HOSPITAL EMPLOYEE HEALTH

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INSIDE

RELIAS MEDIA

Bearing Witness to Patient Stories Can Reduce Physician Burnout

A doctor near death awakens to the coldness of her profession

By Gary Evans, Medical Writer

Rana Awdish, MD, a young, pregnant critical care physician, became a patient spiraling toward death in her own hospital in the course of a single day that began with her shopping for shoes.

She was hit with a sudden devastating illness in 2008, hemorrhaging and experiencing organ failure that resulted in the loss of her unborn child, and very nearly her life. A benign liver tumor had ruptured, causing severe bleeding that led to hemorrhagic shock. She required 26 units of blood, multiple surgeries, and physical therapy to recover and return to work. But her transformative experience as a patient irrevocably changed her view of medicine, which she saw for the first time as too callous, distant, and dysfunctional.

In subsequent speaking engagements, articles, and a 2017 book,[1] Awdish emphasizes a compassionate, patient-centered approach to care, which occurred to her as a great need both personally and within her profession when she was near death.

> "WHAT WE NOW KNOW IS THAT MEDICINE WITHOUT CONNECTION DOESN'T ACTUALLY NURTURE THE PROVIDER."

"When I overhead a physician describe me as 'trying to die on us,' I was horrified," she wrote in an article in the *New England Journal of Medicine*.[2] "I was not trying to die on anyone. The description angered me. Then I cringed. I had said the same thing, often and thoughtlessly, in my training."

Awdish is a specialist in pulmonary medicine and critical care in the same

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hospital where she was a patient, Henry Ford Medical Center in Detroit. *Hospital Employee Health* recently spoke to her for the following interview, which has been edited for length and clarity.

'I Did Not Know My Value if I Could Not Fix Things'

HEH: You wrote that in the transformation from provider to patient, you saw in caregivers an inability to acknowledge patient loss and suffering.

Awdish: For me, as a critical care physician specifically, I had been acculturated to believe that the way we relieve suffering was to treat the disease. Any time that we spent where we were just holding space with emotion was less valuable than doing the work of retrieving someone from the brink of death. As a patient, what I really felt acutely was the need to feel that my suffering was seen.

"Suffering" is a word that we are not comfortable with in medicine. I think part of that is that we feel very impotent in the face of emotional suffering. We know that we can't fix it — we can't "un-sad" anyone. Physicians are very goal-oriented and driven to fix things. In many ways, that is how we measure our value. I, for one, did not know what my value was if I could not fix things. I didn't necessarily think that sitting with someone through an emotional trauma was valuable.

HEH: How did your own illness change your view of this?

Awdish: Going through the years of my own illness, what I really saw was that there was an incredible amount of healing from just being present and available to hold that space. It wasn't just the people around me who showed me that. It was also my patients when I went back to work, and I was approaching things from a different perspective. I made myself available for those difficult conversations, where I didn't have any answer and I couldn't fix it. I would just be available for the pain. What was reflected back to me was how meaningful that was and how it was healing — even though I couldn't heal. I learned that from both my caregivers and my patients.

HEH: Does dropping that guard, becoming empathetic, run the risk of making you more vulnerable to burnout or negative aspects of patient suffering?

Awdish: I think it's quite the opposite. We were taught not to do that to protect ourselves out of a fear that we would deplete ourselves. What we now know is that medicine without connection doesn't actually nurture the provider. It doesn't provide for longevity; it doesn't let you see [the patient and the system] in a way that creates joy in work.

While I think our predecessors touted this idea of "clinical distance," it was at a time when, really, the system itself wasn't resilient. There wasn't space for them to debrief; there were not venues to recuperate after a trauma. It was very sterile, clinical, and male, frankly. I think as more women enter medicine, we can drop that façade a little bit and allow these traditionally feminine attributes of nurturing and caring.

We are seeing now how much value is there. It really is bidirectional — if you open yourself, it doesn't deplete you. It actually nurtures you and helps you find joy in work.

HEH: How do nurses fit into this view?

Awdish: I think nursing has been ahead of us as physicians for a

long time in terms of integrating the whole person into their education, integrating compassion and the presence of suffering. They are a group we can really learn from because we did not have that in our medical education.

