HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

MAY 2017 Vol. 36, No. 5; p. 49-60

INSIDE

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Training for Toxic Work Culture Should Start in Nursing School

Preparing for incivility, bullying, preventing violence

By Gary Evans, Medical Writer

While often seen as separate and disturbingly distinct, incivility, bullying, and violence in healthcare are actually connected across a common culture of toxicity, says a researcher and author on the subject.

"They are not separate issues — they are related," says **Cynthia Clark**, PhD, RN, ANEF, FAAN, professor emeritus of nursing at Boise (ID) State University. "By definition. they are somewhat different, but they exist along a continuum of harmful and aggressive behaviors. You can have a person who behaves badly and never gets to the point of violence. Incivility and bullying, are tragically awful, but generally, people don't die. So violence takes us to a whole new level, but that, to me, is the far right end of a continuum of aggressive behaviors."

> "VIOLENCE TAKES US TO A WHOLE NEW LEVEL, BUT THAT, TO ME, IS THE FAR RIGHT END OF A CONTINUUM OF AGGRESSIVE BEHAVIORS."

The author of a recently published book[1] on this issue, Clark also co-chaired an American Nurses Association committee that linked incivility, bullying, and violence in an ANA position paper. Clark's committee concluded that civility in the workplace is an ethical imperative and should be demonstrated by such behaviors as the following:

- Treat others with respect, dignity, collegiality, and kindness.
- Consider how personal words and actions affect others.
- Take personal responsibility or

Financial Disclosure: Medical Writer **Gary Evans**, Editor **Jill Drachenberg**, Editor **Dana Spector**, and Nurse Planner **Kay Ball** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL EMPLOYEE HEALTH

Hospital Employee Health®,
ISSN 0744-6470, is published monthly by
AHC Media, LLC, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
Hospital Employee Health®
P.O. Box 74008694
Chicago, IL 60674-8694

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SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours, $499. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours, $449. Outside U.S., add $30 per year, total prepaid in U.S. funds.

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This activity is intended for employee health nurse managers.

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accountability for one's own actions.

• Recognize that abuse of power or authority is never acceptable.

• Listen to others with interest and respect.[2]

Protect Thyself

Unfortunately, such attributes are conspicuously absent in some healthcare work cultures. A common denominator across unsocial and aggressive behaviors is work stress.

"Here's the thing in nursing and in healthcare — we are never going to get away from a stressful environment," Clark says. "Let's face it. We're in the business of life and death, so that in and of itself creates a stressful work environment that we need to diminish."

While work culture change takes time, individual healthcare workers must cope with the environment in the moment. To deal with stress in healthcare, Clark recommends setting aside time to center yourself and contemplate gratitude. A metaphor that applies is the common airline safety advice to put on your own oxygen mask before attempting to help others.

"One thing we need to cope well are 'just-in-time' strategies that we can use on the job immediately for about 30 seconds or a minute — just sort of regroup," she says.

For example, Clark advises a quick triple-technique using stretching, breathing, and positive imaging. As described in her book, the technique involves extending the arms upward and standing on tiptoes, drawing deep breaths while thinking a positive affirmation like, "Stress is leaving my body. My work is very important. I am making a positive difference in the lives of my patients."[1]

Another important strategy is "learning how to speak up in a respectful way," she says. "That's tough stuff. That is not an easy skill to build or to master."

Remaining silent about witnessing or suffering toxic behavior can normalize incivility in the work culture. By way of example, consider this comment recently submitted to OSHA, which is promulgating a violence prevention regulation for healthcare. It was submitted to the OSHA docket by **Stacy Maitha**, RN, of the Indiana Emergency Nurses Association in Bloomington:

"'What are you doing, Kelli?' I asked our patient care tech as I saw her round the corner in our emergency department for the second time in just a few minutes. 'I have to step away for a few minutes from the verbal assault I'm receiving back there,' she said. 'Oh you get used to it,' I heard myself say. Her stunned facial expression in response to my flippant comment snapped me out of my autopilot mode and caused me to think about what I had just said. I myself have only been an emergency RN for three and a half years. Kelli has been an emergency department patient care technician for about two years. In that time, I have been kicked, hit, spit on, cursed at and threatened by patients and their visitors. Like most of the people I work with, I have come to expect this behavior from the people we serve in our community hospital. But that day, Kelli's face reminded me that I shouldn't expect it, and that I absolutely shouldn't be telling my co-workers to just 'get used to it.'"

