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THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

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INSIDE

The 'Parallel Pandemic': Clinicians May Face Post-Traumatic Stress

By Gary Evans, Medical Writer

Medical experts are expecting a second wave of mental health issues to hit healthcare workers after the novel coronavirus abates. Some are warning that a "parallel pandemic" of post-traumatic stress will beset healthcare workers who witnessed COVID-19 deaths and suffering in patients and colleagues.

"These courageous people are risking their lives, threatened not only by exposure to the virus but also by pervasive and deleterious effects on their mental health," the authors of a recent perspective article wrote. "Tragically, we are already seeing reports of clinicians dying by suicide amid the pandemic, including the highly publicized death of a prominent emergency medicine physician in Manhattan, the epicenter of the U.S. COVID-19 outbreak. Before the virus struck, the U.S. clinical workforce was already experiencing a crisis of burnout. We are now facing a surge of physical and emotional harm that amounts to a parallel pandemic."[1]

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An immediate step employee health professionals can take is to establish an anonymous reporting system for workers to voice concerns for themselves and their patients. This can provide a critical element of

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"psychological safety" during the pandemic, says **Darrell Kirch**, MD, co-author of the article and president emeritus of the Association of American Medical Colleges.

"For any organization to improve, there need to be ways for employees to feel that they can safely bring concerns forward without fear of retaliation," he says. "There is no place more important for this to occur than healthcare, especially during a time of extreme stress on the system from COVID-19. Even more importantly, workers need to see their leaders responding positively to expressed concerns in order to improve safety and quality."

Kirch and co-authors described the "moral injury" of people called to heal seeing their patients sicken and die. They warned of an "acute and long-lasting" harm, particularly to those facing COVID-19 in the early years of their healthcare careers.

"We work very hard to help medical students, residents, and fellows learn how to cope with the loss of patients and help families grieve," he says. "The COVID-19 pandemic has made that nearly impossible. There are so many patients who are critically ill and must be isolated from their families. This has deprived learners of the opportunity to learn in a measured way how to emotionally process death both for themselves and with the patient's family and friends."

In this pandemic, anxiety has many sources: shortages of personal protective equipment (PPE), lack of testing, and fear of bringing the virus home to a family member.

"Clinicians have expressed uncertainty about whether employers would support them if they got sick," Kirch and colleagues reported. "Amid extra-long work hours, many are also being asked to fill emergency roles for which they feel underprepared. As the COVID-19 crisis stretches on, the burden of stress will only mount."

Protect Staff

The authors cited several high-priority measures organizations can take to protect their workforce during the pandemic and its aftermath.

"Integrate the work of chief wellness officers or clinician well-being programs into COVID-19 'command centers' or other organizational decision-making bodies for the duration of the crisis," they suggested. "Sustain and supplement existing well-being programs."

The authors called for federal funding to care for clinicians who experience physical and mental health effects of the coronavirus. This program should include national surveillance to measure worker well-being and document the outcomes of interventions.

"The COVID-19 crisis has revealed with painful clarity the fraying threads of the U.S. clinician workforce," they noted. "There has never been a more important time to invest in the clinician workforce. We have a brief window of opportunity to get ahead of two pandemics — the spread of the virus today, and the harm to clinician well-being tomorrow."'

Concurring with this concern was **Jim Kendall**, LCSW, CEAP, manager of Work/Life Connections at Vanderbilt University.

"What always happens in disasters — and I've done a lot of disaster work — is that the first thing you pay attention to is your own Maslow Hierarchy of needs,"

Kendall says. "How am I doing, am I safe, and so on. We're expecting a bigger wave of mental health issues to come as the uncertainty passes a little bit and the fatigue sets in."

This wave likely will hit in the next few months, causing some level of staff trauma in healthcare settings that have lacked resources, been inundated with COVID-19 cases, and faced moral distress about how to allocate equipment and supplies.

"Those workers are going to experience post-traumatic stress in a much different way than folks who have had a little bit more resources," Kendall says. "Though that isn't to say that they also won't experience it. They have been in day-to-day situations of not knowing — 'Have I been exposed? Am I exposing my family?' That adds an element of mortality that has not of been part of everyday healthcare."