HEH: How did you bring these new insights into your clinical practice after you recovered from your illness?

Awdish: One of the first things I did when I went back to work was to really look for resources and find out how to have these conversations effectively. I looked to Vital Talk, a national organization that trains physicians in difficult conversations.

I went and trained because it was not something that we learned in medical school, in residency, or fellowship. I went as an attending [physician], and we role-played difficult conversations. I learned how to have those conversations in a way that didn't deplete me. I knew they would be healing for the patient, and, therefore, I wasn't as afraid of them.

I think having that kind of training is necessary. This isn't something where we are asking clinicians to open their hearts and bleed, because that is not sustainable. It's finding ways to be compassionate that are actionable, to show that you will support someone through a difficult time, but feel supported yourself as well.

We can't do this in a dysfunctional system. It requires the system to really support clinicians and ensure that they have the resources that they need. That is why I brought the training back to Henry Ford Hospital along with other physicians who trained with me. We knew that we needed it in order to do this work. *(Editor's note: Vital Talk, which offers training to help clinicians engage in difficult conversations with patients and families, is available at: https://www.vitaltalk.org/.)*

HEH: You point out that it is a misconception that this approach will require more physician time.

Awdish: The myth is that it takes more time. The truth is that it doesn't. There are good studies to show that physicians that are compassionate in any specialty actually have shorter clinical encounters. That makes sense intuitively, because if the patient feels heard, they can let go of needing to retell their story or describe their symptoms again. They feel "seen." I think a lot of what we are avoiding is actually the answer.

HEH: Based on the success of your book, your message seems to be resonating in the healthcare community.

Awdish: Yes, and I have to say that was not my expectation. I honestly believed that what I wrote was more subversive than it turned out to be. I thought it was more counter to the culture. As is often the case with a story, when we are vulnerable we tell our truth. A lot of people can identify and see themselves in it, so it has been picked up as either required or suggested reading at over 50 medical schools now. It is part of the curriculum in hospital business administration, nursing curriculums, and ethics curriculums as far away as Ireland and Australia. I think it struck a nerve. That's wonderful that it is part of the larger conversation about how we can heal. I'm grateful for that, but I think it is really just the beginning. There is so much we can do to really operationalize compassion and make the system work for physicians so that they can apply these things if they want to. It's very rewarding.

HEH: Speaking of telling your story, you wrote of "narrative medicine" and the clinical value of the patient story.

Awdish: All roads lead back to the patient story. Whatever road I've gone down, I keep coming back to narrative medicine because there is something so visceral about really hearing the patient story and receiving it — not extracting it in data points that are relevant to physicians, but letting the patient story really have primacy. I think we can do that, even with our stories.

As clinicians, sometimes we need to tell our story of trauma that comes from a death, or an error, or a really bad night on call. By doing that, we can create affiliation through representation. We can see each other in these stories. At its basic core, narrative medicine reduces us to our humanity. I think it is there that we can really see that we are all the same — physicians and patients. We are interchangeable depending on the moment. What we all want is to be seen and known, and stories can help us do that.

HEH: What do you mean when you say you found that "the wound is the gift?"

Awdish: There are so many hurts and injuries that we all sustain in our training. There are wounds that we sustain as patients. If we can sit with that suffering, that's where the lessons reveal themselves. My book, for me, was a meta lesson in that. If I could sit with this suffering, there was such a gift within it of wisdom, clarity, purpose, and direction that I wouldn't have had otherwise. It was part of my upbringing to believe that good can come out of anything. "The wound is the gift" is really just a different way of saying that. ■

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Federal Healthcare Violence Bill May Get House Vote

Senate version endorsed by presidential candidates

A federal bill (HR-139) that would require an OSHA standard to prevent violence in healthcare passed the House Committee on Education and Labor, clearing the way for a possible vote by the full House.

"This bill enjoys bipartisan support, which is unique in these days," says **Michelle Mahon**, RN, nursing practice representative for National Nurses United. "It is really encouraging to see that the public pressure and the outcry for protection of hospital worker safety has been heard."

The Workplace Violence Prevention for Health Care and Social Service Workers Act was approved by the committee on June 11, 2019.