Can verbal attacks culminate in violence? Establishing direct cause and effect may be elusive in many cases, but healthcare, in general, suffers a toxic continuum where insult can, indeed, be followed by

injury. In comments to OSHA, the National Institute of Occupational Safety and Health (NIOSH) cited the importance of encouraging the reporting of "verbal violence." *(For more information, see related story, page 52.)*

In the aforementioned ANA paper, Clark recommends nurses consider the following strategies when subjected to abuse:

• When RNs experience incivility and bullying, either they can respond directly to the perpetrator, or they can seek out guidance and support through the appropriate channels. When possible, perpetrators of incivility and bullying should be addressed privately.

• RNs are encouraged to use pre-established code words or other mechanisms to seek support when they feel threatened. This outreach may involve the targeted individual or a bystander using a predetermined phrase that signals all available nurses to move toward the target both to provide nonverbal support and to witness the harmful actions taking place.[2]

The Next Wave

Incivility and related aggressive behaviors should be acknowledged and addressed in nursing school to prepare the next wave of healthcare workers to enter a work environment where their resilience will be tested, Clark says. She shared some further insights on this timely topic in an interview with *Hospital Employee Health*.

HEH: This issue certainly seems appropriate to address in nursing school. Why did you decide to advocate civility training as part of healthcare education?

Clark: As faculty, we have a responsibility in educating our nurses the moment they walk into one of our pre-licensure programs on these important issues. What is their professional role in creating a positive work environment? As you begin to unfold that, you look at things such as how to communicate more effectively among members of the healthcare team, particularly when patient safety issues are at stake. How do we negotiate conflict in an effective way? There is a lot of skill-building that students can learn in the academic environment [in conjunction] with their clinical experiences.

HEH: In a nutshell, you define civility in terms of respect and seeking common ground, while incivility is marked by disregard for the other and, in its worst forms, "an assault on human dignity." Are these behaviors being commonly taught in nursing school today?

Clark: Is it being done universally? No. It's being done in some schools, but not in others. It is being done on a grand scale in some [schools] and very little or none in others. I really recommend that we integrate — not change the curriculum, because some faculty are really resistant to adding more to what they already see as a jam-packed curriculum. Instead, we can be smarter or more thoughtful about how we integrate concepts of civility, professionalism, ethical practice and so forth into an already existing curriculum. Those, strategically speaking, need to be active, engaging, with use of simulation, role playing, and those kinds of things. I advocate that schools adopt this as part of their curriculum. Some have; some have not.

HEH: This seems somewhat analogous to nursing schools using safe patient lifting equipment, not only honing their students' skills, but creating the expectation that this should be part of their work culture.

Clark: Yes, some of my students have said to me, you know [this training] is a resumé builder — to go into an interview and be able to say, "Here are the skill sets that I bring." In addition to [clinical skills], they bring these additional [work culture] skills that many recruiters and employers are looking for. The ability to manage conflict, build tools, lead by example. Those kind of skills are in high demand, particularly in a multigenerational workforce.

HEH: You argue that there is a link between incivility, bullying, and even violence.

Clark: Yes, it is a continuum of these behaviors or lack of behaviors — because sometimes it is not only what we do, it's what we don't do. For example, especially in the healthcare field, if we are not speaking up when we ought to be speaking up, when we are disregarding or shunning co-workers, when we are walking away from dealing with a family. Those behaviors can be very detrimental.

HEH: You certainly describe the detrimental effects of bullying, with the account of one nurse in your book who developed post-traumatic stress disorder.

Clark: Yes, he did. Despite his efforts to take measures within that organization at each juncture, he was sort of thwarted and he didn't really recover from the symptomology until he left that organization and started working in another one, where it was much healthier and people were much more collegial and collaborative.

HEH: There has been a somewhat begrudging acceptance of what might be described as a kind of "hazing" culture, including the phrase we have all heard: "Nurses eat their young."

Clark: Well, certainly that is a concept that has been in the literature a long time. You'll notice my book does not include that phrase. I'm trying very hard to move away from those kinds of oppressive statements about our profession, suggesting instead that we heal from that and move on. Of course I've heard that, but this book and my research work is really about how we are going to change the culture — not only in nursing, but in the [healthcare environment]. I believe that nursing faculty can have a key role in doing the heavy lifting on this on the front end — starting at the very nanosecond when students enter our colleges and universities. Start having that conversation.

HEH: You include tools to evaluate one's own civility, like assessing on a scale how often you are rude or discourteous to others. It seems you are suggesting that self-knowledge can then lead to developing skills for resilience in the healthcare environment.

