JAMA coverage of the Johns Hopkins shootings: a dissenting view

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Acceptance of the conclusions of an article by two Johns Hopkins physicians without further investigation gives further credence to statements that good hospital security is either not needed or not possible, the author says. In this rebuttal, he points out the risks that such misconceptions ignore.

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The December 8th, 2010, Journal of American Medical Association (JAMA) article, *Hospital Shootings Rare: But Other Assaults High*, received a lot of attention on the internet. We were surprised by the initial coverage of the Johns Hopkins shooting event in September. The press statements from hospital security experts and local politicians had us scratching our heads. As more information became available some of those statements appeared to be bazaar.

When we first reviewed the JAMA December 8th, , 2010 article we thought that it was a rehash of the 17th September 2010 coverage, A closer look revealed that it was a commentary piece submitted to JAMA as a serious research effort, after action analysis of what may have gone wrong. We assumed it would reflect some thoughtful retrospective content or explanations for, what

appeared to us to be, some misguided impulsive remarks made during the usual heat of the shooting crisis..

We were surprised that the article was authored by two Johns Hopkins physician employees. Our assumption is that some JAMA expert review group reviewed the article and passed it on for publication. We question the "objectivity" of the commentary and find it defensive, self-serving and misguided.

GIVING EXPOSURE TO MISCONCEPTIONS

The hospital authority for Johns Hopkins Corporate Security indicated that the weekly stream of 80,000 patients, visitors and others through 80 entrances that screening is "impossible". Other staff commented on the dangerous crime-ridden East Baltimore neighborhood and the fact that many residents carried firearms.

Contrary to the statement that "few hospitals use metal detection devices" many hospitals across the nation place great reliance on metal detectors in their battle against all manner of violence. We are not sure we agree with Johns Hopkins Security director that "I think at the end of the day we're pleased with the way the plan was implemented" Two dead and one seriously wounded is a questionably acceptable outcome.

We expect politicians to make the usual gaff at these events. We hope that the researchers in the JAMA Commentary did not internalize the published statements "the hospital's security is adequate and that metal detectors would create a hazardous situation for patients entering the hospital." "Why would they want metal detectors going into the hospital?" "People go to the hospital because they got shot", "People wouldn't go to the hospital because of these metal detectors." "They would stay away and die rather go through metal detectors".

The notion that putting Magnetometers in selected entrances would frighten patients and they would boycott the hospital is not worth our attention. Did the enhanced security at Airports keep the holiday travelers away?

A WORKSITE OPEN TO A MUMBAI-STYLE ATTACK

We assume that some Center for

Medicare and Medicaid (CMS) external evaluation contractor has surveyed the organization for its All-hazards/Emergency Management Preparedness. It is a requirement (deemed status) for reimbursement of care for federal beneficiary. The Tucson shooter gives us a glimpse of the potential slaughter capacity posed by one shooter.

Homeland Security terrorism experts warn us that the most likely next terrorist attack would be a Mumbai style event. If you offer some 80 points of entry and no means to reasonably defend against armed intruders, it makes little difference how many outside armed responder are poised to assist. Ten terrorists prepared to kill as many patients, visitors, staff and others before they are killed would create a Terror Multiplier Effect across the nation. This did happen in Mumbai hospitals.

Johns Hopkins is not unique in its desire to keep its work site as an open and welcoming environment. We have watched as millions are spent for patient safety and security. In recent years in the struggle to reduce treatment acquired infections and medical misadventures (errors) has led to initiatives which focus on one side of safety and security and has morphed into an exclusive clinical domain at the neglect of physical safety and security. A century of clinical excellence can be neutralized by an assault from a ragtag group of domestic terrorists or neglected security on hospital-based Cesium Cl blood irradiator, one-half of the dreaded "Dirty Bomb.". The Mumbai attackers were a group of near-teens, poorly trained and armed with conventional weapons easily obtained across the nation.

THE DEGRADATION OF WORKSITE SECURITY AND SAFETY

Fast forward to the subject JAMA article.

The case with which the researchers conclude that hospital shootings are a rare event and that the security experts should focus on the violence associated with the worksite is troubling.

We have seen the degradation of worksite safety and security for some time. The researchers would be better served by researching some root causes of violence in the workplace.

They may want to start with a look at the personal stress on caregivers as organizations' downsize to meet economic challenges. Emergency rooms stretched to their limits. Human Resources Screening, not policy but practice. They may want to look at the screening practice of Outsourced Administrative and Clinical services, how reliable are their screening practices? Take a look at the impact of "Just in Time" deliveries and the additional traffic associated with this economic strategy. When staff cuts are made are the support services (a cost center) Security (both manpower and supporting security equipment) are generally the first to go.

Had the healthcare industry responded to the early Infant Abduction Crisis in the same manner as suggested by the Johns Hopkins's researchers then they would have seen the expensive array of security equipment and other actions not worth the time and expense. All that public display of security measures to keep newborns and vulnerable children, would amount to "emote a false sense of security".

These protective measures have reduced infant and child abductions significantly. How do you determine what is rare shootings in hospitals? Legal experts told us that one child abduction, places a heavy, expensive legal burden on hospitals. We have identified approximately 20 shooting event in hospitals in 2010. Many of those involved multiple deaths. The total would be higher if you included forensic exposures with firearms involvement. If it happens on campus but not in the hospital does it give comfort to patients and visitors? How many hospital shootings should be considered acceptable? Are there any experts there who will say the trend in hospital shootings is on the wane?

THE FOLLY OF DENYING THE GOOD FOR THE 'PERFECT'

The Johns Hopkins researchers posit that any expectation of providing perfect safety and security (their words) in hospitals must be seen in the light of a more hostile, Hobbesian population. Dramatic increases in divorce and "custody battles" has posed a greater threat for infant and child abduction. Would you wait to respond to the reality of dysfunctional families events to enhance your protective net? It is one thing to deny the good for the perfect but to indicate that the good is not in reach is folly. Our concern over the JAMA commentary is that its target audience, physicians, promotes an unrealistic evaluation to a group which has been reluctant to support a robust secure workplace.