"Nurses across the nation hope that this bill will now be heard before the entire house," Mahon says. "With continued public support, and people calling their legislators, this can happen. We have gotten this far."

The issue has been subject to a protracted struggle for years, with OSHA finally agreeing in 2017 to promulgate a standard. Although still considered a political long shot, a similar bill has been introduced in the Senate (S.851) by Sen. Tammy Baldwin, D-WI. As of June 26, 2019, the bill's 20 co-sponsors included the five Democratic senators who are running for president.

"We understand the nature of this struggle, and it is unfortunate," Mahon says. "It should be a priority of the policymakers of this nation to protect healthcare workers from violence. These violent acts are preventable. We have been working on this a long time. We won this victory in California. We expect that this will move forward."

While the California law is considered the model for national legislation, other states have not been quite as successful. For example, Nevada recently passed a healthcare violence bill (A.B. 348) after a series of compromises with state hospital groups.

"Unfortunately, the final version of A.B. 348 fell short of the strongest standard of protections, but we will continue to fight to win them in Nevada and nationally," says **Eleanor Godfrey**, RN, director of health and safety at National Nurses United.

In what has become a depressing recurrence at state and federal hearings, several Nevada nurses testified about the occupational violence they face.

'The Patient Was Right Behind Me'

Christy Tolotti, RN, an ED nurse in Reno, NV, testified that her hospital had already adopted some of the measures in the proposed bill, including alarms, improved environmental safety, and lockdown systems. The problem is that the measures were not implemented until after a violent incident occurred, and she expressed concern that other hospitals will be similarly reactive instead of proactive in preventing violence.

"About a year ago, one of my coworkers was stabbed while doing his job," she said. "I was at work that day and responded to the incident."

A patient had come in and registered, then stepped outside to smoke a cigarette. The patient was in violation of a hospital policy that prohibits smoking right outside a door, and a hospital tech stepped out and informed the patient. When the worker turned to re-enter the building, the patient stabbed him.

"The tech ran outside the door into the ambulance bay," she said. "We have a camera in the ambulance bay, and I happened to see from the camera that the tech was running around. The tech then ran back inside and was stabbed a second time in the process."

Tolotti assisted the tech, who was pale and going into shock, as codes were called and people were yelling.

"The patient was right behind me, yelling and screaming and waving the knife at the staff behind the registration desk, who were protected by a glass barrier," Tolotti said. "The patient's caregiver was trying to get the patient to drop the knife as security finally showed up and apprehended the patient."

The ED tech survived — but, clearly, a worse outcome was entirely possible, she added.

"Our hospital was not ready for such an incident," she said. "And even though there have been improvements in safety since the incident, it has all been reactionary. This is unacceptable."

The staff carry personal alarms, but the onus is on workers to test them and ensure they are working, she said. Environmental

improvements performed after the incident include garage-type doors that can be closed to block off equipment and other items that could be used as weapons if an aggressive, disoriented, or psychotic patient is in the ED, she said.

"Our hospital has a policy that whenever we have a shooting or stabbing victim come into the emergency department, we go on lockdown," Tolotti said. "This is an important policy to protect everyone's safety because there have been multiple times when a gang comes to the hospital to try to 'finish off' the victim."

'Categorically Different'

Such is the reality that healthcare workers face in a unique work environment, emphasizes **Amy J. Behrman**, MD, FACOEM, FACP, medical director of occupational medicine at the University of Pennsylvania in Philadelphia.

"It is categorically different," she tells *Hospital Employee Health*. "The injuries that are incurred in healthcare settings are perpetrated by people that are delirious, in pain, out of control. Solutions that might be entirely appropriate for someone on an overnight retail shift are not going to work for a healthcare setting. I bring this up because there has been some discussion about whether this should be a more general OSHA mandate [on workplace violence]."

Berhman is the co-author of a letter supporting the federal legistlation recently issued by the American College of Occupational and Environmental Medicine (ACOEM).

"California has model legislation for this, but personally, I believe that a national mandate would be in the best interest of healthcare personnel rather than a state-by-state basis," she says. "The numbers suggest that either there is more reporting, or there are more incidents of violence against healthcare personnel, or some mix of those two. It is certainly a severe and worsening problem. And the nurses bear the brunt of everything we are talking about."