Clark: That's absolutely spot-on. As I got into the research on this, one of the findings that kept coming up over and over, no matter how I measured it, is that in many cases people had no clue how to talk [respectfully] to another individual or a group of people. That's why I developed several indices — one for students to take a look at themselves in their role as learners, one for faculty to take a look at themselves in terms of how we are educating. But the workplace civility [index] is for all of us. I kept it general enough that anyone in any workplace can do that, and take a look at how they might be coming across to people and how they might find ways to enhance and improve interactions.

HEH: The quote you cite from the poet Rumi seems to sum it up: "Yesterday I was clever, so I wanted to change the world. Today I am wise, so I am changing myself."

Clark: Yes, don't you love that, and it goes all the way the way back to Socrates, who I believe first said "know thyself." So I think we need to take a look in the mirror before we can address other people's behaviors. ■

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Canada Faces a Surge in Healthcare Violence

NIOSH emerging as key ally on U.S. OSHA reg

While OSHA continues to promulgate a violence prevention regulation, our neighbors to the north are dealing with a similar problem of threatened healthcare workers.

In the province of Ontario, with a population of some 15 million people, patient demand for treatment has outstripped available beds, creating delays and crowding that stress both healthcare workers and patients, says **Michael Hurley**, president of the Ontario Council of Hospital Unions.

"The hospitals are operating at over 100% occupancy levels," he tells *Hospital Employee Health*. "We have had a closure of psychiatric facilities and there are a number of other factors. We have people waiting longer for services, so in the ERs [and other areas of healthcare] we are seeing an increasing number of assaults. I think a part of that is tied to frustration."

Citing other aggravating factors that will be familiar to employee health professionals, Hurley also notes that the problems are not limited to Ontario.

"[Funds] for treating psychiatric facilities in the community have been cut back systematically; I'm sure they have in the U.S. as well," he says. "There is a shortage of acute care beds. Only the most acutely ill people get into them and these units are understaffed. The staff are vulnerable. Compounding this problem you've got opioid use — people coming into emergency rooms really stoned and aggressive."

Factoring gender and cultural bias into the equation, Hurley thinks violence against women is too easily accepted in Canada and nurses do not feel empowered to speak out.

"[Healthcare] is a predominantly female work environment and those social attributes permeate," he says. "It's not just a visitor or patient assaulting a nurse or healthcare worker — it's also that management doesn't necessarily want that reported."

Hurley and colleagues recently

wrote a letter to labor officials in the province, demanding the protection of healthcare workers be made an immediate priority. Existing violence protection regulations should be enforced in healthcare inspections and audits, the union argues.

"[We have] documented incident after incident of abuse, threats, assaults, and sexual harassment, both physical and verbal, within the healthcare sector," the union letter states.

The union is participating in an ongoing research project that has not been published yet, but documents violent incidents described by 54 healthcare workers participating in group interviews.

"The study documented widespread and systemically accepted violence in each of the locations and occupational groups," the letter states. "The researchers met many healthcare staff who had sustained serious, life-altering injuries and many who suffered from post-traumatic stress disorder (PTSD), which has deeply affected their quality of life and the well-being of their families. … Lack of respect, underfunding, and understaffing were universally identified as significant contributors to workplace violence. [Violent incidents are] not reported — partly because of the long-standing culture of acceptance and partly because the victims fear retribution."

NIOSH Advice to OSHA

Similar themes have been expressed in comments to U.S. OSHA, which announced Jan. 10, 2017, that it will promulgate a proposed regulation on healthcare violence. OSHA issued a request for information[1] on Dec. 7, 2016, asking for comments and suggestions as to how to best proceed with violence prevention strategies in healthcare.

One recently filed comment of note came from the National Institute of Occupational Health and Safety (NIOSH), which lacks enforcement power but could play a key role in developing the standard. A branch of the CDC, NIOSH submitted comments that were certainly supportive and informative, but carefully avoided outright endorsement of a regulation.

> "[WE HAVE] DOCUMENTED INCIDENT AFTER INCIDENT OF ABUSE, THREATS, ASSAULTS, AND SEXUAL HARASSMENT, BOTH PHYSICAL AND VERBAL, WITHIN THE HEALTHCARE SECTOR."

"The comments are suggestions for OSHA to consider if a rule is promulgated," NIOSH told *HEH* in response to an email inquiry.

For example, NIOSH advised OSHA "to make the standard effective and enforceable, [it] will need to provide guidelines and examples, such as variables for determining reporting thresholds (e.g. severity of physical injury/ mental duress and level of threat/ physical force used by perpetrator)."