Nurses at High Risk of Suicide

While there have been reports of physician suicide related to COVID-19, nurses also are at high risk, says **Judy Davidson**, DNP, RN, FCCM, FAAN, nurse scientist at the University of California, San Diego. There were two documented cases of nurse suicides when the pandemic hit Italy, she says.

"We haven't seen any [reports] in the news in the United States," she says. "We do not currently monitor that in the U.S. Sometimes, you don't really know [about suicides] until years later. My message to the community is not to wait for those numbers to be known. We will have more suicides if we don't take action using preventive strategies. Pandemics cause panic attacks, anxiety, depression and post-traumatic stress. If these things are not dealt with, they could lead to suicide."

Many healthcare workers already were operating at the thin margins of stress and burnout, meaning they were at higher risk when the pandemic hit, says Davidson, a nurse suicide researcher and co-leader of a prevention taskforce at the American Nurses Association. "The whole focus is to protect the mental health of the nursing workforce nationwide," she says.

A female-dominated profession, the nursing workforce carries a higher overall risk of stress disorders than male-dominated professions.

"We have the pre-existing risk of being a nurse, the added risk of a pandemic, and then the risk of being female," Davidson says. "There is a gender-driven issue here. We can't ignore these risks tumbling all over each other. We can't ignore the fact that we are at great risk. We need to take preventive measures."

These measures, including counseling, work support, and frequent communication with colleagues, can help some people emerge from stress and trauma feeling stronger.

"It is known that not everybody responds to stress the same way," she says. "Some end up with 'post-traumatic growth.' They actually feel stronger and more resilient later because they got through this. How does that really happen? First, it is a spiral down into depression, and then a lot depends on the support you're getting in the work environment: support of colleagues toward each other, support in the moment, and support by the leadership team."

Davidson encourages staying in contact with workers placed in home quarantine due to suspected or confirmed COVID-19.

"Keep contact with them virtually so they are not isolated and lonely, which can increase the risk of suicide," she explains. "We need to stay connected socially as a preventive strategy."

Break the Stigma

There is a long-standing stigma about seeking mental healthcare for medical workers, in part because they fear it will affect their licensing and future employment. The Joint Commission (TJC) recently emphasized that it has no requirement to seek such information, and it should not be a barrier to mental health therapy.

"[C]linicians have concerns that seeing a mental health professional could adversely affect their career if they are asked about a previous history of mental health issues during the credentialing or licensing process," TJC stated. "We strongly encourage organizations to not ask about past history of mental health conditions or treatment."[2]

As an alternative, TJC supports the recommendations of the Federation of State Medical Boards and the American Medical Association to limit inquiries to conditions that "currently impair the clinicians' ability to perform their job."

It is critical that healthcare workers feel free to access mental health resources, TJC stated. It is encouraging accredited facilities to remove policies that "reinforce stigma and fear about the professional consequences" of seeking counseling.

The evidence indicates mental health therapy prevents harm, so it is time to get past the issue of stigma in healthcare even was we struggle to overcome it as a nation, Davidson says.

"I have been [at Vanderbilt] 20 years," Kendall says. "We talked about stigma then, and I think stigma still exists. But we have managers who encourage [counseling], and it is part of our infrastructure to talk about mental healthcare. We have not had the horrible issues that New York has had. We have had PPE and equipment. I think the mental health of our staff has been spared from some of the stories I see nationally."

Although Vanderbilt has fared well in terms of supplies and available beds, one of the initial sources of healthcare worker angst was not allowing family members to visit loved ones with COVID-19. The nursing staff developed a system using electronic devices to allow some visibility and communication.

"It creates great distress for the nurses when families can't be there," he says. "The nurses worked very hard to bring that humanity in even when visitors were not allowed."

Vanderbilt routinely reaches out to workers in home quarantine, including medical checks and counseling.

"We do regular checks with the employees who have tested positive," Kendall explains. " Our counselors call and check — not just how you are doing physically, because there are a bunch of people checking on that. We say 'What do you need? How are you doing psychologically?' We follow up the first contact with an email that lists resources for family issues. Then, we schedule a time a week later to get back with them. We want them to know this is about them personally as well as their physical and mental health."

In addition, Kendall and staff are continuing support programs, like an ongoing meeting with the cardiac intensive care unit to discuss challenging incidents. They added wellness checkups for all workers on COVID-19 units, but noticed a surprising development.