> "IT SHOULD BE A PRIORITY OF THE POLICYMAKERS OF THIS NATION TO PROTECT HEALTHCARE WORKERS FROM VIOLENCE."

As previously reported in *Hospital Employee Health*, California's Occupational Health and Safety Administration (Cal/OSHA), working with nurses in the state, adopted workplace violence regulations in 2016.

California nursing groups are ensuring that violent incidents in healthcare are reported under the new law, which is considered a first step in assessing its effectiveness, Mahon says.

"There is now some transparency and oversight in that regard," she says. "We do know from the reports so far that the most common place for violence to occur is the patient room, followed by the emergency department and behavioral health units. We know now that specific units need further intervention and more prevention standards. The information [gained from reporting] will guide additional protection on these units."

Citing the California law as the gold standard, National Nurses United wrote[1] that the following elements should be included in a federal law:

- Broadly define workplace violence to include threats and the use of physical force, including incidents involving the use of firearms or dangerous weapons;
- Require employers to develop unit-specific and facility-specific prevention plans, instead of a general plan;
- Actively involve employees in developing, implementing, and reviewing the plan, and provide robust training programs for employees;
- Ensure that employers assess hazards and provide correction procedures, including staffing, trained security personnel, environmental risk factors, patient-specific risk factors, alarm systems, and job design and facilities;
- Require that employers establish effective reporting processes and policies to ensure that employees can report workplace violence without fear of retaliation; systems for communication between co-workers, shifts, emergency services, and law enforcement about risks for violence; and violent incident logs to track all incidents and threats;
- Mandate effective and prompt responses to all workplace violence incidents as well as appropriate follow-up, including providing prompt treatment to injured employees and investigating whether any measures could prevent similar incidents in the future. ■

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Public Becoming Aware, Concerned About Healthcare Burnout

As part of its continuing effort to raise awareness about the risks of burnout in pharmacy workers, the American Society of Health-System Pharmacists (ASHP) took the unusual step of surveying the public about a condition that is widely reported in healthcare.

Overall, 74% of U.S. adults surveyed said they are concerned about burnout among healthcare professionals. The survey was performed May 28-30, 2019, with ASHP contracting the Harris Poll to conduct the research.

The National Academy of Medicine's definition of clinician burnout includes feelings of emotional exhaustion, dissatisfaction, and detachment from work. ASHP is participating in the academy's Action Collaborative on Clinician Well-Being and Resilience, a project that is exploring the root causes of burnout and evidence-based solutions.

"There is a lot of research, momentum, and awareness of this issue," says **Christina Martin**, PharmD, MS, director of membership forums for ASHP. "One of the primary reasons for this survey was connecting [to the public]. We have emerging research on the impact on the pharmacist and the pharmacy workforce, but this was tying in the patient perspective. The patients want their healthcare clinicians to be healthy and well."

The ASHP survey found that healthcare professionals may be conveying signs of burnout without knowing it. Overall, 60% of respondents said their healthcare providers seem tired and rushed.

"The patients are listening," she says. "They are aware, and 80% of these patients surveyed say their perception of quality of care decreases when their doctor, nurse, or pharmacist is burned out."

Although the general findings reaffirmed anecdotal reports of public awareness of healthcare burnout, Martin expressed some surprise that one in four respondents identified "hospital pharmacists" as healthcare professionals who are experiencing burnout.

"That one piece did catch our eye," she says. "The degree of interaction is different site-to-site, but 26% perceived that their hospital pharmacist is burned out."

In a 2018 study, researchers found that 53% of pharmacists met at least one criterion for burnout. *(For more information, see related story on page 91.)*

"A majority of those respondents were frontline practicing pharmacists," Martin says. "Only about 19% identified as being a leader or an administrator. Some of the risk factors that may have influenced the results — and in thinking about the other published literature in medicine and nursing — are the competing responsibilities."

Juggling responsibilities to patients and clinicians is a common issue. Additional duties may be expected in teaching facilities.

"Frontline pharmacists have teaching and precepting responsibilities, so they have to ensure that they are meeting the school or a learner's program responsibilities," she says.

Pharmacists also are being called to serve on antibiotic stewardship committees that are becoming common in many hospitals.

