<td>52</td>
</tr>
<tr>
<td>1993</td>
<td>232</td>
<td>150</td>
<td>101</td>
<td>60</td>
</tr>
<tr>
<td>1994</td>
<td>245</td>
<td>162</td>
<td>108</td>
<td>61</td>
</tr>
<tr>
<td>1995</td>
<td>247</td>
<td>178</td>
<td>85</td>
<td>62</td>
</tr>
</tbody>
</table>

* All daily figures are rounded to nearest whole number


UMC's trauma department, while not nearly as frequented as the general emergency department, treats the county's most seriously injured patients. In 1994 (the most recent year official Nevada State trauma data is available), UMC received 3,711 serious trauma cases via police car, ambulance, private vehicle or helicopter (see table #5).
<table>
<thead>
<tr>
<th>Year</th>
<th>TOTAL #</th>
<th>PENETRATING #</th>
<th>VEHICULAR #</th>
<th>FALLS/ETC #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>1,336</td>
<td>279</td>
<td>717</td>
<td>340</td>
</tr>
<tr>
<td>1990</td>
<td>2,423</td>
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<td>2,696</td>
<td>597</td>
<td>1,423</td>
<td>676</td>
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<td>2,649</td>
<td>575</td>
<td>1,454</td>
<td>620</td>
</tr>
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<td>1993</td>
<td>3,458</td>
<td>780</td>
<td>1,948</td>
<td>730</td>
</tr>
<tr>
<td>1994</td>
<td>3,711</td>
<td>863</td>
<td>2,057</td>
<td>791</td>
</tr>
</tbody>
</table>

* All percentages rounded to nearest percent.


Of these 3,711 victims the majority (2,848 or 77%) were categorized as blunt trauma. These blunt trauma patients were most frequently injured in motor vehicle accidents (MVAs). In fact, 55% of all trauma center patients in 1994 were the result of MVAs. Twenty-one percent of the victims received their injuries in falls or miscellaneous accidents. The remaining 863 trauma center patients (23%) were victims of penetrating trauma. Penetrating trauma is the result of either stabbing or...
gunshot wounds (GSWs). It is significant to note that while all trauma patient categories have increased dramatically, the percentage of penetrating injuries has increased 209% while vehicular related injuries increased 187% and falls etc. increased 133%.

C. ECONOMICS

To say that the University Medical Center has had a tumultuous economic history would be an understatement. As the only public hospital in Clark County, UMC is obligated to treat and admit all patients requiring medical care. In the cases of non-paying patients who arrive on the doorsteps of private hospitals, these patients are [supposedly] treated in the emergency department, but without insurance or the ability to pay, are then transferred to UMC for admission. To assist with indigent care, in 1996, the State of Nevada provided UMC with $15 million dollars. At the same time, Clark County contributed $7.1 million dollars (Schweers 1996:8A). One additional subsidy is a Clark County property tax that raises approximately $4.2 million dollars for emergency room assistance (ERA Funds). Ironically, without subsidies, UMC for the fiscal year ending June 30th, 1996, still showed a small profit of $53,857 (see Table 6).
Table 6

UMC REVENUES: WITH AND WITHOUT OUTSIDE INCOME AND GOVERNMENT SUBSIDIES

<table>
<thead>
<tr>
<th>YEAR</th>
<th>INCOME (LOSS) FROM OPERATIONS*</th>
<th>PROFIT (LOSS) OF ALL REVENUE OVER EXPENSES**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>+1,050,698</td>
<td>+6,613,364</td>
</tr>
<tr>
<td>1993</td>
<td>+1,887,952</td>
<td>+5,590,487</td>
</tr>
<tr>
<td>1994</td>
<td>(22,293,282)</td>
<td>(9,552,069)</td>
</tr>
<tr>
<td>1995</td>
<td>(17,071,557)</td>
<td>(827,394)</td>
</tr>
<tr>
<td>1996</td>
<td>+53,857</td>
<td>+21,540,819</td>
</tr>
</tbody>
</table>

* Does not include outside income, Nevada, or Clark County subsidies.
** Including outside incomes, Nevada and Clark County subsidies.

In 1994 and 1995, including subsidies, UMC still posted losses totaling over $10 million dollars. Though in 1992 and 1993, profits of over a million dollars, prior to [smaller] government subsidies, were recorded each year. The dramatic turnaround is often credited to William Hale, UMC's chief executive officer. While Hale gives public credit to the County Commission for its leadership and support, and his UMC staff for their energy and dedication; it was widely reported that Hale’s pursuit of contracts with managed [health] care corporations and his success advertising for paying patients was the key to UMC’s recent fiscal rebound (Schweers 1996).
As the only trauma center in Southern Nevada, trauma patients of all types are transported to UMC as per protocol by the Mercy Ambulance Company, Henderson and Boulder City Fire Departments. Many people in the higher economic strata may view the University Medical Center as the hospital of last resort, and would not go there willingly in a medical emergency (Schweers 1996). However, they will find themselves transported there after sustaining traumatic injuries. Of the 3,711 trauma patients UMC received in 1994, 23 percent (or 863) of those were patients who were victims of firearm or stabbing injuries. The other 77 percent of UMC’s trauma patients were either victims of motor vehicle accidents (2,057 or 55 percent) or falls and other non-categorized injuries (791 or 21 percent); (Table 5); (Annual Trauma Report 1994:54).

While these firearm and stabbing victims are extremely expensive to treat and most victims are non or under-insured (Headden 1996:34; Skolnick 1992:2994; Wagner 1990:23); in Clark County, they are outnumbered by automobile and other accident victims, who for the most part are insured. Hospitals may lose money treating the penetrating trauma victims, but these costs can be offset if the majority of the trauma patients have insurance. It is reported that a blunt trauma/penetrating trauma injury ratio of 4:1 has been defined as a healthy mix financially for the viability of most trauma programs (Laskowski-Jones 1993:123). UMC currently maintains the ratio of approximately 4.5:1 of blunt to penetrating injury patients. Yet the UMC trauma center is not making a financial profit. This report does not contain specific breakdowns of reimbursement rates for various patient categories (blunt/penetrating), but overall profit (loss) figures are available.
Tables 7, 8 and 9 show the fiscal breakdown of UMC’s emergency department and trauma service since 1994.

Table 7

1994 EMERGENCY AND TRAUMA DEPARTMENT FINANCIAL BREAKDOWNS

<table>
<thead>
<tr>
<th></th>
<th>EMERGENCY</th>
<th>TRAUMA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTUAL COST</td>
<td>$14,947,155</td>
<td>$36,704,943</td>
<td>$51,652,098</td>
</tr>
<tr>
<td>TO PROVIDE CARE:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHAT UMC CHARGED:</td>
<td>31,467,694</td>
<td>49,938,698</td>
<td>81,406,392</td>
</tr>
<tr>
<td>WHAT UMC EXPECTED TO COLLECT:</td>
<td>11,583,727</td>
<td>29,320,633</td>
<td>40,904,360</td>
</tr>
<tr>
<td>OPERATING PROFIT/LOSS:</td>
<td>-3,363,428</td>
<td>-7,384,310</td>
<td>-10,747,738</td>
</tr>
</tbody>
</table>

Source: UMC Controller’s Office, Fiscal Services.
### Table 8

**1995 EMERGENCY AND TRAUMA DEPARTMENT FINANCIAL BREAKDOWNS**

<table>
<thead>
<tr>
<th></th>
<th>EMERGENCY</th>
<th>TRAUMA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTUAL COST</td>
<td>$12,027,241</td>
<td>$48,920,264</td>
<td>$60,947,505</td>
</tr>
<tr>
<td>TO PROVIDE CARE:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHAT UMC CHARGED:</td>
<td>35,167,371</td>
<td>61,073,988</td>
<td>96,241,359</td>
</tr>
<tr>
<td>WHAT UMC EXPECTED TO COLLECT:</td>
<td>12,629,487</td>
<td>34,480,354</td>
<td>47,109,841</td>
</tr>
<tr>
<td>OPERATING PROFIT/LOSS:</td>
<td>+602,246</td>
<td>-14,439,910</td>
<td>-13,837,664</td>
</tr>
</tbody>
</table>

Source: UMC Controller’s Office, Fiscal Services.