"We haven't had as many takers on that as I would have imagined — maybe a drop-in here and there," he says. "I think they feel supported because we offer it. I have to remember sometimes it is not how many people attend — it is the fact that the organization offers it. People can say, 'They care about my well-being, and I'm OK.'"

Building on many existing worker wellness programs in place, Vanderbilt now is holding online meetings with all groups and departments.

"One of the things that we are finding is that this is dynamic and fluid in terms of how it hits different employees through the workforce. You have your frontline workers in hospitals who have experienced this in a much different way than some of the folks who were asked to work remotely," he says. "While working remotely sounds like a panacea on the front end, it is a lot more complicated if you have not done it much."

In addition to those who must work with their children at home, there is a tendency to start work earlier, lose track, and find yourself on the office computer at 10 p.m.

"We are reminding people that you cannot inundate yourself with COVID-19 24 hours a day and stay sane," Kendall says. "You have to turn the TV off. Decide where you are going to get your information. Take some breaks. We encourage mindfulness as one of the methods, but we also are encouraging people to get outdoors and walk using masks and safety precautions." ■

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CDC Tips to Recognize and Cope with Stress

The Centers for Disease Control and Prevention (CDC) has posted information for healthcare personnel on coping with stress and building resilience during the COVID-19 pandemic.

"Experiencing or witnessing life-threatening or traumatic events impacts everyone differently," the CDC stated. "In some circumstances, the distress can be managed successfully to reduce associated negative health and behavioral outcomes. In other cases, some people may experience clinically significant distress or impairment, such as acute stress disorder, post-traumatic stress disorder (PTSD), or secondary traumatic stress (also known as vicarious traumatization). Compassion fatigue and burnout also may result from chronic workplace stress and exposure to traumatic events during the COVID-19 pandemic."

Common stress symptoms include:

- anger, denial, irritation;
- feeling uncertain, nervous, or anxious;
- feeling helpless or powerless;
- feeling unmotivated;
- feeling tired, overwhelmed, or burned out;
- feeling sad or depressed;
- experiencing sleep problems;
- inability to concentrate.

The CDC gave these tips for coping with stress:

- Communicate with your co-workers, supervisors, and employees about how the pandemic is affecting your work.
- Remember that everyone is experiencing the same unusual situation with limited resources.
- Identify and accept things you cannot control.
- Remember that you perform a crucial role in fighting the pandemic, and you are doing the best you can with the resources available.
- Keep a consistent daily routine to increase your sense of control.
- Try to make time for healthy meals and adequate sleep. Take rest breaks and check in with supportive colleagues, co-workers, friends, and family. Exercise and spend time outdoors when you can.

Editor's Note: If you are concerned that you or someone in your household may harm themselves or someone else, call the National Suicide Prevention Lifeline at: 1(800) 273-8255. ■

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A Veteran Nurse Becomes a Patient, Faces Down COVID-19

'A lot of things go through your mind when you think of your own life'

A long-time nurse knew to remain calm and turn her healing power inward as she fought COVID-19 in isolation for six long days in a hospital.

"You feel like you're suffocating, and you can't take deep breaths," says **Kay Ball**, PhD, RN, CNOR, CMLSO, FAAN. "That gives you a panicky feeling sometimes. When I was on the oxygen, I felt a lot better. I'm sure [other patients] are feeling the same way — you panic because you can't take in enough air. You get headaches and you feel fatigued."

Ball has decades of nursing experience, and has been a professor of nursing at Otterbein University in Ohio since 2010. She also is a perioperative nurse educator and consultant, well known for her research on the hazards of surgical smoke in the operating room. She is the nurse planner for *Hospital Employee Health*. Ball described her hospitalization and recovery from COVID-19 in the following interview, which has been edited for length and clarity.

HEH: First, how are you feeling now?

Ball: I think I have totally recovered. It is something I wouldn't wish on anybody.

At the beginning of April, I started getting nauseated. I didn't want to eat, had headaches, and was very tired. I had abdominal pain in the lower right quadrant, but I didn't want to take up a COVID bed. I started thinking, "Do I have appendicitis?" Finally, my family practice doctor told me I should probably go to the hospital. That was reconfirmed by a good [physician] friend of ours. There were three hospitals [in the Columbus,

OH, area], and I took the smallest one because I happen to know people there. I went to the ER [emergency room] and they performed a COVID-19 test. That hadn't even crossed my mind. A CAT scan of my right abdomen showed nothing. The doctor told me "I am almost positive you have COVID-19," although they had not gotten the test results back. He showed me my chest X-ray and said "You have viral pneumonia, and it's probably COVID."