A particularly complicated task is dealing with drug shortages, with some drugs in short supply and others exorbitantly priced.

"Many of our pharmacists say, 'I entered pharmacy to help patients,'" Martin says. "It is a caring profession, a healing profession. When a pharmacist is making recommendations for drug therapy and they are unable to get the medication needed due to shortages or escalating costs, it interferes with the pharmacist-patient relationship. Drug shortages alone may not be the sole source of burnout, but they are one of the many risk factors."

Editor's note: ASHP offers resources for identifying and preventing burnout, as well as strategies to use during drug shortages and other materials, available at: https://wellbeing.ashp.org/. ■

More Than Half of Healthcare Pharmacists Report Burnout

Overall, 53% of pharmacists reported a high score in at least one of three burnout indicators, researchers found.

"Emotional exhaustion was indicated most frequently in the study," the authors reported.[1] "This is often considered the core symptom, and is frequently predicted in other healthcare professions."

An attempt to correlate burnout to specific practices and workloads was not successful. In general, factors contributing to burnout include low pharmacist-to-patient ratios and expectations to conduct research in addition to daily duties.

The researchers used the Maslach Burnout Inventory-Human Services Survey to assess burnout in an anonymous email survey. Of 329 respondents, 53.2% reported scores indicating a high degree of burnout on at least one subscale of emotional exhaustion, depersonalization, and reduced personal sense of accomplishment.

"Twenty-eight respondents (8.5%) had scores indicating burnout on all three subscales," they reported.

Hospital Employee Health reached out to lead author **Mary E. Durham**, PharmD, MS, BCPS, interim director of pharmacy services at Truman Medical Centers in Kansas City, MO, to discuss the issue.

HEH: Can you cite a few factors specific to pharmacy work that contribute to feelings of burnout?

Durham: Pharmacy staff are a frontline resource to patient care. When patient volumes and patient acuity rise, pharmacists may feel increased pressure to deliver safe, efficient, and high-satisfactory care. The ever-changing American healthcare system affects pharmacy just as it affects other healthcare professionals. It is hard for staff to escape the rapid rate of change within their institutions, and this can be depleting over time.

HEH: Why are pharmacists within the first 15 years of their career at higher risk for burnout syndrome?

> FACTORS CONTRIBUTING TO BURNOUT INCLUDE LOW PHARMACIST-TO-PATIENT RATIOS AND EXPECTATIONS TO CONDUCT RESEARCH IN ADDITION TO DAILY DUTIES.

Durham: Pharmacists that are newer in their career have only ever experienced rapid change, and I think we are seeing a professional impact on well-being and resilience. Pharmacists have to remain flexible to handle many pressures; they must produce high-quality care with a top level of customer service while continually adjusting to their work environment that is impacted by merging health systems, payment model changes, and the electronic renaissance of healthcare. Many pharmacists are also feeling the pressure to continually invest in themselves through advanced education and training to remain competitive.

HEH: Is a lack of resources and adequate staff a common problem in hospital pharmacies?

Durham: I think there is a need for tangible resources that promote well-being. Most institutions have an employee assistance program, but the most at-risk team members need something more. These employees may be less likely to reach out for assistance when they are at their greatest need.

HEH: While your findings primarily apply to teaching hospitals, do you think burnout in pharmacists is more widespread and occurs in smaller hospitals as well?

Durham: Certainly. The environmental impact of healthcare's rapid changes and that of our profession can affect any institution.

HEH: What are some of the primary ways to establish resilience in pharmacists, and reduce or prevent burnout?

Durham: We have to communicate with each other, reach out early and often, and be able to identify and connect with that individual who is at risk for burnout before they go down an irreparable path. Educate your staff and peers on the resources available for resilience and well-being, and encourage their use. Encourage your teams to take PTO [paid time off], and fully disconnect from work while doing so. Make this a regular part of any touch base, whether informal or incorporated into performance management discussions. Everyone has a story, and we need to listen. ■

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Negative Attitudes Can Lead to Poor Outcomes

Patients of surgeons who are rude to colleagues have more complications

Patients are at greater risk of complications and adverse outcomes if surgeons break team protocols or treat colleagues poorly, reports **William O. Cooper**, MD, MPH, of the Center for Patient and Professional Advocacy at Vanderbilt University School of Medicine in Nashville, TN.