### Table 9

**1996 EMERGENCY AND TRAUMA DEPARTMENT FINANCIAL BREAKDOWNS**

<table>
<thead>
<tr>
<th></th>
<th>EMERGENCY</th>
<th>TRAUMA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTUAL COST</td>
<td>$12,802,627</td>
<td>$59,451,668</td>
<td>$72,254,295</td>
</tr>
<tr>
<td>TO PROVIDE CARE:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHAT UMC CHARGED:</td>
<td>39,151,764</td>
<td>68,571,705</td>
<td>107,723,469</td>
</tr>
<tr>
<td>WHAT UMC EXPECTED TO COLLECT:</td>
<td>14,027,666</td>
<td>36,055,293</td>
<td>50,082,959</td>
</tr>
<tr>
<td>OPERATING PROFIT/LOSS:</td>
<td>+1,225,039</td>
<td>-23,396,375</td>
<td>-22,171,336</td>
</tr>
</tbody>
</table>

Source: UMC Controller’s Office, Fiscal Services.
The emergency department has rebounded from a $3.3 million loss in 1994 to show a profit of $1.2 million for 1996. In contrast, the trauma service has deficits increasing from $10.7 million for 1994 to $22.1 million for 1996.

An interesting analysis of cost shifting efforts from 1994 to 1996 reveals the emergency department increased its WHAT UMC CHARGED dramatically compared to ACTUAL COST TO PROVIDE CARE (see Table 10). In 1994, the emergency department via cost-shifting billed patients 110% above the actual cost to provide their care. These cost-shifting efforts still resulted in a $3.3 million dollar loss. However in 1995 and 1996, the emergency department billed patients 190% and 205% respectively over the actual cost to provide care. These cost-shifting efforts resulted in a $602 thousand and $1.2 million net surplus respectively for 1995 and 1996.

On the other hand, a detailed analysis of UMC's trauma center charges (WHAT UMC CHARGED) versus actual costs of providing care (ACTUAL COST TO PROVIDE CARE), for the 1994, 1995, and 1996 years show a decreasing trend of cost-shifting (see Table 10). In 1994 the trauma service charged 36% over the actual costs of providing care. This overcharge still resulted in a net loss of $7.3 million. But for some inexplicable reason the trauma center did not attempt to increase their cost shifting percentages. Instead, they decreased their cost-shifting overcharges to 24% in 1995, and to 15% in 1996. This resulted in even more significant net losses of $14.4 and $23.3 million for 1995 and 1996 years respectively.
Table 10

EMERGENCY DEPARTMENT AND TRAUMA CENTER
COST-SHIFTING % vs. PROFIT 1994-1996

<table>
<thead>
<tr>
<th></th>
<th>EMERGENCY DEPARTMENT</th>
<th>TRAUMA CENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OVERCHARGE %</td>
<td>NET (LOSS)/PROFIT</td>
</tr>
<tr>
<td>1994</td>
<td>110%*</td>
<td>$(3,363,428)</td>
</tr>
<tr>
<td>1995</td>
<td>190%</td>
<td>+ 602,246</td>
</tr>
<tr>
<td>1996</td>
<td>205%</td>
<td>+1,225,039</td>
</tr>
</tbody>
</table>

* All percentages are rounded to nearest whole number.


As Table 11 shows, the emergency department and the trauma center’s combined accrued losses from 1994 to 1996 have increased from $10.7 million to $22.1 million (106%). During the same period, however, UMC’s hospital-wide losses have been reduced and a small profit has been identified.
Table 11
COMPARISON OF OVERALL HOSPITAL REVENUES VERSUS TRAUMA CENTER AND EMERGENCY DEPARTMENT REVENUES 1994-1996

<table>
<thead>
<tr>
<th></th>
<th>OVERALL HOSPITAL INCOME (LOSS) FROM OPERATIONS*</th>
<th>EMERGENCY DEPARTMENT AND TRAUMA CENTER INCOME (LOSS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>(22,293,282)</td>
<td>(10,747,738)</td>
</tr>
<tr>
<td>1995</td>
<td>(17,071,557)</td>
<td>(13,837,664)</td>
</tr>
<tr>
<td>1996</td>
<td>+ 53,857</td>
<td>(22,171,336)</td>
</tr>
</tbody>
</table>

* Does not include outside income, Nevada or Clark County subsidies.
Sources: UMC Controller's office, Fiscal Services.

The economic cost of violent crime is staggering - as are the costs resulting from automobile accidents, heart disease and cancer. While UMC's trauma center is losing a considerable amount of money treating patients suffering from gunshot and stab injuries, in addition to victims from motor vehicle accidents; the emergency department does not seem to be as negatively affected. Ultimately, the trauma center's financial deficit does not seem to be adversely affecting the hospital's overall financial recovery.

It would be interesting to reexamine the University Medical Center, if, for instance. UMC ever lost its exclusive trauma center monopoly. Even though the trauma center is losing considerable amounts of money, its financial status could be reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
even worse. Many of the more cost efficient and profitable motor vehicle injury patients would now have a choice of hospital selection. The cost inefficient patients (shooting and stabbings) would still be transported to UMC by virtue of North Las Vegas being in a closer proximity to UMC; while the more profitable motor vehicle accident patients may be ultimately transported elsewhere.

D. THE SECURITY DEPARTMENT

The UMC security staff is not only responsible for the four main buildings on campus, but also for the nine buildings that comprise the outpatient clinics, physician offices and QuickCare centers. Presently there are 37 full and part time security officers employed. The department’s current budget is $1,613,294 a year. Table 12 shows an increasing budget from 1994, though security chief Mike Parker informs this researcher that he is being instructed to cut 10% from his budget for the upcoming fiscal year.

Table 12

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>$1,333,602</td>
</tr>
<tr>
<td>1995</td>
<td>$1,573,896</td>
</tr>
<tr>
<td>1996</td>
<td>$1,613,294</td>
</tr>
</tbody>
</table>

Source: UMC Controller’s Office, Fiscal Services.
While UMC does not have any formal security checkpoints or metal detectors, Parker stresses that most of the high pressure areas (such as the E.D.'s; Trauma Recess; and ICUs) have two doors and keypad coded locks. As for the types of patients that Parker believes pose the greatest physical threat to the staff's safety he believes they are, "the mental patients, drug induced patients and the alcoholics." A new security officer, with about one year of experience agrees, "It's a draw. The drug O.D.'s and the drunks are bad," he says pausing for a moment, "but the mental patients might be the most dangerous."