HEH: As you explain, you were sent home under precautions and advised to take zinc and vitamin C to boost your immune system. You were told to come back to the hospital if you started to struggle with breathing.

Ball: I had not thought about my breathing, but I was breathing very shallowly. If I took a deep breath, I would cough. I went home and sent an email to my four nurse friends, one of whom lives right in this area. I said I needed a pulse oximeter. My friend called around, found the only one available, and brought it over and put it on my front porch. I didn't even see her. I didn't sleep in my own bedroom that night because I didn't want to expose my husband. I didn't know then that he was going to test positive, too. All night long I did my pulse oximeter readings, which should be in 95-100 in a healthy person. Mine were low-to-mid 80s. I had a fever of 100.3°F, which is not really that high of a temperature, but it just came up. In the morning we decided I needed to go back to the hospital. They put me on oxygen right away because I had such a low oximeter reading.

HEH: Your test was positive for COVID-19?

Ball: Yes, and I was put in isolation. When you are sick you are isolated; when you are healthy you are quarantined. I was isolated in a room on a COVID floor they had set up. The nurses would gown up and use all the PPE [personal protective equipment] and take it off at the door before they went out. They didn't come in very often; about three times a day. The doctor would come in about once a day. But we have to protect our PPE. We only have so much. They can't keep going in and out, because every time they go in they have to change to a new gown and gloves. That's hard, and it's expensive.

HEH: How did your treatment proceed?

Ball: I was having a pretty rough day, and they started me on hydroxychloroquine. The doctor told me to lay prone — on my belly — five times a day for about 20 minutes each time. That allows the alveoli — the air sacs in your lungs — to open up in the lower part of your lungs. They have found that the prone position works for acute respiratory distress, and patients can breathe better. When I flipped back over, I was able to take deep breaths a lot easier. It was a chore because I had all these monitors on my chest; they were monitoring my heart because I was on hydroxychloroquine. I knew it caused arrhythmia. As a nurse, I was feeling my heart to see if I had any [signs]. Being a nurse, you've got to nurse yourself. They also gave me a spirometer that you use to take deep breaths and told me to do that several times a day, too. Because I was in isolation, they would put my food tray on a shelf right by the door. If I wanted to eat, I had to go get the tray myself. That was good because it made me get out of bed, although I didn't feel very good at all. I watched TV and slept a lot because I was so tired.

HEH: You were on oxygen, but you did not require intubation and a ventilator?

Ball: No. When you are just on oxygen, how you recover is going to depend on how you are doing. I had an O_2 cannula and it felt so much better when I was on oxygen because I could take a deep breath. Every time you take a deep breath with COVID, you kind of cough. One of the things they say is take a deep breath in the

CDC: ALMOST 300 HEALTHCARE WORKERS DIED OF COVID-19

In incomplete data that almost certainly reflect an undercount, 294 healthcare workers have died of COVID-19, the Centers for Disease Control and Prevention (CDC) announced.

"Data were collected from 1,358,065 people, but healthcare personnel status was only available for 285,282 (21%) of people," the CDC reported. "For the 62,690 cases of COVID-19 among healthcare personnel, death status was only available for 35,673 (56.9%)."[1]

As of June 3, the CDC reported 1,827,425 COVID-19 cases in the United States and 106,202 deaths. ■

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morning — if you have to cough, something might be going wrong. Those were some of the telltale signs I experienced. Some of the nurses came in and called me "Dr. Ball" because I have my PhD. They knew I taught nursing at a university, but they were so good because they would still explain everything they were doing. Every night I got a shot in my belly of [enoxaparin sodium] to prevent blood clots. That can be a big problem.

HEH: Did you experience feelings of your own mortality during the lowest points?

Ball: A lot of things go through your mind when you think of your own life. When is your time going to be and all that. I had just started a survey of nurses on the effects of surgical smoke. I was thinking that I needed to call my statistician in Texas and tell him my sign-in passcode. I wanted somebody to be able to access this information.