"You can see in a complex surgical operation how that would potentially impact things," he says. For, example, when a patient is not doing well, the surgeon may yell at an anesthetist.

"The next time they are paired together, that anesthetist may be distracted, waiting for the surgeon to blow — or be hesitant to speak up if the patient's blood pressure starts to drop or the patient is not doing well," he tells *Hospital Employee Health*.

Cooper and colleagues hypothesized that patients of surgeons with a higher number of co-worker reports about unprofessional behavior could experience a higher rate of postoperative complications than patients whose surgeons have no such reports.

"Among 13,653 patients in this cohort study undergoing surgery performed by 202 surgeons, patients whose surgeons had a higher number of co-worker reports had a significantly increased risk of surgical and medical complications," the authors wrote. "Surgeons who model unprofessional behaviors may help to undermine a culture of safety, threaten teamwork, and thereby increase risk for medical errors and surgical complications."

The study assessed data from two academic medical centers in the National Surgical Quality Improvement Program. Both hospitals acted on reports from co-workers describing unprofessional behavior by surgeons.

The researchers went back three years preceding an operation in assessing reports of unprofessional behavior by the surgeon. The main outcomes assessed were postoperative surgical or medical complications within 30 days of the operation.

Among 13,653 patients who underwent operations performed by 202 surgeons, 1,583 experienced complications.

"Patients whose surgeons had more co-worker reports were significantly more likely to experience any complication," they found. "The adjusted complication rate was 14.3% higher for patients whose surgeons had one to three reports, and 11.9% higher for patients whose surgeons had four or more reports compared with patients whose surgeons had no co-worker reports."

The researchers examined four types of behaviors that generated reports by co-workers. One was failing to follow accepted care protocols, such as handling a central line without gloves, Cooper says. Others included unclear or confusing communications from the surgeon to colleagues.

"There were some that were just rude and disrespectful," he says. "Others were just failing to follow through on professional responsibilities like signing verbal orders, or other things that are an important part of team function."

While this behavior can have a chilling effect on workers speaking out, some workers also express concerns during procedures, he explains.

"In our work, we find that many times a nurse or another worker does speak up and reminds the surgeon, but he goes ahead and does it anyway," he says. "The clear majority of surgeons, like all physicians, perform in perfectly respectful ways and never have any problem at all. It is a very small proportion that account for a disproportionate share of these kind of behaviors."

Put simply, the patients of these bad actors are at higher risk for surgical site infections and other adverse events.

"We also looked at things like strokes, pneumonia, and urinary tract infections," Cooper says. "We found that danger increased in most surgical and medical complications."

The primary intervention is sharing the data with the surgeon, using a trained peer messenger.

"We find that 80% of the time that a surgeon or another physician is an outlier, they will self-correct and reduce the number of unprofessional behaviors they have," he says. "For the small number of individuals who don't respond to the peer intervention, we recommend that hospitals do a physical and mental health evaluation to see whether there could be burnout, mental illness, substance abuse, or other problems."

Ongoing research indicates that this general pattern could manifest in other healthcare teams and work groups.

"We have studied this in advanced practice nurses and see a similar type of distribution," Cooper says.

"We are piloting some work looking at staff nurses, and we are seeing there is a non-random distribution that a small number of nurses account for a disproportionate share of unprofessional behaviors. We are proposing and planning to implement similar interventions." ■

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Healthcare Workers Are Working Sick During Flu Season

Study finds 95% work at least one day with acute respiratory symptoms

The CDC reminds the public every influenza season that those infected can spread the virus one day before symptoms appear. Yet, even when the first symptoms occur, healthcare workers (HCWs) may continue working with acute respiratory illness.

The continuing problem of presenteeism was documented recently in a study[1] of nine Canadian hospitals, where healthcare staff worked an average of two days with upper respiratory symptoms during flu seasons.

The workers were enrolled in active surveillance for acute respiratory illness (ARI) during the 2010-2011 and 2013-2014 flu seasons. Daily illness diaries during ARI episodes were used to compile symptoms and job attendance.