HEH asked NIOSH if it had such guidelines and examples to provide OSHA.

"NIOSH does not have specific guidelines," a NIOSH representative said in a statement attributed generally to agency researchers. "Findings from several independent surveys, reported in the workplace violence literature, indicate underreporting of workplace violence by healthcare workers may be an issue. The requirements for reporting an injury or illness on the OSHA 300 log are not applicable to reporting all injuries or illnesses that may result from workplace violence. The level of property damage is an example of a threshold that could be set to indicate the potential for physical violence to persons. For example, workplace violence may result in property damage, but not any physical injury to the worker. Although not required to be reported on any OSHA form, this type of incident should be reported to management and an incident investigation should be conducted to assist with preventing similar incidents in the future."

On the issue of healthcare staffing, NIOSH said in the comments submitted to OSHA that "staffing issues could be addressed by establishing a range of staff-to-patient ratios based on industry best practices and input from healthcare and social assistance workers."

HEH sought clarification whether NIOSH had any data showing that insufficient staffing is linked to violence, or on what staff ratios should be recommended in healthcare.

"When workplace violence occurs, it is usually a combination of factors in any given situation that can be cited as contributing factors," NIOSH responded. "Staffing issues have been mentioned in several peer-reviewed articles as a contributing factor. Many issues,

including previous incidents of workplace violence, determine the level of staffing required in any healthcare unit/department/facility."

In terms of incivility and threats, NIOSH cited an FBI report on workplace violence in advising OSHA on the importance of "an environment that encourages reporting verbal violence."

An OSHA standard may also need a "section specific to home healthcare and social service workers because of the unique work conditions," NIOSH advised the agency. Documentation of workplace violence training should be required, NIOSH noted, recommending OSHA "maintain records for at least five years of relevant workplace violence incidents (like verbal abuse) that are not required to be reported on the OSHA 300 log, but are important to consider in the context of a comprehensive violence prevention program." ■

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Expect Zika Return, Reinforce HCW Safety

First cases appearing in Florida

Employee health professionals should prepare for the return of Zika virus, as the CDC expects the mosquito-borne infection threat to return to the U.S. as the warmer months arrive. That poses employee health challenges that come down to the same essential message: prevent blood exposures, needlesticks, and alert employees who are pregnant or trying to become so.

Florida is already under fire, as state health officials reported the state had 29 cases as of March 20, 2017. The vast majority were in travelers returning from countries where Zika is spreading, but two cases were locally acquired via mosquitoes and two were of unknown origin. The state reported Zika infections in 13 pregnant women for 2017. All Florida county health departments now offer free Zika risk assessment and testing to pregnant women.

As this issue went to press, the CDC was advising pregnant women to consider postponing travel to Miami-Dade County.

"If you are pregnant and must travel or if you live or work in Miami-Dade County, protect yourself from mosquito bites by wearing insect repellent, long clothing, and limiting your time outdoors," the state health department advised. According to CDC guidance, providers should test all pregnant women who lived in, traveled to, or whose partner traveled to Miami-Dade County after Aug. 1, 2016.

"This is the first time a mosquito-borne disease has ever caused birth defects in humans," **Lyle R. Petersen**, MD, MPH, director of the CDC's Division of Vector-Borne Infectious Diseases, said at a recent two-day Zika summit at the CDC. "The last time an infectious pathogen — rubella virus — caused an epidemic of congenital defects was more than 50 years ago. … This is also the first mosquito-borne virus that has shown to be sexually transmitted in humans."

Again, though the primary threat is to pregnant women and unborn children, adherence to standard precautions and injection safety should block occupational transmission to workers if patients with Zika are hospitalized or treated in other healthcare settings.

The CDC recently reported Zika-affected pregnancies with birth defects in the U.S. were about 20 times higher than pregnancies occurring before the virus emerged as an epidemic in the Americas last year. "Defects and other early brain malformations, eye defects, and other central nervous system problems, were seen in about 3 of every 1,000 births in 2013-2014," the CDC reported.[1] "In 2016, the proportion of infants with these same types of birth defects born to women with Zika virus infection during pregnancy was about 6%, or nearly 60 of every 1,000 completed pregnancies with Zika infections."

The birth defects include microcephaly, with the critical risk period to the fetus occurring in the first trimester of pregnancy, Petersen said. The virus attacks the brain before the cranial plates of the skull are fully set, causing them to collapse in to form the small head, he said.