I was blessed. I survived, and I didn't have to be intubated. I think it was because so many people were praying for me. I started feeling toward the end of my hospitalization that I was going to come through this. I knew I was getting better because I started to have an appetite. They brought me some roasted pork and mashed potatoes with warm gravy. That tasted so good. I didn't eat everything, but the ice cream and sherbet always tasted good.

HEH: How did it feel to be discharged?

Ball: Just going through that door to get out — as soon as I got in the car, I started crying. I was pretty emotional after being in isolation that long. The thing I would say to healthcare workers is to try to be as healthy as you can so your own immune system will fight this ravaging virus.

HEH: Your husband tested positive as well, but remained asymptomatic?

Ball: Yes. Recently, we got antibody testing and we were both positive on that.

So many people have asked me how I got it. My husband and I were staying at home. When we went to the store, we wore N95 respirators and gloves. We were doing everything, but I am a face-toucher. I tell people, "Don't touch your face," but you put your hand underneath your chin leaning on a table. It can come in through the nose or mouth, or maybe I just scratched my face; it can come through the mucosa around the eyes. My bottom line now is do not touch your face — make sure you wash your hands.

The other thing I am experiencing now — and you probably are, too — is people go out to grocery stores, and they don't even wear a mask. The mask is not to protect you; it is to protect everyone around you. I don't know if I can get it a second time. If you think that masks don't prevent the spread of germs, when you come in for surgery we will let your anesthesiologist, surgeon, and nurses know. We are glad not to wear a mask around your incision. Think of it that way. If I was going in for surgery, would I tell my surgical team not to wear masks? We are not protecting ourselves, we are protecting you. Think about that when you are out in public — you are protecting everybody around you.

HEH: Where are you on the surgical smoke research paper you mentioned?

Ball: I am trying to write the article for the *AORN Journal* [Association of periOperative Registered Nurses] based on the nurse responses — 1,300 nurses responded to my survey in a one-month period. It shows that we have so many nurses now with respiratory problems from breathing in surgical smoke when we cut and coagulate tissue. Many commented on how COVID has pushed their hospitals to have a smoke-free surgical department. Hospitals are mandating smoke evacuation in some of their places. Some of the surgeons who were so resistant are saying "We better not be breathing this stuff in if we are operating on a COVID patient — we don't know how it is transmitted." That has been a silver lining. ■

Study of SARS-CoV-2 Finds Airborne Particles, but Are They Infective?

It is 'enough to tell a healthcare worker to protect yourself as much as you can'

A pre-published study under peer review suggests particles of SARS-CoV-2 can linger on surfaces and travel in the air beyond six feet. Ongoing work is bolstering the initial findings, says **Joshua Santarpia**, PhD, an associate professor of pathology and microbiology at the University of Nebraska Medical Center.

"Clearly, there is no proof of airborne transmission yet. But we feel like with this and several other studies, there is enough information to suggest that for healthcare workers, airborne isolation is warranted," he says. "There has been a lot of discussion about 'We don't know enough to say whether this is airborne or not.' I think there is a lot of evidence that suggests it could be. That to me is enough to tell a healthcare worker to protect yourself as much as you can."

Santarpia and colleagues studied the environment of 13 patients confirmed positive with COVID-19 infection, collecting air and surface samples in isolation rooms to examine viral shedding.

"While all individuals were confirmed positive for SARS-CoV-2, symptoms and viral shedding to the environment varied considerably," the authors noted. "Many commonly used items, toilet facilities, and air samples had evidence of viral contamination, indicating that SARS-CoV-2 is shed to the environment as expired particles, during toileting, and through contact with fomites. Disease spread through both directly — droplet and person-to-person — as well as indirect contact — contaminated objects and airborne transmission — are indicated, supporting the use of airborne isolation precautions."[1]

Although still subject to peer review, the findings are controversial because public health officials originally recommended N95 respirators for healthcare workers treating COVID-19 patients under airborne precautions. The recommendation was temporarily amended to wearing surgical masks if N95s were not available, a stopgap measure that could be reversed as soon as supplies were in stock. That wording appears to have been dropped from current CDC recommendations, which present a variety of options to preserve PPE and reuse N95s if warranted.[2]

> "WE FEEL LIKE WITH THIS AND SEVERAL OTHER STUDIES, THERE IS ENOUGH INFORMATION TO SUGGEST THAT FOR HEALTHCARE WORKERS, AIRBORNE ISOLATION IS WARRANTED."

