TRIAGE BRIEF

The weekly dispatch on medicine, media, and the moments that define both.

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FROM THE EDITOR

Welcome to the first issue of Triage Brief. Here's my promise to you: every week I'll hand you two things you won't find anywhere else. First, a current news story that looks like politics or crime or economics — but is actually a hospital communications crisis in disguise. Second, a scenario that will test your own crisis instincts. This week's story begins with a murder-suicide inside a hospital waiting room. But the story the media covered was only the surface. The deeper story is about a workforce under siege — and a healthcare system that has spent years treating violence as an occupational hazard rather than a preventable emergency.

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THIS WEEK'S STORY

A Murder-Suicide in a Hospital Waiting Room

Category: Workplace Violence / Hospital Security | **Urgency:** HIGH

On Sunday, March 2, 2026, a patient and a visitor were killed in what police described as a murder-suicide at Baptist Health Brookwood Hospital in Homewood, Alabama. The shooting renewed a debate that rarely goes anywhere: should hospitals require metal detectors? The Alabama Hospital Association noted that metal detectors are not mandatory in the state and that each facility develops its own security plan. Local TV, wire services, and national healthcare trade media all ran with the security angle — but largely missed the deeper story.

THE MEDICAL REALITY — WHAT THE ER SEES THAT THE NEWS DOESN'T

The Brookwood shooting is a headline. The real story is a decade-long epidemic. Healthcare workers are five times more likely to experience workplace violence than workers in any other industry. We make up about 13% of the workforce but absorb 60% of all workplace assaults nationally. In my ER, violence is not a rare event — it is a shift-by-shift reality. Physical assaults, verbal threats, objects thrown. Most of it never makes the news because nurses and techs are taught to absorb it as part of the job. A 2024 survey of emergency physicians found that 91% had either been a victim of workplace violence themselves or had a direct colleague who had. Seventy-one percent said it was getting worse. The shooting in Homewood was a visible explosion of a pressure system that has been building for years.

THE HISTORICAL PARALLEL

The closest precedent: The normalization of violence against healthcare workers in the post-pandemic era — and the nearly identical institutional response to it that followed the 1970s violence surge against ER nurses.

In the 1970s, as emergency medicine became a recognized specialty, ERs across the U.S. began seeing dramatic spikes in patient violence. The response from hospital administration then was strikingly similar to what we hear today: it's part of the job, each hospital develops its own plan, incidents remain rare.

Sound familiar? It took nearly two decades — and relentless advocacy from nursing organizations — before OSHA issued its first workplace violence guidelines for healthcare in 1996. We are now twenty-eight years past those guidelines, rates are climbing again, and the dominant institutional response remains: 'it varies by hospital.' The 2025 AHA report put the annual cost of violence to hospitals at $18.27 billion. That number didn't move the needle on mandatory policy either.

> "The emergency department has become the most dangerous room in the hospital — not for patients, but for the people treating them." — Emergency Nurses Association, 2024 Annual Report

HOSPITAL RESPONSE ANALYSIS

How Baptist Health Brookwood — and Alabama Hospitals — Handled This

Let's be honest: this story was not primarily about Brookwood's response. The media covered the shooting; the hospital stayed largely silent. But that silence, combined with the boilerplate statements from the Alabama Hospital Association, is itself a communications decision — and a revealing one. Here is how the response played out across five lenses:

LENS	ANALYSIS
What They Did	The hospital issued no public statement in the first 24 hours. The Alabama Hospital Association spokesperson stepped in, noting that metal detectors are 'not mandatory' and that hospitals develop their own plans. The headline quotes went to law enforcement, not clinical leadership.
What They Should Have Done	Within the first four hours: a brief, human statement from a physician or CNO — not a PR director — expressing grief, commitment to staff and patient safety, and a specific next step (e.g., 'We will conduct a full security review and share findings within 30 days'). The absence of a clinical voice allowed the story to be framed entirely around guns and access, rather than the broader workforce safety crisis.
The First Statement	What was actually said: 'Each hospital develops its own emergency operations plan according to their geography and available resources.' This is technically accurate and strategically catastrophic. It signals no ownership, no urgency, and no plan. What should have been said: 'We are devastated. Our staff and patients deserve to feel safe, and we are committed to ensuring that — starting today.'
The Spokesperson Decision	The Alabama Hospital Association CEO — not a clinician — was the primary institutional voice. This is the wrong call. In a story about patient and worker safety inside a clinical environment, a physician or nurse executive carries authority that a trade association CEO cannot. The reporter's implicit question is 'are hospitals safe?' — that question demands a clinical answer.