Many of the problems with visitors to the hospital, specifically in the E.D., revolve around extended waiting times. As a more experienced officer elaborated, "it could be the wait. Or sometimes they're unhappy with the way their friend or family member is being treated." It is interesting to note that there is not as much trouble in the Recess waiting room as there is with the general emergency department. And not nearly as much trouble with the patients in Recess. As the young security officer explained, "most of the trouble takes place in the main E.D. Trauma doesn't get as many problems because the patients there, are really legitimately hurt. They usually want or need help."

Even though just about every casino, supermarket and 7-11 has armed security officers, Parker is proud that his staff does not carry guns.

We're a health care facility. And thankfully, we haven't gotten to the point where we're a police force. We try to use passive means to assure safety. We have a formal non-violent crisis intervention training program. The only weapon we carry is pepper foam. That's like pepper spray, but it doesn't get into the ventilation system when it's used. If it's necessary, someone comes into the hospital with a weapon, for example, we cordon off the area and call Metro.
Not all of UMC’s security officers share Parker’s views. One officer expressed his reservations,

I think we need more protection. People see us and know we don’t carry weapons. Unless you’re a big guy like myself, many people think you can just talk over or not obey the officer. I think we should be better armed, maybe even have a canine unit.

One older security officer forcefully stressed, “without Metro being here, we’d all be carrying weapons.”

The Las Vegas Metropolitan Police Department (Metro) is located nearby. In fact, a Metro officer is on duty twenty-four hours a day at UMC. The officer is usually stationed at the entrance to the adult emergency department. A Metro substation, complete with a cell, had been physically inside the hospital at one time.

But when the E.D. was expanded five years ago the officer and substation were removed. Following a near riot between rival gang members outside the hospital three summers ago, UMC agreed to pay the salary of the Metro detail, and the officers were reassigned shortly thereafter. The cost for the Metro detail comes out of the security department budget - roughly $37,000 a quarter, or about $148,000 a year; just over 9% of the overall annual security department budget.

One Metro officer on duty explained,

Metros return wasn’t due specifically to one incident. It was a combination of events. The growth of the town, increases in crime and drive-bys [shootings], and a high number of non-reported [to the police] batteries that were coming to the hospital. The hospital then had to deal with them. Usually by calling us.
According to the Federal Bureau of Investigation's Uniformed Crime Reports, the number of aggravated assaults in the Las Vegas Metropolitan Police Department Jurisdiction increased nearly 170% from 1990 to 1994 (see table 13).

Table 13

NUMBER OF AGGRAVATED ASSAULTS REPORTED TO THE POLICE 1990-1994

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>1,831</td>
</tr>
<tr>
<td>1991</td>
<td>1,932</td>
</tr>
<tr>
<td>1992</td>
<td>1,926</td>
</tr>
<tr>
<td>1993</td>
<td>3,183</td>
</tr>
<tr>
<td>1994</td>
<td>4,934</td>
</tr>
</tbody>
</table>


Current Metro duties include providing security back-up, making arrests if required, and taking whatever official police reports are necessary. "The Metro officer will go anywhere in the hospital that the police need to be involved."

At one time four additional hospital security officers employed by the hospital, but their positions were cut when the Metro police officer was permanently reassigned to UMC. According to Parker, "we lost those officers when the Metro officer came back. And as great as it is to have the Metro guy right downstairs, he doesn't do security work. He doesn't really patrol or do security checks."

When asked about optimum staffing, Parker is mostly content,

if I could have whatever staff I could have.... hmmm... all I really want is my four full time officers back. If I could get those guys back I could be more proactive. I'd like to have one officer on duty at all times just patrol-
ling. Like a neighborhood cop. Roving to all the nurses stations, chatting for a few minutes, getting to know the people.

This roving and chatting is what one senior security officer describes as the security department's main function, "though we write a lot of reports, mainly for property investigations, the functions we do most is keeping people going the right way, information and crowd control."

Parker believes that there is a perception problem with his security department, which is why he very much wants the replaced officers back.

As it stands now, the officers patrol. But the staff doesn't really think that we do. The nurses don't feel we provide the service. But the nurses don't really see us. We're there - but not seen. We've become part of the background. Which is why it's important to get that extra officer. This way he'll be able to stop and interact with the staff.

In addition to the extra security officers, Parker would like to have upgrades for some of his older equipment. Radios, computers, alarm systems, cameras and panic buttons for all locations are on the chief's wish list. But with impending budget cuts looming, Parker is not sure he will be able to purchase them.

There is this silent alarm locator system that I would love to get. The system consists of a beeper that each member of the staff would carry on their person. In an emergency, the staff could activate the pager and it would send a distress message to the dispatch center, alerting an officer to the location of the person requesting help.

There are no formal policies on workplace assaults or dangerous situations. While some written policies are in the works, security has a number of unwritten policies. It is commonly known throughout the security department that if someone intentionally assaults a staff member, it's considered assault and they call Metro. According to Parker.
we used to be more forgiving about some of these assaults a few years ago. If the person who assaulted the staff member came back, and apologized, he was drunk, upset, no one got too badly hurt, sometimes we'd let it slide. But since we've had so many more incidents and the place has gotten so large, we've been unable to do that anymore.

Prior to 1994 (Parker becoming chief) the security records system was very different, and as such not an accurate representation of security activities. Table 14 is a breakdown of the number of incident reports written by UMC security officers from 1994 to 1996. Table 15 reflects a division of security incident reports from 1994 to 1996 analyzed by type and percentage. While not representative of all security activities, a clearer sense of roles and responsibilities are provided. It is important to note, however, that many official job responsibilities and actions are not listed in this table. In fact many incident reports may never be written. For example, if a security officer is notified of a disturbance on the fourth floor of the hospital, but by the time the officer arrives the situation is under control and not requiring further security involvement, the officer will simply note in his personal log book his response. A formal incident report of the request for security will not be filed.
Table 14

YEARLY TOTALS OF INCIDENT REPORTS FOR THE
UMC SECURITY DEPARTMENT 1994-1996

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>INJURY: (pt, visitor, employee)</td>
<td>21</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>ASSAULTS ON STAFF (1995, 1996 only)</td>
<td>8</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>BURGLARY (building, auto)</td>
<td>6</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>VEHICLE ACCIDENT</td>
<td>20</td>
<td>25</td>
<td>13</td>
</tr>
<tr>
<td>TOWED VEHICLE</td>
<td>20</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>DRUG/ALCOHOL</td>
<td>10</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>PROPERTY DAMAGE</td>
<td>5</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>SPECIALIZED INFO ONLY</td>
<td>26</td>
<td>42</td>
<td>27</td>
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<tr>
<td>DISTURBANCES (pt, visitor, employee)</td>
<td>27</td>
<td>29</td>
<td>22</td>
</tr>
<tr>
<td>MISSING PROPERTY PERSONAL</td>
<td>93</td>
<td>91</td>
<td>72</td>
</tr>
<tr>
<td>MISSING PROPERTY FACILITY</td>
<td>35</td>
<td>37</td>
<td>39</td>
</tr>
<tr>
<td>ROBBERY (1995, 1996 only)</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>VANDALISM (vehicles)</td>
<td>16</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>SUICIDE</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>THREAT/ BOMB</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>THREAT/ OTHER</td>
<td>9</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>TRESPASSING</td>
<td>22</td>
<td>32</td>
<td>35</td>
</tr>
<tr>
<td>VANDALISM (facility)</td>
<td>19</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>WEAPONS POSSESSION</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>SECURITY ALARMS</td>
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<td>1</td>
<td>0</td>
</tr>
<tr>
<td>SECURITY OPERATIONS (1995, 1996 only)</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>SECURITY OBSERVATIONS (1995, 1996 only)</td>
<td>15</td>
<td>11</td>
<td></td>
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<tr>
<td>COMPLAINTS</td>
<td>5</td>
<td>9</td>
<td>4</td>
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<tr>
<td>FIRES</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>PROCEDURE/POLICY VIOLATIONS</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>BREAKING/ENTERING</td>
<td>16</td>
<td>7</td>
<td>16</td>
</tr>
</tbody>
</table>