The patients were admitted to the Nebraska Biocontainment Unit (NBU) for individuals requiring hospital care, and the National Quarantine Unit (NQU) for isolation of asymptomatic or mildly ill individuals not requiring hospital care. The patients had private rooms with a bathroom. Healthcare workers wore full personal protective equipment (PPE) with N95 respirators in accordance with airborne precautions. Samples were obtained at various times during hospitalization. The researchers took surface and air samples.

Of the 163 samples collected in the study, 77% had a positive polymerase chain reaction (PCR) result for SARS-CoV-2. Overall, 77% of all personal items sampled were determined to be positive for SARS-CoV-2 by PCR. Eighty-three percent of cellphones tested positive, as did 65% of in-room TV remotes. Room toilets were 81% positive, as were 75% of the bedside tables and bed rails and 82% of the window ledges. Sixty-three percent of in-room air samples were positive, as were 67% of hallway air samples, the researchers reported.

"Air samples that were positive for viral RNA by RT-PCR were examined for viral propagation in Vero E6 cells," the authors concluded. "Cytopathic effect was not observed in any sample, to date, and immunofluorescence and western blot analysis have not, so far, indicated the presence of viral antigens suggesting viral replication. However, the low concentrations of virus recovered from these samples makes finding infectious virus in these samples difficult. Further experiments are ongoing to determine viral activity in these samples."

Those experiments are showing more signs of viral replication, which should eventually bolster

the equivocal findings in the pre-published paper, Santarpia says.

"I believe we had some pretty solid evidence that we were seeing replication in cell culture from one of the surface samples in this study," he explains. "That is complicated by peer review. There is disagreement whether we demonstrated that or not. In the studies we have done since, we are seeing replication in some fraction of samples we are taking. I would stay it is certainly possible; it is not yet proven."

Finding particles beyond the six-foot social distancing parameter was not that surprising, but the question again is whether they would be infectious. There have been studies since "that indicate the even larger droplets are going to go farther than six feet, which sort of makes sense intuitively," Santarpia says. "We are working to determine particle size right now, but it does jibe with everything people are working on. [Six feet] is completely arbitrary. The particle size distribution is pretty broad, depending on what [people] are doing."

For example, some particles in hallways could have been caused by air flow changes as healthcare workers exited the rooms. No healthcare workers were infected, underscoring that wearing full PPE under airborne precautions protects workers from occupational transmission of the coronavirus.

"Taken together, these data indicate significant environmental contamination in rooms where patients infected with SARS-CoV-2 are housed and cared for, regardless of the degree of symptoms or acuity of illness," the authors concluded. "Contamination exists in all types of samples: high- and low-volume air samples, as well as surface samples, including personal items, room surfaces, and toilets." ■

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The Fine Line Between Tragedy and Comedy

A doctor who talked herself off the ledge — literally

Lynette Charity, MD, a board-certified physician and anesthesiologist, was on the ledge of a bridge ready to jump to her death. She measured the distance and the rate of fall in her mind, hoping she would hit a rock rather than drown.

That was 22 years ago. Today, she is a public speaker and stand-up comic, using humor to address burnout and suicide among healthcare workers. "I tell people — spoiler alert — I didn't kill myself," she says.

Retired from medicine after a 41-year career, Charity halted her in-person public speaking and comedy gigs when the COVID-19 pandemic hit. Now, she is trying to reach out to colleagues and others via telehealth to emphasize the need to remove stigma from mental health counseling for healthcare workers so they can get the care they need now more than ever.

"Now, my job, I feel, is to just talk to people," she says. "More importantly, to just listen. I have colleagues who have lost their practices. Who have been let go from hospitals in this time when we need personnel to be on the frontlines. There are people out there firing doctors because they are speaking out about their stresses. You cannot be on the frontline thinking before the next patient you see, 'I've worn this PPE [personal protective equipment] all week and it may not protect me. I could get COVID and I could die, and then who will take care of my family?'"

Hospital Employee Health sought more detail on Charity's unusual story in the following interview, which has been edited for length and clarity.