"We found that 50% of participants working in Canadian acute care hospitals reported episodes of ARI during each influenza season, with 95% of those who reported an ARI working one or more days of their illness," the authors reported.

Healthcare personnel worked for a mean of 1.9 days with symptoms of an ARI and took an average of 0.5 days of sick leave during flu season. Overall, HCWs were more likely to work if symptoms were less severe, particularly on the illness onset date.

"HCWs in our study were more likely to work on the first day of illness, when viral shedding and risk of transmission are higher," they noted. "HCWs working in high-risk areas were more likely to work during an ARI, emphasizing the need to be concerned about the risk of transmission to vulnerable patients."

HCWs were significantly less likely to work while ill in facilities that established exclusion policies for symptomatic workers, or that mandated one week furlough for laboratory-confirmed influenza.

"Our data provide an estimate of the impact of such policies: HCWs in acute care settings would miss an average of two additional days of work each influenza season," they concluded.

Recommendations for employee health professionals included educating workers on viral transmission risks and raising awareness of when they could infect patients or colleagues.

"Although only 3% of days worked while ill in our cohort were because the HCWs could not afford to stay home, 80% of our participants had paid sick leave," the authors said. "Policies that provide pay for HCW absence during communicable disease illness episodes may help reduce the percentage who work while ill."

Hospital Employee Health sought additional comment on the findings from principal author **Brenda Coleman**, PhD, clinical scientist in the infectious disease epidemiology research unit at Mount Sinai Hospital in Toronto.

HEH: At least one ARI episode was reported by 50.4% of participants each study season. Can you comment on the hospital's flu immunization rate, and whether any of these workers had the flu?

Coleman: More than 70% of participating healthcare workers were vaccinated against influenza, which is higher than the 50-55% coverage rates reported for all staff in the hospitals. Yes, participants did test positive for influenza — these data are currently being analyzed. About 9% tested positive for influenza.

HEH: Do you think the sick policies generally were too lax in the hospitals studied, and that presenteeism is a problem in the facilities?

Coleman: Sick policies need to be clear, and managers and supervisors need to enforce them. However, we understand that more data about the

transmission of respiratory viruses are needed to inform good policies.

HEH: Even mildly symptomatic workers could be a threat to immune-compromised patients, but you found that sick workers were caring for these patients.

Coleman: Yes, we enrolled staff working with immune-compromised patients. It was because of the vulnerability of these and other patients, including newborns, that we were interested in answering the question about working while ill. However, we did not have the sample size required to determine whether staff working with immune-compromised individuals were less likely to attend work while ill than other hospital staff.

HEH: Did you attempt to assess any patient illness related to care by symptomatic workers?

Coleman: No, not in this study. However, it is our intent to try to assess this in future research.

HEH: Did you find evidence of policies that discourage sick leave, like requiring vacation days be taken first? Similar policies are thought to incentivize presenteeism in U.S. hospitals.

Coleman: No, we did not measure sick leave policy impact on presenteeism. However, we agree that some policies, like requiring the use of vacation days and caps on the number of sick episodes, can encourage working while ill.

HEH: Can you elaborate on the point of balancing the effect on the hospital of workers missing two days of work vs. the patient safety benefit of sick workers staying home?

Coleman: The intent of the comment about two additional days of missed work was that it would provide the hospital with a number that could be used in its decision-making about what impact a policy change might incur. We do not have the data available to determine what that impact might be on patient health.

HEH: Was fever used as an indicator for taking sick leave in the hospitals, suggesting those with mild respiratory symptoms could work if they did not run a fever?

Coleman: Yes, many hospitals have policies about not attending work while febrile. As you point out, this would make it acceptable to work with mild symptoms. However, we do not yet know how transmission rates are affected by specific symptoms and their severity.

HEH: Can you comment on the finding of more physicians generally working sick than nurses? Is this a matter of work culture, or the possibility that doctors had more autonomy and were not necessarily bound to employee policies?

Coleman: Physicians are expected to follow hospital policies regardless of their working relationship. However, as many of them are self-employed — no sick leave, greater autonomy — and have other staff who are dependent on their individual attendance, it creates a difference between their professional safety culture and that of other hospital workers.