TOTAL # SECURITY REPORTS: 382 417 363

Source: UMC Security Department Figures.
Table 15
PERCENTAGE OF INCIDENT REPORTS FOR THE UMC SECURITY DEPARTMENT BY TYPE IN 1994-1996

<table>
<thead>
<tr>
<th>TYPE OF INCIDENT REPORT</th>
<th>PERCENTAGE OF REPORTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MISSING PROPERTY PERSONAL</td>
<td>22%*</td>
</tr>
<tr>
<td>MISSING PROPERTY FACILITY</td>
<td>10%</td>
</tr>
<tr>
<td>TRESPASSING</td>
<td>8%</td>
</tr>
<tr>
<td>SPECIALIZED INFO ONLY</td>
<td>8%</td>
</tr>
<tr>
<td>DISTURBANCES</td>
<td>7%</td>
</tr>
<tr>
<td>INJURIES</td>
<td>5%</td>
</tr>
<tr>
<td>TOWED VEHICLES</td>
<td>4%</td>
</tr>
<tr>
<td>VEHICLE ACCIDENT</td>
<td>5%</td>
</tr>
<tr>
<td>VEHICLE VANDALISM</td>
<td>3%</td>
</tr>
<tr>
<td>BREAKING AND ENTERING</td>
<td>4%</td>
</tr>
<tr>
<td>PROPERTY DAMAGE</td>
<td>4%</td>
</tr>
<tr>
<td>THREAT/ OTHER</td>
<td>3%</td>
</tr>
<tr>
<td>ASSAULT ON STAFF</td>
<td>2%**</td>
</tr>
<tr>
<td>ALL OTHER REPORTS</td>
<td>17%</td>
</tr>
<tr>
<td>TOTAL % OF SECURITY REPORTS</td>
<td>100%</td>
</tr>
</tbody>
</table>

* All figures are rounded to nearest whole percent.
** Adjusted to reflect 1995 and 1996 years only.

Source: UMC Security Department Figures.

In 1995, there were 8 hospital staff members assaulted. 11 staff members were assaulted in 1996. Though assaults are obviously a concern, they are not the
The usual reason people get arrested at UMC. The most frequent charge resulting in an arrest is trespassing. According to one Metro officer,

usually the person refused a warning to leave the premises. We usually try to warn them first. Then we issue a citation [like a ticket]. But if the visitor gets too upset and begins creating a disturbance, and they still refuse to leave, then they get arrested.

Another non-written official policy which is common knowledge is the practice of not putting two different gang members in the same unit or ward. And while staff concerns about gang members frequently arise, Parker is not as concerned.

Gang people are not as much of a threat as most people think. We’ve had more incidents involving mental patients and drug/alcohol abusers. More security time and effort is spent with those patients, and not the gang members. Sometimes it’s tough to tell who the gang members are. Frequently people get stereotyped incorrectly. It could be a high-school kid, wearing baggy pants, or a funny hat, and he gets called a gang member.

Security department records confirm Parker’s beliefs. In fact, very few of the disturbances listed in Table 14 were gang related. Over the past three years only four of the listed seventy-eight disturbances reports filed were identified as gang related.

Another Metro officer who has worked the UMC post on and off for a couple of years adds,

sometimes there are gangs here. Tension between gangs occurs occasionally. Guys flashing signs, talking smack. Usually you tell the gang people you can send one representative or family member to the hospital. Or else we’ll come in with our gang unit. Sometimes the gang unit will come to the hospital on their own in an effort to ID new gang members.

While there have not been any reports of people following someone to UMC to finish them off in the ways Washington D.C. has recently experienced [D.C. Man Dies After Being Shot at SW Gas Station and Hospital (Constable 1996); D.C.]
Ambulance Shooting Intensifies Workers’ Fears (Pierre & Vogel 1996); Fatal Shooting in Hospital Emergency Room (NY Times 1996) most of the security and police personnel, while doubting that will happen here, acknowledges the possibility. Parker points out that Recess and E.D.'s are dual access (2 locked doors) and a security officer is stationed at both front doors. “Upstairs there may not be as many officers. So depending upon the situation we may put a security officer on that floor.”

One tactic the hospital uses to prevent such an occurrence is categorizing certain patients as NFP (not for publication). When a patient is NFPed, the hospital doesn’t release their name, use their real name on any written charts or documents, and screens visitors closely according to a predetermined list of acceptable guests. The NFP code is used quite frequently. Any victim of violence may have that label attached. Domestic abuse victims, sexual assault victims and gang members are often labeled NFP. “Anyone who we might think, or their family thinks, might be at additional risk can be NFP’ed.”

Another security tactic initiated four years ago, though not used as frequently as the NFP, is known as Lockdown. When the hospital is undergoing lockdown, all available security officers are assigned to guard all the entrances, physically lock certain units, escort staff to their cars, and prevent anyone not directly involved in patient care or administrative duties from entering the hospital. A discrete flashing red light mounted outside the trauma and pediatric center warns staff of a lockdown condition. According to Parker.

Lockdown is used only once a month or so. It’s more precautionary than necessary. A couple of summers ago it was more frequent than it is now. Once in a while, following a drive-by shooting, or gang shooting, we’ll
go on *Lockdown* for an hour or so. Just to see if anything develops. If nothing does, we'll rescind it.

While *Lockdowns* and escorting the staff to their cars are dramatic and scary, Parker downplays such events,

our biggest crime problem is an internal one. There isn't as much crime against the hospital (employees stealing hospital property), but crimes against persons. Someone steals a radio, or $10 from a room, or a patient. Personal stuff. Occasionally there are small groups of people who come into the hospital looking for easy access to stuff. They walk up and down halls, checking doors, desks. It becomes an opportunity thing. We're always going around telling staff to: lock their doors; put their purses in the back of a deep drawer; lock your desk. It's difficult to accurately determine the extent of this criminal activity, because frequently it isn't reported.

Without question more security reports are filed for missing personal property than any other category. Missing facility property usually runs a close second. In fact when one combines the missing personal property reports and missing facility property reports, for the past three years, one finds that nearly 32 percent of all incident reports filed are property related. In comparison, if you were to add up all the reports of disturbances, threats against persons, assaults, burglaries, robberies, weapons possession and breaking and entering, the combined totals would still barely top 15 percent of all reports. Incidents specifically involving vehicles (accidents on UMC property, towed vehicles and vandalism) accounted for 12 percent of all reports. Security operations, documenting injuries (not assaults), assisting visitors with specialized information, property vandalism and a host of other lesser known functions round out the remaining 39 percent of security reports.