HEH: You note that COVID-19 has amplified an existing problem within the medical profession.

Charity: Burnout used to be a gradual process. Now, you have been slapped in the face. Over the last three or four months, these frontliners have faced death, death, death. Constant working, not sleeping, not eating, not having proper equipment, fearing for their lives, and for their families' lives. There really is no place for them to go for help. We are doing all this self-isolation. Now, we have to do self-care. We have to have support. We have to have a buddy. We have to have someone so we can vent our frustrations. When there is a cry for help sometimes, especially coming

from physicians, nurses, or other healthcare workers, we say, "This is very devastating, but this is our job, this is what we need to do. We have to sally forth and take care of these patients." It is being constantly internalized with no outlet. I tell people, "Now, you have to find a lifeline of some sort."

HEH: Last year, you began thinking about making a change and retiring from anesthesiology?

Charity: I was thinking, how best can I serve? Public speaking has been my side gig. I decided I needed to make this my mission. My mission now is to go anywhere people want to hear me speak about the frustrations of the healthcare system and the stigma associated with mental health issues. Primarily as a physician, but healthcare workers in general, we cannot get the care we need for fear that we are going to lose our license, not get credentialed, and lose our means of income.

Last September, I decided to retire from clinical medicine. I'm still a doctor, and my licenses are still active if I wanted to go back to clinical medicine. But I really do feel right now that I have another mission. I am in a position after 40 years in medicine, working hard, doing the right thing with investments. We have raised our children, and we have a grandchild now. We are at a point in our lives where we can give back. It's not for financial gain, it's to help. There are thousands of medical students who graduated in May. Those medical students need our help to navigate this COVID and post-COVID world so they don't go through the things we have gone through. I personally have a history of depression. I have been burned out. I almost died by suicide. I have stories to tell with messages behind them that I need to share. This is what I want to do.

HEH: As you note, you started to dabble into comedy to lighten your message while still working part-time in anesthesia.

Charity: I did my first open mic and went up on stage and did my set. About five days later, I was in the operating room and my patient came in. I said, "Hi, I'm Dr. Charity, your anesthesiologist." He sits bolt-up right and says, "I know who you are!"

"THOSE MEDICAL STUDENTS NEED OUR HELP TO NAVIGATE THIS COVID AND POST-COVID WORLD SO THEY DON'T GO THROUGH THE THINGS WE HAVE GONE THROUGH."

I'm thinking I did something wrong. It turns out he had been there that night when I did my first set. He said, "You're a real doctor? You're funny!" I said, "A star is born." I tell people, "As an anesthesiologist, I put people to sleep for 40 years. Now, it's time for me to wake them up." I speak on a very somber topic, but I put humor in it — even when I tell my own story.

HEH: To the degree you are comfortable telling it, what is your story of your contemplation of suicide?

Charity: I was struggling. It was 1998. I have suffered with depression all my life. I have sucked it up and tried to suppress it because I was afraid of being found out. That is what we all fear — that we could lose our license. I was on a bridge about to jump. The voices are telling me, "I'm not a good doctor. I'm not a good mother. I should just die." There are all these voices chattering at me in my head. Then another voice comes out and says, "Call your mama." I was leaning over about to let go and I immediately stopped. I pulled back and said, "If I kill myself before I call my mother, she is going to kill me!" That was the relationship we had. My mom was the matriarch of my family, and here I am ready to end it all. A lot of time suicide is spontaneous. No suicide note, no nothing. Something happens — a trigger — and people jump off a building. A physician has a death and immediately walks out into traffic. Somebody jumps from the hospital because they had a bad outcome or even just because a patient was yelling at them. I tell people if I had jumped in that water it would have been over very quickly because I am not a good swimmer. I was contemplating how long [it would take at] 32 feet per second. How far would I fall, and hopefully I will hit a rock and be knocked unconscious because drowning is not really a nice way to die. All of these thoughts were in my head.

HEH: Did you find that humor was one of the keys to overcome depression and help others?

Charity: Last year I did a workshop for physicians and other healthcare workers on medical improv. I had them stand up and tell me the worst thing an administrator, nurse, patient has said to you. Then we came up with appropriate comebacks — not, "shut your pie hole." You just can't say things like that. By the end of it, everybody was laughing. We need more of this — where people can just let their hair down and be vulnerable. We are not allowed to be vulnerable.