The prevailing consensus is that most Zika infections are largely asymptomatic and inconsequential unless the infected person is pregnant or has had unprotected sex while the virus was circulating in the blood or persisting in a human reservoir like semen. Thus, we have seen the tragic

birth defects, failed or terminated pregnancies, transmission to sexual partners both male and female, and Zika infection following a needlestick.

In addition, 2016 saw the strange case of a 73-year-old patient in the U.S. who apparently transmitted Zika to a visiting acquaintance — possibly through tears — before dying with an incredibly high level of circulating virus in the blood.[2] The secondary case developed symptomatic Zika infection, but subsequently recovered. It is possible that hormonal treatment for prostate cancer somehow accelerated viral replication in the index case, investigators concluded.

As employee health professionals are well aware, Zika is just the latest example of bloodborne threats to healthcare workers. This underscores the importance of using sharps designed to prevent injuries, the prompt reporting of any needlesticks, lacerations, and other exposure incidents to supervisors as soon as possible.

Healthcare workers should use standard precautions during patient care regardless of suspected or confirmed Zika infection status, NIOSH and OSHA recommend.[3] However, employers should consider enhanced precautions in situations where workers are at increased risk of exposure to Zika virus or other hazards.

"While there is no evidence of Zika transmission through aerosol exposure, minimizing the aerosolization of blood or body fluids as much as possible during patient care or laboratory tasks may help prevent workers from being exposed to other pathogens," the agencies recommend. "Additional protections, including engineering controls to ensure containment of pathogens or enhanced PPE to prevent or reduce exposure, may be necessary during any aerosol-generating procedures or other such tasks."

ANA Trains for 'New Normal'

As emerging, novel viruses seem to have become the "new normal" for employee health professionals, several research and training projects are being undertaken to shed light on how best to protect staff from infectious threats.

The healthcare system has certainly been tested by Ebola, Zika, and MERS, with a common finding that training and consistent, correct use of PPE is an ongoing concern.

The 2014-2015 Ebola outbreak spread to some 28,000 cases and caused more than 11,000 deaths. One of them was a patient admitted to a hospital in Dallas in October 2014. He died, but infected two nurses, who survived. There was considerable confusion about the case, and some initial speculation that the nurses must have had a break in infection control technique or PPE. While the exact route of transmission was never determined, a report by an expert investigative panel described a chaotic scene where any number of factors could have led to the occupational infections. Healthcare workers were confused and "lost confidence" trying to protect themselves with PPE guidelines that were in flux at that critical time, the panel concluded.

As a result of the Ebola outbreak, the American Nurses Association (ANA) has entered into training and resource collaborations with the CDC.

"The ANA has been involved in infection prevention and control for quite some time, ranging from antibiotic stewardships to preventing healthcare-associated infections, but after the Ebola outbreak we wanted a more formalized collaboration between ourselves and the CDC," says **Seun Ross**, DNP, MSN, CRNP-F, NP-C, NEA-BC, director of nursing practice and work environment at the ANA.

The nurse-patient relationship is arguably the most critical aspect of care delivery, and the ANA is particularly proud that nurses are consistently ranked as the most ethical of all professions.

"We have ranked No. 1 in that category for the past 15 years and that is a position we don't want to concede," Ross says. "We want to continue that trust [in nursing as an ethical profession]. We want to make sure that nurses are knowledgeable to handle anything that comes their way. Certainly, emerging infectious diseases are in that category and may involve at any time a different understanding of [infection control recommendations]. We want to do everything we can to minimize any concern or hesitation on the part of the nurse."

Thus, the ANA collaborated with the CDC to form the Nursing Infection Control Education (NICE) Network. The plan is to present CDC training materials at conferences and meetings of nursing specialty groups.

"The CDC is developing a basic training program and we are going to take it and gear it more toward nurses for ANA and some 20 other nursing associations," Ross says. "We will do it in collaboration with them at each of their conferences so we can reach a broader range of [nursing specialties]. After nursing school, once you get your first job, every hospital does basic infection control. With the NICE Network, we plan on teaching hand hygiene, PPE, fundamental principles, and prevention of infection transmission. We will use all

of that as a baseline and expand on that and talk more about emerging infections."

In additional Ebola education efforts, the federal government has awarded $12 million over the next five years for training development at three hospitals that all cared for infected patients in their respective biocontainment units during the outbreak. The facilities participating in the collaborative training and education effort are Emory University in Atlanta; the University of Nebraska Medical Center in Lincoln; and Bellevue Hospital Center in New York City. Training will include rapid suspect or confirmed case identification and immediate isolation as well as appropriate donning and doffing of PPE. ■

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The Ethical Quandary of Moral Distress

When nurses cannot 'do the right thing'

Imagine you are nurse treating a cancer patient.