The latest security activity just starting to be tracked (not included in the above listings), is the number of times security is requested by the medical staff to
restrain a patient. Restraining patients may be necessary for any number of reasons.

The patient may be disoriented by a medical condition such as Alzheimer's disease or strokes; medically unstable and requiring emergency care; under the influence of drugs or alcohol, or just plain violent. Table 16 shows the first trackable data on the number of patients restrained.

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<td><strong>Table 16</strong></td>
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<td><strong>NUMBER OF PATIENTS THE UMC SECURITY DEPARTMENT IS INVOLVED IN RESTRAINING</strong></td>
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<td><strong>DEC. 1996</strong></td>
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<td><strong>FEB. 1997</strong></td>
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Source: UMC Security Department figures.

One of Parker's biggest complaints is his inability to do thorough background checks on prospective hospital employees,

because of privacy laws we can only get access to felony convictions. Not misdemeanors, not felony arrests pleaded down to misdemeanors. We could have people working here with 10 or 15 arrests or misdemeanor convictions for petty theft and I don't get to know it.

Finally, Parker describes the trends in hospital security as if they were a pendulum.

it swings one way then another. People get very high on this or that concept, whether it be metal detectors or armed security officers, and for a while that's how things are done. Then it swings back, and people say we need to be kinder, gentler, more understanding, and that's the way it gets done for a while. It's a reflection of the community. Depending upon its mood.
E. THE NURSING STAFF

The nursing staff’s views of hospital safety issues clearly revolve around their day-to-day interactions with violent or potentially violent patients. Their experience treating large numbers of victims of violence also effects their outlooks. The following excerpts from staff interviews display the attitudes, experiences and concerns of the nurses who are exposed to the most serious, dangerous, and volatile hospital workplace environments - the critical care units. These units include the emergency department, trauma resuscitation unit, and intensive care units. The following five nurses are highlighted:

Cindy* has been a registered nurse for five years. She has worked at UMC for the past six years (one year as a licensed practical nurse). Cindy works day shifts and is assigned to the Neurological Intensive Care Unit (Neuro ICU), which is located on the third floor of the main hospital.

Gary has worked the day shift at UMC for the past three years. He has always worked in the trauma center which is located on the first floor of the trauma and pediatric building. The trauma E.D. is also called Recess, which is short for resuscitation.

Penny has also worked at UMC for the past three years. Her first two years were in the Trauma ICU. This past year Penny has been working the 3pm to 3am

* All names are fictitious.
shift in Recess.

Nina has been a nurse for seven years, but she has only been at UMC for the past six months. Nina works the 3am to 3pm shift and is assigned to the Trauma ICU, which is also on the first floor of the trauma and pediatric building. Previously, Nina worked in the emergency department of a trauma center in Texas.

Wendy has been a nurse for five years and has worked at UMC for the past four. At first, Wendy worked on a med/surg floor. For the past three years she has worked on the first floor of the main building, in the adult E.D. mostly on the night shift.

All of the nursing staff interviewed (N=10) reported being threatened by patients or visitors to the hospital in one manner or another.

"I've been threatened bunches of times by patients and visitors," says Penny.

"Threatened? Sure!," says Gary. He add, "I've also been punched, scratched, bitten. slammed up against the wall, things like that."

"Hell," says Wendy, "sometimes I think. Oh God, if one more drug addict grabs. shoves or spits at me, maybe I'll assault him."

These types of physical encounters have become so commonplace to the staff at UMC that most of the nurses don't even consider them assaults. Initially, Cindy admitted to being assaulted on the job only once. She was stabbed in the arm by a patient who had hidden a syringe in her pocket. After a probe asking whether she had ever been punched or hit Cindy answered, "oh yea! of course, many times." Being hit
or shoved by patients is so commonplace, that most of the time Cindy didn’t even consider those to be like real assaults.

There are no security check points or metal detectors at UMC. “I wish there were,” says Gary, “I’m sure the whole staff wishes there were.”

Weapons do enter UMC much to the dismay of the staff. Cindy elaborates, “security is supposed to confiscate weapons when they [patients] come through the E.D. But that doesn’t always happen. Another problem is that friends of patients occasionally bring weapons into the hospital for the patients.

Penny recalls treating a number of patients who rolled in the door with weapons.

one time these two guys rolled in at the same time. They had been fighting, I don’t know about what. One guy stabbed the other. And then the stabbed guy shot the stabber. By the time both got here they were pretty bad. They didn’t even realize we took their toys away from them.

For most of the staff, (9 of 10) the presence of patients or visitors with weapons is commonplace. Only Nina has not encountered patients with weapons but she is expecting that to happen eventually.

Every nurse interviewed (N=10) reported having to call for help numerous times since they’ve worked at UMC because of threats or actual violence against them. A basic pattern of coworker response develops. According to the nurses, the first line of defense is usually a good loud yell. Penny explains,

usually there are a lot of people around in Recess. And everyone is pretty quick to respond if you let out a yell. Other nurses and docs come running. The paramedics and firemen are great. They come running if you shout out. Then security shows up. Then Metro if you still need help.
Wendy agrees, “there are always people in the main E.D. I don’t think I’ve ever had a problem when a few people didn’t come over immediately.”

Calling for help is not as easy for all UMC nurses at all times. Cindy occasionally works by herself in the Neuro ICU and shouting might not bring help. Cindy has also reported to security a number of incidents regarding visitors to her unit who were carrying many types of weapons, guns included. Penny admits that she was more worried about her safety when she worked in the Trauma ICU, then now that she works in Recess,

"in the Recess area there are always a lot of security and police around. But in the back ICU areas, or upstairs on the floors, there’s less security. Less staff, less police and less traffic in general. If something would happen, I might not have been able to get help fast. And that used to worry me."

In addition to physically yelling for help, the staff can access security by other means. Calling security by phone is the most common way of accessing extra help. There are panic buttons located in a few of the sensitive areas of the hospital. The emergency room, main waiting room, pediatric emergency room, and psychiatric center are hard wired with panic buttons. The security department hopes to get the rest of the hospital wired eventually. The hospital’s phone system has a direct line to the security department and a special number, that when dialed, transmits the phone call directly to the security officer’s radio. But not a single nurse this researcher spoke with was aware of that option.

"The absence of official policies or written procedures for dealing with violent or dangerous persons is surprising. The security department claims that some policies"
are "in the works" but nothing currently exists. Which is interesting since most of the staff interviewed believed there were some sort of official policy. While nearly everyone thought there was a policy - "the hospital has policies for everything," - no one could recall anything specific from this supposed policy.

Possibly the most well known unofficial - official - policy is in the treatment of patients the staff perceives to be at additional risk. Gang members, for example, may be subject to retaliation or additional assault by rival gang members while in the hospital. Penny describes some of the tactics the hospital does differently when a gang shooting or incident has occurred,

the hospital flags the gang member's chart with an NFP. That stands for not for publication. It's designed to not tell people that someone is in the hospital. But that doesn't really work, since everyone knows this is where the shooting victims get taken. After the kid is admitted, the parents are supposed to fill out a form specifying the five or six people allowed to visit. We try to enforce that. And if tension is really running high, we have a condition called lockdown. During lockdown: all the extra doors are locked, extra security and Metro arrive, and the nurses and staff are escorted to their cars by the police or security. Just having to need that can be pretty scary.