Editor's Note: More information about Dr. Charity is available at: https://drcharityspeaks.com. ■

OSHA Issues Alert on Safety of Nursing Home Workers

34 staff members infected in one outbreak

The Occupational Safety and Health Administration (OSHA) is advising nursing homes to regularly screen staff for symptoms of COVID-19, as long-term care has been hit by devastating outbreaks of COVID-19.[1]

The OSHA recommendations include:

- Perform regular symptom screening for staff and residents;
- Send sick workers home or to seek medical care;
- Closely monitor staff and residents who may have been exposed to COVID-19;
- Ask visitors to inform the facility if they develop a fever or COVID-19 symptoms within 14 days of a visit;
- Maintain at least six feet between workers, residents, and visitors to the extent possible;
- Stagger employee breaks to avoid break room crowding;
- Consider alternatives to in-person group gatherings, meetings, and resident activities;
- Closely monitor personal protective equipment (PPE) supplies, burn rate, and supply chains;
- Create a process to decontaminate and reuse PPE, such as face shields and goggles, when possible;
- Follow Centers for Disease Control and Prevention (CDC) recommendations to optimize PPE supplies;
- Encourage workers to report any safety and health concerns.

The combination of a highly infectious virus and a frail resident population in a closed environment — where infection control has historically been difficult to implement — has resulted in devastating outbreaks of COVID-19 in U.S. nursing homes.

As of April 23, a report by the Kaiser Family Foundation revealed that more than 10,000 reported nursing home residents and staff have died of COVID-19 in the 23 states that publicly report mortality data.[2]

"Our data also finds that there have been over 50,000 reported cases, accounting for 11% of coronavirus cases in 29 states," according to the report. "In six states reporting data, deaths in long-term care facilities account for over 50% of all COVID-19 deaths — Delaware, Massachusetts, Oregon, Pennsylvania, Colorado, and Utah."

Although incomplete reporting undermines full accuracy, it is clear that nursing homes are bearing the brunt of the pandemic. There are more than 1 million residents in about 15,000 nursing homes nationally, **Terry Fulmer,** PhD, RN, FAAN, president of the John A. Hartford Foundation, said during a recent webinar.

"Our healthcare system has failed our nursing homes and all those who live and work there," she lamented. "It is heart-wrenching to see the devastating toll this is having on our residents and staff in long-term care facilities. We have to act now to prevent further death and suffering."

In one of the first reported nursing home outbreaks of COVID-19 in the United States, the CDC recently described transmission in a Washington state facility that resulted in 23 deaths in February and March. The novel coronavirus infected 81 residents, 34 staff, and 14 visitors. Overall, 57% of residents, 36% of visitors, and 6% of staff were hospitalized. All staff survived, but the mortality rate was 27% in infected residents and 7% in visitors, the CDC reported.[3]

"Limitations in effective infection control and prevention, and staff members working in multiple facilities, contributed to intra- and interfacility spread," the CDC concluded. "Long-term care facilities should take proactive steps to protect the health of residents and preserve the healthcare workforce by identifying and excluding potentially infected staff members, restricting visitation except in compassionate care situations, ensuring early recognition of potentially infected patients, and implementing appropriate infection control measures." ■

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HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **Mental health experts warned of "moral injury" to clinicians treating COVID-19 patients who worsen and die. They warned of an "acute and long-lasting" harm, particularly to:**

   a. older workers who fear infection.
   b. first responders.
   c. nurses with children.
   d. those in the early years of their career.

2. **Judy Davidson, DNP, RN, said there are two documented cases of nurse suicides during the COVID-19 pandemic in:**

   a. China.
   b. Italy.
   c. the United States.
   d. Germany.

3. **Although Vanderbilt Medical Center has fared well overall in the pandemic, Jim Kendall, LCSW, said one initial source of healthcare worker angst was:**

   a. lack of testing.
   b. lack of public transportation.
   c. barring family members from visiting loved ones with COVID-19.
   d. inadequate relief staff for needed breaks.

4. **The Centers for Disease Control and Prevention reported a COVID-19 outbreak in a nursing home that infected 81 residents, 34 staff members, and 14 visitors. How many staff members died?**

   a. None
   b. 3
   c. 5
   d. 7

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.