You are aware that the patient is suffering and no longer wants to be treated, yet family members push for continuing chemotherapy in hope of a cure. The patient continues treatment to appease this aim, suffering personal misery and giving rise to what nursing researchers term "moral distress" in the caregiver.

This condition is distinct from other emotional states caused by the pressures and obstacles that make healthcare such difficult work, explains **Cynda Hylton Rushton**, PhD, RN, FAAN, who participated in a symposium on the topic and was the lead author of a resulting paper.[1]

"Although it has overlapping characteristics, it is often distinguished from other emotional states by its focus on the moral or ethical aspects of the situation," says Rushton, a professor of clinical ethics in the Johns Hopkins Berman Institute of Bioethics and the School of Nursing.

Rushton and colleagues outline a path to "moral resilience" for nurses and other healthcare workers feeling conflicted about a given situation and the inner desire "to do the right thing." Moral distress is more likely to occur as healthcare complexity increases, leading to ethically challenging scenarios that may contribute to burnout, they report.

Some of the building blocks for moral resilience cited in the paper include mindfulness meditation, ethics education, and organizational support. Thus, individual action within a broader framework of culture change is required.

"Addressing moral distress requires both individual and organizational strategies — neither is sufficient alone," Rushton tells *Hospital Employee Health*. "A misconception about moral resilience is that it suggests that one is ignoring or being complacent about the real and complex ethical issues that are present in our workplaces. On the contrary, skills such as mindfulness offer the foundational mental and emotional stability that is needed for conscientious clinicians to recognize and respond to threats or violations of personal and professional integrity. Without such stability, clinicians risk causing harm to themselves and others."

Clinicians also need to cultivate "moral efficacy" — the ability to recognize, deliberate, and act in ways that are aligned with their personal and professional ethical standards, Rushton notes.

"In order for moral distress to be addressed effectively, clinicians must practice in environments that support ethical practice [through] such structures as ethics committees, employee assistance programs, policies, and processes that support clinicians," she says.

This will require moving beyond "either/or thinking" and realizing there is some interplay between individual moral beliefs and the ethical mindset of their place of employment, she notes. ■

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Tuberculosis Proving Difficult to Reduce in U.S.

Maintain vigilance in testing healthcare workers

With the recent commemoration of World TB Day, the CDC reported that tuberculosis continues to decline in the United States, but not on a pace to reach the goal of tuberculosis eradication.

"In 2016, a total of 9,287 new tuberculosis cases were reported in the U.S.," the CDC reported.[1] "This provisional count represents the lowest number of U.S. TB cases on record and a 2.7% decrease from 2015. The 2016 TB incidence of 2.9 cases per 100,000 persons represents a slight decrease compared with 2015 (-3.4%). However, epidemiologic modeling demonstrates that if similar slow rates of decline continue, the goal of U.S. TB elimination will not be reached during this century. Although current programs to identify and treat active TB disease must be maintained and strengthened, increased measures to identify and treat latent TB infection (LTBI) among populations at high risk are also needed to accelerate progress toward TB elimination."

That means employee health professionals must remain vigilant with TB testing programs for healthcare workers, with the frequency determined by using the standard CDC risk assessment. *(View the CDC's TB risk assessment worksheet at: http://bit.ly/2olPLY7.)*

A Legendary Killer

Poet John Keats, gunfighter Doc Holliday, First Lady Eleanor Roosevelt. All died of an ancient malady once called consumption — because it seemed to "consume" its wan sufferers as it took the life from them breath by bloody breath.

TB is a largely treatable disease that still manages to kill millions worldwide, can lie dormant for years until a carrier becomes immune compromised, and has developed strains highly resistant to drug therapy. Impoverished crowded communities in Asia and Africa still suffer the major toll of TB — and, of course, any disease in the world is but a plane ride away.

THE CDC ESTIMATES THAT OVER THE LAST TWO DECADES, TB CONTROL EFFORTS HAVE PREVENTED AS MANY AS 300,000 PEOPLE FROM DEVELOPING THE DISEASE, SAVING MORE THAN $6 BILLION IN COSTS.

"TB cases continue to occur in every state and region in the United States," the CDC reports. "Analysis suggests that eliminating TB will require a dual approach: strengthening existing TB programs/systems to diagnose and treat active TB disease, and intensifying efforts to identify and treat latent TB infection among those who are infected with TB bacteria but are not yet sick."