While the security department believes that persons with mental illness present the most credible threat to staff safety, none of the nurses interviewed agreed. The two types of patients the nurses predominantly (9 of 10) feel affect their safety and security are the gang members and persons under the influence of drugs or alcohol. Gang members seem to be the obvious, first choice as a potential patient threat. As Gary quipped, "the gangbangers who've been in here three times are a lot more of a threat than the little old lady who fell and broke her hip."
As Cindy explains,

I've had the Skinheads, the Latino and black gangs in here too. They come up here in a very threatening manner and start demanding things. They try to order the staff around. And if you don’t snap to it, they can get very loud. They’re rude and disruptive to the staff. And disruptive to the other patients as well.

While most nurses interviewed (8 of 10) expressed concerns when gang members were in the hospital, nearly all (9 of 10) critical care nurses agreed that the alcohol and drug related patients present the most common threat to their safety. Nina explains, “it’s the drug or alcohol abusers who aren’t critically injured who wake up in my unit withdrawing or behaving violently that pose the greatest threat.” And while Nina doesn’t admit to be overtly scared, there is a degree of nervousness that she expresses. “it isn’t really fear. It’s sort of a nervousness. You’re always aware that something could happen. It probably won’t, but it could.”

Gary thinks that the drunks might be the hardest types of patient to treat, “they don’t know what’s happening to them. And they don’t care.”

Wendy agrees, “you try to help them, but most really good drunks don’t want your help.”

Penny believes that the while the drunks are occasionally trouble, the drugged out patients, especially those on PCP and Angel Dust, pose the greatest threat to her safety. And while Penny is concerned for her safety, she is hesitant to say so. She phrases her statement carefully,

it’s more of an awareness thing. You’re aware of the possibility that violence could occur at any minute. So you’re better prepared to handle it. If you think something’s up, you call security over, or the police, or just ask someone to standby and give you a hand.
Cindy believes the increase in violence against nursing staff stems from a general lack of respect.

It’s funny. I felt safer when I worked [as a nurse] in the jails, then I do working at UMC right now. When I was working with the prisoners I was their only source of help. So they were more respectful and polite. More polite and respectful than the guards, that’s for sure. At the hospital, you’re just one of many people who are supposed to help. And patients and family feel that you have to do whatever they want, when they want. And they can get pretty upset when you don’t.

Cindy’s feeling of not being safe at UMC is not an isolated occurrence. It is important to note that when Cindy started at UMC she did feel safe. But after five years of incidents she no longer feels that security is adequate. And she does not feel that the hospital is at all concerned about her personal safety. As to when she specifically feels unsafe at work Cindy says, “it depends on what type of patient and visitors are in my unit.”

Gary concurs,

when I first started working here [UMC] I felt that security was adequate I didn’t know any better at first. There was a security officer right outside the door. But now, no. I don’t think security is adequate. Many times Recess gets the officer who is assigned light duty. Crowd control is the biggest security problem. It isn’t always the overt violence, but a general safety thing. Or lack of safety thing.

Gary is also convinced that the medical center doesn’t care about staff safety. “Everything comes down to money. And unless it [keeping staff safe] directly affects the big people in the hospital, they don’t care.”

Penny, Nina and Wendy are not as critical. While Nina feels “basically
safe" she does not believe the hospital is that concerned for her personal safety.

Penny also feels basically safe. Primarily because hospital security and a Metro officer are nearby. Depending upon the type of patient Wendy is treating she usually feels safe enough to do her job without too many worries. While not 100% confident that the hospital is overly concerned with her safety, Wendy has this to say about the security department.

for the most part, most of the security officers are good guys. I think many of the officers try to do a good job. O.K., I'll admit it, there are a few of them who are really pretty lazy. But some are pretty solid too. I think most of the Metro guys are pretty good too.

There are no official classes or orientations regarding violence or dangerous situations for the new nurse employed at UMC. None of the nurses interviewed could recall any instruction from management or supervisors regarding such incidents.

There were no formal training classes to prepare us for workplace violence. Nothing on personal safety. There is something now. a class on non-violent crisis something or another, but it's on your own time. You don't get paid for it. So almost no one goes to it.

Medically, the toughest patients to treat are what staff calls the full traumas. Gunshot wounds to the chest and persons run over by trucks would elicit a full trauma response from the staff. Emotionally, Cindy believes the attempted suicides are the most difficult.

the most draining patients have got to be the self inflicted gunshot wounds. It's really hard to spend a lot of time working really hard to save someone who tried to kill himself. I mean, come on, if he didn't care about living, why should we spend so much time and effort trying to keep him alive?

Other emotionally draining situations for Cindy are the domestic abuse cases. It gets me crazy to see women who get so busted up, lying in their
hospital beds, when the abuser husband, or boyfriend, comes to visit. He’s acting so lovey, dovey, hugging and kissing her. I want to go over to him and kick the crap out of him. It makes me ill.

Kids getting hurt, or killed, definitively affect the staff. As Penny says, “it’s tough to see a kid get hurt.”

Gary agrees,

emotionally. treating kids takes the most out of you. Recently we had four kids really badly hurt when the pick-up they were riding in the back of overturned. All four kids were ejected. You feel sorry for the kids, and it pisses you off. What the hell were they doing in the back of the truck in the first place?

The two types of patients that Penny thinks take the most out of her are the child abuse cases, which she says have been more frequently lately; and those patients she calls the innocents. “The innocents are those patients who didn’t deserve what happened to them.”

Nina elaborates on the term innocent.

It’s like the good guy - bad guy thing. If a store owner was shot during a robbery, for instance, he would be an innocent. If the robber also got shot by the police, he would be a deserved.

There is a difference in the way the staff feels when they treat different patients. And while each nurse interviewed claimed that they “provide the same level of medical care to each patient,” there was a distinct difference in their compassion and emotional levels. The staff elaborates,

I know it shouldn’t matter, but it does matter how some patients received their injuries. You work hard treating both, but there is a degree of good guy versus bad guy patient. You seem to feel worse when the good guy patient dies.

There is a sense of innocent versus deserved it patient. You can’t help it. For the innocent victim, a guy who fell, got hit by a car, or
was robbed, there is a little extra compassion.

You try not too, but it happens. Sometimes you think that maybe the patient deserved it [getting shot or stabbed]. But there are other times, when you get talking with them, and if they’re nice, you think maybe they didn’t deserve it. But then again, when they’re here for the third time for another stab wound, you figure, maybe they really do deserve it. It becomes very easy to not have compassion.

As for the worst part of dealing with all the violence and trauma, Penny thinks the staff is getting more and more bitter. Penny thinks many of them really need new jobs.

There is a tendency to immediately put people into a scumbag label. Sometimes the people working here now are so quick to slap that label on someone and call them a scumbag without really knowing the whole story. More times than not, they are scumbags, but I wish some people would wait a bit before deciding that. Since I’m new here, I think I see that in other people. Better than they see it in themselves. I hope I don’t get that way. But if I keep working here, I’m afraid I might.

Cindy is capable of recognizing herself in Penny’s observations.

I guess I do have certain prejudices that have probably gotten worse over the years. When you treat the same gang member or lowlifes day in and day out, it sometimes reaches a point where I don’t even want to go into their rooms anymore.