For example, other hospital staff could theoretically be more easily replaced for sick days than physician specialists. ■

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Adequate Staffing Protects Patients and Workers

Study shows link between staffing, patient infections

While proponents for better nurse-patient staffing ratios generally cite patient safety, studies also linked staffing improvements to reductions in injuries to healthcare workers.[1-4]

Nurses fighting to improve inadequate staffing levels at hospitals often cite patient safety, which holds a high moral ground while also speaking directly to the bottom-line concerns of the C-suite. As staff ratio laws are debated in various states, a new study might be presented as evidence of the issue.

Understaffing of registered nurses for two consecutive work shifts showed a statistically significant increase in healthcare-associated infections (HAIs), the researchers reported.[5]

"Clinically, it makes sense because if the understaffing is for only one shift, nurses can manage the workload," says lead author **Jingjing Shang**, PhD, RN, associate professor at Columbia University School of Nursing in New York City. "However, if [the unit is understaffed] the whole day, the consequences will show up."

Shang and colleagues examined "whether [HAIs] and nurse staffing

are associated using unit-level staffing data." Previous studies have suggested there is a link, but "the association between HAIs and nurse staffing are inconsistent and limited by methodological weaknesses," the authors noted.

'Significant Increase of the Infection Rate'

They analyzed data from a large urban health system between 2007 and 2012. HAIs were diagnosed using CDC definitions. To allow for the incubation period of pathogens, researchers assessed staffing levels two days before infection onset.

Overall, using a measure of patient-days, researchers 15% of patients "had one shift understaffed, defined as staffing below 80% of the unit median for a shift, and 6.2% had both day and night shifts understaffed. Patients on units with both shifts understaffed were significantly more likely to develop HAIs two days later," the authors reported. The analysis included urinary tract infections, bloodstream infections, and pneumonia.

"If only one shift was understaffed, the risk was also high but not significant," Shang says. "In the units that had both day and night shifts understaffed, we definitely saw this significant increase of the infection rate."

The study also showed an increase in infection risk when units lacked support staff, such as licensed practical nurses and nurse assistants. The bottom line for hospital leaders is that dollars saved by cutting staffing will result in the expense and suffering of HAIs.

"In addition to their medical and financial impacts, HAIs also have psychological and social consequences for patients such as depression, anxiety, disability, and job loss," Shang and colleagues emphasized.

Hospital administrators are the primary audience they wanted to reach with the paper, Shang says.

The threshold of 80% median unit staffing to define understaffing was drawn from previous research by the authors, serving as the line of demarcation between sufficient nursing levels and increased risk of HAIs.

As nurse staff levels decrease, the risks of cutting corners increase, resulting in lapses and breaches of infection control measures, such as hand hygiene and glove use.

Previous studies are limited in the way they assessed the effect of staffing on nursing, often averaging staffing over the whole hospital, Shang says. "They are not very specific on a unit level," she says.

The authors of the Columbia study sought more precision on the unit and shift level, using payroll data to determine when the nurses clocked in and out, she says.

"The infections in our study are based on CDC definitions," Shang says. "They are very precise, and are based on lab results, cultures, and symptoms. We measured the staffing very precisely, and the infections are based on clinical outcomes — not administrative data." ■

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HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **What type of training did Rana Awdish, MD, seek after returning to medicine after a near-fatal illness?**

   a. Using humor to interact with patients
   b. Holding difficult conversations with patients
   c. Gratitude journals for providers and patients
   d. Daily compassion practice with colleagues

2. **Amy J Behrman, MD, FACOEM, FACP, medical director of Occupational Medicine at the University of Pennsylvania, favored which approach to preventing violence in healthcare?**

   a. Laws adopted at the state level
   b. Policies left to individual facilities
   c. A federal regulation
   d. Increasing criminal penalties

3. **A recent study found that 53% of pharmacists reported a high score in at least one of three burnout indicators. Which of the following was the most commonly reported indicator?**

   a. Depersonalization
   b. Sleep disturbance
   c. Emotional exhaustion
   d. Reduced sense of accomplishment

4. **Which driver of burnout was specifically cited as interfering with the pharmacist-patient relationship?**

   a. Research responsibilities
   b. Drug shortages
   c. Supervision duties
   d. Educational responsibilities

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 healthcare 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.