The CDC estimates that over the last two decades, TB control efforts have prevented as many as 300,000 people from developing the disease, saving more than $6 billion in costs.

"Unfortunately, these efforts alone will not be sufficient," the CDC notes. "More than 85% of U.S. TB cases are associated with reactivation of latent TB infection, often acquired years earlier. It's estimated there are up to 13 million people living in the U.S. with latent TB infection. … While they do not have symptoms and cannot spread the bacteria to others, 5% to 10% of them will eventually develop active TB disease if left untreated."

TB has plagued humankind for thousands of years because it is both patient and mutable. It is the ultimate opportunistic infection and can demonstrate high levels of resistance if drugs are not administered properly and taken with full compliance.

"Treating a single person for drug-susceptible TB disease costs about $18,000 — some 36 times more than the $500 it costs to proactively treat a person for latent TB infection," the CDC reports. "The cost for treating drug-resistant TB disease is even higher, ranging from $154,000 to $494,000," up to nearly 1,000 times treatment costs for a latent TB infection.

Drug-resistant TB

In 2015 data — the most recent available — 88 cases of multidrug-resistant TB occurred in the U.S., comprising 0.4% and 1.2% of culture-confirmed TB cases among U.S.-born and foreign-born persons,

respectively, the CDC notes. Among those 88 multidrug-resistant TB cases, 72 (81.8%) occurred in people with no reported history of TB disease. Fortunately, only one case of extensively drug-resistant TB — which can be virtually untreatable — occurred in the U.S.

State-specific TB incidence for 2016 ranged from 0.2 cases per 100,000 persons in Wyoming to 8.3 in Hawaii, with a median state incidence of 1.9. California, Florida, New York, and Texas reported more than 500 cases each in 2016, accounting for 51% of reported cases nationwide. Seven other states and Washington, DC exceeded the national TB incidence rate: Alaska, Arkansas, Georgia, Maryland, Minnesota, New Jersey, and North Dakota.

"Among 9,287 TB cases reported in 2016, U.S.-born persons accounted for 2,935 (31.6%) cases, and 6,307 (67.9%) cases occurred among foreign-born persons," the CDC reports. "TB incidence among U.S.-born persons (1.1 cases per 100,000) decreased 8.4% from 2015. Incidence among foreign-born persons (14.6 cases per 100,000) decreased 3.2% from 2015, but was approximately 14 times the incidence among U.S.-born persons."

In 2016, four of the top five countries of origin for foreign-born people with TB disease were considered high TB burden countries by the World Health Organization: China, India, Philippines, and Vietnam. People from these countries accounted for 36% of incident TB cases among foreign-born people in U.S.

"Because approximately 90% of TB cases in foreign-born persons in the U.S. are attributable to reactivation of LTBI, targeted testing for and treatment of LTBI among foreign-born persons from countries with high TB prevalence could be an effective strategy to decrease TB incidence," the CDC concludes. "The current recommendation … to test persons at increased risk regardless of length of time in the U.S. is in keeping with evidence that reactivation of LTBI remains a substantial concern, even in foreign-born persons who have lived in the United States for many years." ■

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Mumps Outbreaks Widely Reported

Fears measles may also strike given alarmist vaccine rhetoric

Given the current outbreaks of mumps in the U.S. and the similar surge in measles the last few years, the last thing employee health professionals need is people avoiding the MMR vaccine and not immunizing their children.

As this issue went to press, there were mumps outbreaks reported in California, Arkansas, Illinois, and Edmonton, Canada.

Undiagnosed cases — particularly of highly transmissible measles — can set off a laborious and expensive scramble to determine worker exposures and existing immunity.

As employee health professionals are aware, proof of healthcare worker immunity to mumps includes:

• written documentation of vaccination with two doses of live mumps or MMR vaccine administered at least 28 days apart;

• laboratory evidence of immunity;

• laboratory confirmation of disease; or

• birth before 1957.

Could such outbreaks of vaccine-preventable diseases become more common, threatening to tip herd immunity? Public health advocates are concerned that the thoroughly refuted link between the MMR vaccine and autism will resurface in the current political climate. Longtime vaccine safety critic Robert F. Kennedy, Jr. and actor Robert DeNiro recently offered a $100,000 prize to anyone that can prove vaccines are safe.