Wendy voices similar feelings,

Sometimes I want to throw my hands up in the air and just yell at some of these kids who are doing such stupid things to themselves. I mean, come on, get with it. I’m not a prude, and I wasn’t an angel when I was a younger. But I wasn’t ruining my life either. Sometimes it seems that every one of my patients is drunk or on drugs and I can’t decide if I want to cry, or just go home.

Nina, on the other hand believes that her greatest worry associated with dealing with so many victims of crime and violence, is something she calls a constant awareness problem.
it's possible that the worst thing about treating so many victims of crime and violence is the realization that these traumas can occur to anyone, at anytime. It becomes scary to think that every time you go to the store you could get caught in a robbery. This random violence can completely destroy someone's life. The realization and awareness that at anytime this could be me, might be the scariest thing.

It seems to Gary that we've lost an entire generation of kids to drugs and guns and violence.

when I was a kid you could be anything you wanted: the president, an astronaut, anything. But now, we get these kids shot, stabbed, whatever and they have this blank look to them. You can see it in their eyes. They don't think they'll live long enough to grow up, let alone be anything.
CHAPTER 5

DISCUSSION

Determining the relationship between crime and violence and an organization as complex as UMC is far from a simple task. This chapter discusses some of the pertinent findings of this study, as they relate to the economics, security department, and critical care nursing staff of the University Medical Center.

A. ECONOMICS

Economically the medical center would surely benefit if they were never to receive another gunshot or stab wound patient. Proportionally, the number of penetrating to blunt injury patients are within the acceptable range for trauma center viability. Nevertheless, UMC acquires far less economic reimbursement than it expends to provide trauma care. Although the trauma unit charged patients 15% more than the actual costs to provide their care in 1996, the hospital center received 65% less than it required to break even. UMC’s trauma unit is not only not making a profit, it is operating with increasingly large deficits. The emergency department, however, is economically solvent. By billing patients 190% and 205% more than the actual costs to provide care, the E.D. was capable of posting small profits for the 1995 and 1996 fiscal years. Nevertheless, their positive returns in no way compensate for the trauma unit’s deficits.
This financial downside, however, may not be as detrimental as it appears. If the trauma center operates at a loss but the hospital center, in general, makes enough of a profit to compensate for this individual departmental losses, overall financial viability is maintained. As trauma care losses mount, the hospital’s bottom line does not seem to be adversely affected. Would the hospital do better economically without gunshot and stab patients? Of course if would. But do gunshot and stabbing patients compromise the medical center’s overall financial well being? From this analysis, the answer is no.

Hospital expenditures in response to internal crime, violence, and public safety issues are exclusively within the UMC security department’s domain. UMC does have a department of risk management & safety, but their responsibilities are predominantly matters pertaining to either staff medical malpractice, or visitor and employee “slips, trips and falls.”

UMC’s security expenditures have not changed dramatically in response to crime and violence. The return of the Las Vegas Metropolitan Police Department detail three years ago was welcome, but came at a price. Four security positions were eliminated, and the cost for the Metro detail was deducted from the security department’s budget. While this budget has increased nearly 21% since 1994, it is facing a 10% reduction for this upcoming fiscal year. The security department’s primary capital expenditures have been for safety and monitoring equipment. Additional panic buttons, better surveillance cameras and more sophisticated access/entry systems have been installed or slated for installation as per security’s
request. Security also believes that better key-pad door locks have been successful in reducing incidents in the critical care units.

B. SECURITY

The security department is cognizant of the perception and realities of high-risk areas within the hospital. As such, most high risk areas now have at least two doors, which can be locked individually or in unison. Both the emergency department and trauma Recess have security officers stationed outside the units 24 hours a day.

While some UMC staff have been critical of the security department in general, and of their safety in particular, there have not been any reported incidents of UMC staff members lodging official complaints with OSHA or other governmental agencies. It was widely reported in local newspapers that one hundred and twenty members of Sunrise Hospital's [Las Vegas] emergency department endorsed a written complaint to OSHA detailing their concerns about "inadequate security, security personnel, unlocked entrances and a lack of panic buttons" (Huff 1997:1B).

In a conscious attempt to ward off similar complaints, the UMC security department has made dedicated efforts to become more proactive in their hospital roles. While there have not yet been official policies issued regarding gang and other in-hospital violence, the security department is committed to having those prepared and distributed shortly. Nevertheless, unofficial official policies for known gang situations have been developed and instituted. When Mercy ambulance workers advise the hospital from the field that a gang member or potentially volatile patient situation is about to arrive on UMC's doorstep, security gets activated preemptively.
and attempts to be in the E.D. or trauma Recess prior to the patient’s arrival. It is believed that the presence of uniformed security officers will not only alleviate some staff concerns, but also prevent a minor situation from getting out of control.

Lockdowns were being utilized prior to Parker’s promotion to chief of security, but he has amended their application. Instead of using lockdown only after a situation has arisen, security now occasionally institutes a lockdown preventatively. After an hour or so, if nothing threatening develops, the lockdown condition can be canceled. But if trouble had arisen, the security department would have been in a better position to handle it.

C. NURSING STAFF

Violence and crime are complicated, multifaceted problems, intertwined with a variety of major social problems for which no easy solutions are apparent. Poverty, unemployment, racism, drugs and other injustices contribute in complex ways to violent behavior (Rosenberg, O’Carroll & Powell 1992). One nurse astutely noted the blank looks on many of the young trauma victim’s faces. Prothrow-Stith (1993), points out that children chronically exposed to violence in their homes and communities begin to show signs of depression, passivity, and regression to a younger emotional or psychological state. Even when outward symptoms are not as obvious or dramatic, it is noted that these children have little energy for school work or other activities that would allow them to prepare for an independent future. The increasing violence entering the hospital setting is just one of many factors linked to the extraordinarily high rate of stress and burnout for the health care provider.
It is also commonly accepted that employees who are threatened or harmed by violence become less productive or simply leave for a safer workplace (Nudelman 1995). The costs of burnout, especially in nursing are staggering. These costs not only affect the institution financially, but in human terms to the patients, as well as to the nurses themselves (Eastburg et al. 1994). Research has shown that a staff support group is a critical component of a burnout prevention program (Riordan & Saltzer 1992). While UMC does have an employee assistance program, its purpose is primarily to assist staff with drinking, drug, marital, gambling or other personal problems - not specifically job related stress.

This stress on the UMC's critical care nurse may be one of the reasons perception differences between the nursing staff and security department exist. Nurses interviewed believe a major impact of crime and violence is the threat to their personal safety by gang members and those patients under the influence of drugs or alcohol. Security officer interviews and data gathered from three years of incident reports suggest that the major cost of crime in the hospital center has more to do with minor property offenses and not threats or assaults against staff members. A follow-up study involving greater numbers of nurses and security officers would be valuable to determine how these discrepancies became so ingrained between these hospital factions.

Perhaps the most notable finding of this study, however, is the personality shifts and attitudinal changes that many of the critical care nurses interviewed seemed to have undergone. Howard & Strauss (1975:21) commented on the variable health care one could receive depending upon his or her status, "the health care that we get
has a humanizing/dehumanizing content. Where it falls on this scale depends on the clarity with which our race, social class, economic status, and degree of deviance can be determined."