The Historical Mistake Repeated	In 2018, after the UAB Highlands Hospital shooting that killed a nursing supervisor, the same pattern emerged: law enforcement statements, no clinical voice, no systemic response, no change in metal detector policy. Eight years later, same city, same script. When your institution's crisis communications response is indistinguishable from your response to the last crisis, you have not learned from history — and reporters remember.

THE LESSON

Silence is a statement. When a hospital says nothing in the first four hours of a crisis, the media fills that vacuum — and they will not fill it in your favor. A brief, human, clinically-voiced statement that acknowledges grief and commits to a specific next step costs nothing and controls everything.

THE RULE OF THUMB

The 3 Cs of the first statement: Concern (we are devastated), Commitment (we will act), and Context (here is what we know right now). In that order. Every time.

WHAT WOULD YOU DO?

This Week's Scenario: The Iran Angle

Difficulty: High | **Setting:** Large Academic Medical Center, major U.S. city
Source Event: U.S.-Israel strikes on Iran (began Feb. 28, 2026) — damage to Tehran's Gandhi Hospital and Khatam al-Anbia Hospital reported; Iranian-American community in your city is large and frightened.

THE SCENARIO

It is 9:15 a.m. on a Tuesday. You are the CMO of a large academic medical center in a U.S. city with a significant Iranian-American population. You receive the following:

"A local TV reporter has called requesting a comment. She is covering the mental health impact of the Iran conflict on local Iranian-American communities and specifically wants to ask whether your hospital has seen an increase in anxiety, depression, or trauma-related presentations in the ER since the conflict began Feb. 28. She notes that two hospitals in Tehran — Gandhi Hospital and Khatam al-Anbia — have been damaged in U.S.-Israeli strikes. She is going live at noon."

Your hospital's media relations team has no standing policy on commenting about geopolitical events. Your ER medical director has texted you separately: 'We have seen a real uptick in anxiety presentations from Persian-speaking patients this week. Worth noting publicly?'

You have 90 minutes before the reporter needs a response.

YOUR DECISION POINTS

— Do you comment? This is not a clinical emergency at your hospital — it is a community mental health trend intersecting with a geopolitical conflict. What are the risks of speaking? Of staying silent?

— If you engage, who speaks — and what is the one thing you want the public to hear? Write your two-sentence soundbite.

— Your ER director wants to go on record about the uptick in anxiety presentations. Do you support that? What guardrails do you put in place before he speaks?

— The reporter asks directly: 'Does your hospital have additional mental health resources for Iranian-American patients affected by the conflict?' You do not currently have a specific program. How do you answer?

— Three days later, a local Iranian-American advocacy group calls to thank your hospital publicly for its "compassionate response" — which appears on their social media with a clip from the noon broadcast. Your board chair calls asking why the hospital commented on a war. How do you respond to the board chair?

THE DEBRIEF — PUBLISHED NEXT ISSUE

This scenario tests whether hospitals can distinguish between a clinical story and a political story — and whether silence is ever the right answer when your community is hurting. Spoiler: a hospital that says nothing while its community grieves is making a values statement whether it intends to or not. Next week I'll walk through the three possible response strategies, what each signals to the public and to staff, and why the ER director's instinct to speak is probably correct — but only with the right framing.

QUICK READS

Three things worth reading this week:

— **AHA Report, June 2025** The Burden of Violence to U.S. Hospitals — estimates the total annual cost of workplace and community violence to hospitals at $18.27 billion. Essential reading for any CMO building a security investment case.

— **ACEP Survey, January 2024** 91% of emergency physicians have been a victim of workplace violence or know a colleague who has — and 71% say it is getting worse. The data your board needs to see.

— **Al Jazeera / WHO, March 2026** Reports of damage to Gandhi Hospital and Khatam al-Anbia Hospital in Tehran during U.S.-Israeli strikes — a reminder that hospitals as protected sites under international humanitarian law is more principle than practice.

Until next week —

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