Specifically, the challenge cited is to "find a peer-reviewed scientific study demonstrating that thimerosal is safe in the amounts contained in vaccines currently being administered to American children and pregnant women."[1]

The FDA concluded in a 1999 review of the issue that there was "no evidence of harm from the use of thimerosal as a vaccine preservative, other than local hypersensitivity reactions."[2] Nevertheless, the use of the mercury-containing preservative has been largely phased out, with the FDA reporting that the vast majority of vaccines for children 6 years of age or younger marketed in the U.S. contain no thimerosal or only trace amounts.

"The fact that thimerosal was voluntarily withdrawn has become

something in and of itself, a rallying cry that there was something tainted about it the first place, which is untrue," says **William B. Miller, Jr.**, MD, scientific advisor to OmniBiome Therapeutics, which includes vaccine research. "The idea was the methyl mercury at allowable amounts is difficult to gauge, so let's not allow any if we can. It is true that how you make the vaccine and what you use for stabilizers has changed over time. It is true that vaccinations can have adverse effects. We recognize there are straightforward allergic reactions, particularly to egg products that are part of the manufacturing stabilization process. So it's not as if there is absolutely 100% safety. There is a risk to everything you ever do in life."

That said, thimerosal and mercury have basically been removed from vaccines down to trace levels for at least a decade, he says.

"And the incidence of autism is rising," Miller says. "The cause and effect was not only established in the first place, but now there is an indication that there was never any linkage because the incidence is continuing to change despite the fact that the additive that the objection is based upon has been removed."

Earlier this year, Kennedy was reportedly in discussions with then-president-elect Donald Trump about possibly forming a vaccine panel of some sort, but as of press time it was unclear whether that will be pursued.

The mere mention of forming such a panel alarmed public health officials, says **William Schaffner**, MD, a professor of preventive medicine at Vanderbilt University in Nashville. "[Kennedy] visited the president-elect, came out and made that statement, and then the [Trump] transition team walked that back, so that's in flux at the present time," he says. "Many of us are concerned that the integrity of vaccines would be challenged by such a presidential commission. Much of the concerns about vaccines are unfounded, and particularly this myth that autism is related to vaccination. As a scientific and public health question, that is now settled. There is no association between autism and vaccines."

The concern stems in part from a September 16, 2015, Republican presidential debate, when then-candidate Donald Trump linked vaccines to autism by citing the amount of immunizations given in a short period to babies and young children. The comments were roundly condemned by the medical community, with the American Academy of Pediatrics (AAP) calling them both false and dangerous.

The theory gained traction after publication of a later-retracted study in *Lancet* that falsely suggested MMR vaccine administration triggered the onset of autism in children.[3] However, it appears that much of the autism increase has been due to changing definitions — "diagnostic substitution" — that have increased the number of intellectual disabilities defined as autism. This surveillance artifact accounted for a 64% increase in autism diagnosis from 2000-2010, researchers concluded.[4]

Despite the preponderance of evidence, the anti-vaccine message has had an effect, particularly in the uptake of the MMR vaccine. A 2015 study estimated that some 9 million U.S. children were susceptible to measles, a disease that had been virtually eradicated in the U.S. through routine vaccination.[5] While these unvaccinated children run the risk of a serious or complicated infection, they also pose a transmission threat to infants too young to be vaccinated and others who are contraindicated for vaccination or can mount little immune response even if given MMR. ■

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COMING IN FUTURE MONTHS

- Haunting: The effect of losing a patient on HCWs
- OSHA proposed rule on healthcare violence
- Know how to make the business case for your program
- Portlandia: Employee health research from APIC meeting

HOSPITAL EMPLOYEE HEALTH

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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CE QUESTIONS

1. **Cynthia Clark, PhD, RN, said while bullying and violence are directly related, incivility is a matter of common manners and should not be seen as aggressive.**

   a. True
   b. False

2. **Michael Hurley, president of the Ontario Council of Hospital Unions, cited which of the following as a contributing factor to surging violence in healthcare facilities?**

   a. Laws against arming healthcare workers
   b. Recording verbal insults as acts of violence
   c. Hospital beds full and patient demand exceeding capacity
   d. All of the above

3. **Cynda Hylton Rushton, PhD, said healthcare workers with strong religious upbringings are particularly prone to "moral distress."**

   a. True
   b. False

4. **According to the CDC, more than 85% of U.S. TB cases were associated with:**

   a. birth in Asia
   b. reactivation of latent TB infection
   c. failure to implement directly observed therapy
   d. All of the above

CE OBJECTIVES

After reading each issue of *Hospital Employee Health*, the nurse will be able to do the following:

1. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
2. Describe how the clinical, administrative and regulatory issues particular to the care of hospital employees affect health care workers, hospitals, or the healthcare industry at large;
3. Cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.