For the critical care nurses studied, the determining factor appears to be the mechanism by which the patient received his or her injuries. The *innocents versus deserved* and the *good guy versus bad guy* patient, seem to be the new social class. Not one single nurse interviewed made a derogatory comment regarding a patient’s race, economic status, ethnic background, or sexual orientation. They were, however, extremely critical of their patient’s drug or alcohol usage, criminal behavior, or membership (confirmed or suspected), in a gang. While each nurse admitted particular prejudices, and dissatisfaction with having to treat specific patients, none of the subjects admitted to providing any less care for these patient outcasts. There were admissions of providing less compassion and less emotional involvement, but not less medical care. This claim of equal medical care may be accepted at face value or dismissed as an outright fabrication. A third possibility does exist. It is possible that these critical care nurses were unable or unwilling to recognize the subtle disparities in their treatment modalities. Studies of medical personnel have shown that as the terminally ill patient’s health deteriorates, the length of time their health care providers afford them decreases (Kastenbaum 1995; Lester 1988). It is hypothesized that health care provider’s decisions to spend less time with dying patients is a subconscious one. Perhaps an analogy can be made between nurses working with terminally ill patients and those nurses working in the critical care units. A more detailed and comprehensive examination would determine if these critical care nurses
do indeed provide equal care for those *deserved* patients and for patients who were judged *innocent* by the nursing staff.
In January of 1989 a brutal murder occurred in New York City. Specifically, Kathryn Hinnant, a thirty-three year old pregnant woman, was raped, strangled and beaten to death in her office at work. What makes this horrific crime pertinent to this thesis was Ms. Hinnant’s occupation. She was a physician, a pathologist to be precise, and she was killed inside the Bellevue Hospital Center in Manhattan.

While vicious murders are not unheard of in the United States, the setting for this heinous crime hit a particularly sensitive nerve. As Roger Rosenblatt (1989:7) eloquently stated, “society establishes very few places where healing and sympathy are the standard activities. A hospital is such a place.”

In many instances, the traditional views of the hospital and emergency department as a safe haven have been turned upside down. Domestic violence victims may be followed into the hospital by their abusers. E.D. workers use pseudonyms for known gang members, in case rival gang members pursue the victim into the hospital. And assaults on medical staff are increasing at record paces. A maximum security prison should have to occasionally execute lockdowns - not a medical facility.
Crime and violence seem to have the greatest impact on the UMC nursing staff. Every nurse interviewed admitted to being threatened by patients and visitors to the hospital. Many nurses have been physically accosted, luckily few staff members report serious injury. The health care professionals who work the critical care units at UMC appear to be a dedicated group of people. They function in extremely stressful and tense surroundings. Every nurse interviewed expressed concern for their physical safety. Burnout is a frequently described emotion. Most nurses working in the critical care units entered the field because of the challenge, the excitement, and the desire to help those most in need. And while the hours are long, and the shifts difficult, most expressed a willingness to try to persevere and continue in their current positions.

I believe an emotional and psychological toll on these emergency workers does occur over time. While emergency personnel try to cheat death, they know that inevitably death claims us all. But there is a difference. The most disturbing patients for these critical care nurses are the children who die. Whether from a medical emergency or violence, the death of a child seems to effect the staff on a deeper, more personal level, than that of adults. For adult patients there seems to be a growing undercurrent of discontent depending upon the mechanism of injury. Formal treatment modalities for all patients may be the same regardless of how they received their injuries. But the nurse’s compassion and emotional involvement with certain patients is dramatically different.

In many ways it is easier for the staff to come to grips with unintentional violence and illness. Heart attacks, falls and motor vehicle accidents seem to be some
of the inevitable circumstances surrounding day-to-day life. But the intentional
violence that man subjects onto his fellow man seems to emotionally and
psychologically undermine the good intentions and dedication the critical care staff
attempts to brings forth. Almost four out of five serious trauma patients who arrive at
UMC are victims of motor vehicle accidents or other blunt trauma. Nevertheless it is
the shooting and stabbing victims that seem to most adversely affect the staff. When
the nursing staff is less affected by the death of a patient because they view him, or
her, as a patient deserved of whatever demise befell him, serious misgivings must be
maintained. Is this what we expect from the persons most in a position to render care
and compassion? When society is capable of destroying one of the basic tenets of
nursing, we must take a serious look at ourselves.

The greatest hidden cost of crime and violence on the University Medical
Center of Southern Nevada may not a tangible, concrete figure or factor. A draining
of the human spirit is occurring. Through sheer volume and intensity, crime and
violence has dented the emotional armor of UMC’s critical care nurses. This
weakened resolve may be an early warning sign for health care professionals. We
cannot continue to subject our caregivers to these stresses and strains with impunity.

For one day, we all may be lying in our hospital beds wondering if the nurses
are ever coming back.
APPENDIX

A. Approval

B. Interview Guide
DATE: September 17, 1996

TO: Paul Shapiro (CRJ)
M/S 5009

FROM: Dr. William E. Schulze, Director
Office of Sponsored Programs (X1357)

RE: Status of Human Subject Protocol Entitled:
"Crime and Its Relationship to University Medical Center"
OSP #383s0996-080e

The protocol for the project referenced above has been reviewed by the Office of Sponsored Programs and it has been determined that it meets the criteria for exemption from full review by the UNLV human subjects Institutional Review Board. This protocol is approved for a period of one year from the date of this notification and work on the project may proceed.

Should the use of human subjects described in this protocol continue beyond a year from the date of this notification, it will be necessary to request an extension.

cc: R. McCorkle (CRJ-5009)
OSP File
APPENDIX B

INTERVIEW GUIDE

1) Personal Safety:

Have you ever been threatened by a patient?

Have you ever been threatened by a visitor to the hospital?

Have you ever needed assistance because your safety was being threatened?

When you needed help, who provided it? (security, coworkers, police, etc.)

Have you ever been assaulted on the job?

Were you injured?

Have you encountered patients who were carrying weapons?

Have you encountered visitors to the hospital who were carrying weapons?

2) Security:

What ways are there to request help when you’re working?

When you first started at UMC did you feel that security was adequate?

Do you still feel that security is adequate?

Do you feel safe when you’re at work? (why or why not)

Do you feel that the hospital is concerned with your personal safety?

When training, inservice, or instruction did UMC give you to ensure your personal safety?

Are there policies on workplace violence, assaults or dangerous situations?
Are there security checkpoints or metal detectors at UMC?

3) **Gangs:**

- Have you ever had to treat gang members?
- Were you more scared than when treating other patients?
- Did any members of the gang come to visit the patient?
- Were there problems?
- Does the hospital have any set policies or protocols for dealing with gang members?
- Does security get more involved when gang members are in the hospital?
- Does the Las Vegas Metropolitan Police Department (LVMPD) get more involved when gang members are in the hospital?
- There have been some highly publicized incidents of gang members following victims to the hospital to “finish off the job”. Has anything like that happened at UMC?
- Does that possibility scare you?

4) **Attitudes:**

- Is there a difference in the way you feel when you treat a victim of violence (e.g. shooting victim vs. motor vehicle accident)?
- Does it matter how your patient received his/her injuries?
- Does it take “more out of you” emotionally to treat certain types of patients?
- Do you think your job is more PHYSICALLY, EMOTIONALLY or PSYCHOLOGICALLY demanding?
- Which type of patient is the hardest to treat?
- How long do you plan to continue working at UMC?
- What do you think are some of the hidden costs of crime and violence on UMC?
BIBLIOGRAPHY


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