HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

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Exodus: Emotional Suffering Driving Nurses From the Field

More than 500,0000 jobs abandoned since pandemic began

By Gary Evans, Medical Writer

The seemingly never-ending pandemic, driven by unvaccinated high-acuity patients, has nurses suffering a cascade of negative emotions and leaving the field in an exodus expected to worsen with COVID-19 vaccine mandates.

According to a survey by the American Nurses Foundation (ANF) that netted responses from 22,215 nurses from Jan. 19 to Feb. 16, 2021, nurses feel "betrayed" (12%), "guilty" (11%), and "like a failure" (10%). Nurses reported more than one emotional state as the highest-percentage answers exceeded 100%: exhausted (51%), overwhelmed (43%), irritable (37%), and anxious (36%). Only 1% of respondents felt suicidal, but that still is 222 nurses thinking of taking their own lives.[1]

In a recent survey of 234 registered nurses in California, 15% of respondents reported thoughts of suicide in the previous month.

"That is extremely distressing," says lead author **Alyson Zalta**, PhD, associate professor of psychology at the University of California, Irvine. While her paper awaits publication, Zalta previewed a few of the findings for *Hospital Employee Health*.

> "NURSES HAVE BEEN IN AN IMPOSSIBLE POSITION WITHIN THE CONTEXT OF THIS PANDEMIC AND THE DECISIONS THEY HAVE HAD TO MAKE."

In addition to patient care challenges, the denial and politicization of COVID-19 have taken a toll on nurses. "Nurses have been in an impossible

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position within the context of this pandemic and the decisions they have had to make," she says. "The way our society has responded to this event has really been pretty damaging for nurses."

Rather than "burnout," Zalta prefers to describe this damage as "moral injury," a condition somewhat similar to that experienced by soldiers in combat. In general, moral injury occurs in a person who witnesses, participates in, or fails to prevent some harmful event. This event might be well beyond their power to stop, but their ethics and moral code are violated and they are emotionally harmed.

"Nurses, for example, may have too many patients to care for at one time," Zalta says. "While they are taking care of one patient, they realize a patient is coding in another room."

As a result of such conditions, 13% of the nurses surveyed said they plan to leave the nursing field, adding to an escalating national nursing shortage that threatens to undermine patient care.

"Turnover is a major issue and seriously compromises the health of the workforce," Zalta says. "We're certainly seeing that there are work place issues as well as the broader sociopolitical climate that are driving distress."

Nearly 1 in 5 HCWs Have Quit

In another national poll of 1,000 healthcare workers conducted between Sept. 2 and Sept. 8, 2021, 18% said they had quit a job, and 12% said they were laid off. In addition, 19% said they were considering quitting and leaving healthcare altogether.[2]

Moreover, researchers who reviewed death records found nurses who quit or are fired for mental health issues, substance use, or chronic pain are at risk for suicide. The researchers selected nurse suicide cases for those who appeared to have a job-related problem prior to death, as coded on forms or described in investigation narratives.[3] Although the study was based on pre-pandemic data, one of the authors concluded suicidal ideation was partly linked to the loss of "identity" as a nurse, a psychological detriment that could manifest more generally as more nurses leave their chosen field. (For more information, see the June 2021 issue of *Hospital Employee Health*.)

"Employment in healthcare is down by 524,000 [jobs] since February 2020, with nursing and residential care facilities accounting for about four-fifths of the loss," the Bureau of Labor Statistics recently reported.[4]

Nursing is a compelling calling and is year in and out voted the most trusted profession. The COVID-19 pandemic has changed the equation, but it is initially surprising to see nurses willing to give up their careers rather than be vaccinated against SARS-CoV-2. Another wave of resignations already is forming as hospitals and healthcare facilities of all stripes move to mandate COVID-19 vaccination to meet new federal requirements. In the aforementioned ANF survey, 28% of nurses who were not yet vaccinated said they had no intention of doing so. Overall, 28% reported a desire to quit.[1]

Stigma, Refusal of Help

In another recently published survey of 7,378 nurses conducted

from 2017-2018, 5.5% of respondents reported experiencing suicidal ideation within the past year. That is 403 nurses who were so distressed they experienced suicidal thoughts before the pandemic. Moreover, nurses with suicidal ideation were less likely to report they would seek help (72.6%) than those without these thoughts (84.2%).[5]

"There certainly are data out there that suggests emotional distress is very high in our frontline workers, the people who are really taking care of the COVID-19 patients," says lead author **Liselotte Dyrbye**, MD, an internist at the Mayo Clinic in Rochester, MN. "It would not surprise me at all if suicidal ideation was more prevalent in nurses now than it was at the time of our study. I also would not be surprised if burnout was more common. Nurses who are burned out are more likely to have suicidal ideation."

Some reluctance to seek therapy could be concerns about a board flagging their license or giving up confidentiality, she notes.

"The other obstacle is stigma, which is unfortunately still quite prevalent," Dyrbye says. "Then, difficulty getting access. You might finally get an appointment with a mental health professional, but then you are scheduled first shift. It's hard to find anybody to cover you because you are already short-staffed, and you need to go take care of your patients, which is your primary duty. That is really concerning because they need to go get care."

There is a feeling among nurses that only others in their profession can relate to their stress and work conditions during the ongoing pandemic.

"Some hospitals are offering support groups and therapeutic groups to allow nurses to get together and talk to each other on company time," Zalta says. "I think it is really valuable to communicate that the psychological heath of the nursing workforce is something that organizations care about. Encouraging peer support for nurses to be able to talk about their experiences is really important."

To a considerable extent, nurses were predisposed to a mental health crisis, with higher divorce and burnout rates than the general public, well before SARS-CoV-2 emerged. Moreover, the crucial healing connection with the patient has largely been lost in today's "mechanized" corporate medicine, says **Jan Bonhoeffer**, MD, an author and pediatrician at University Children's Hospital in Basel, Switzerland. *(See related story in this issue.)*

"This has clearly been exacerbated during the pandemic," he says. "The rates of depression, burnout have been skyrocketing in many countries. I feel this is way beyond the U.S. This is a global phenomenon. The data are just coming out now. We're just gradually seeing this, and I believe we will continue to see it in the next few years to come — not only for healthcare professionals, but also for families."

Similarly, Dyrbye found in her study (again, before the pandemic) that 38% of nurses reported symptoms of burnout and 40% had substantial indicators of depression. "This is directly related to work-related stress," she says. "We know that the nurses on the frontline of the COVID-19 pandemic now are experiencing more work stress and certainly more burnout."

Burnout is the direct result of job demands that exceed job resources. "There are many was to mitigate the high stress that nurses are experiencing," Dyrbye says. "One is to make sure that there is adequate staffing so the patient load isn't too overwhelming. Also, that they have adequate access to PPE [personal protective equipment] — that is another big factor. And providing people with a positive work environment with leaders who are really skilled at building teams. Nearly all the solutions lie in the work environment. We really need system-level solutions."

NIOSH Request for Information

The CDC's National Institute for Occupational Safety and Health (NIOSH) published a request for information, asking for "interventions to prevent work-associated stress, support stress reduction, and foster positive mental health and well-being among the nation's health workers."[6] As this report was filed, the deadline to submit comments was Nov. 26.

"Health workers face many demands at work, which may include difficult working conditions, long work hours, rotating and irregular shifts, exposure to human suffering and death, and increased risks for personal exposure to disease and harm," NIOSH stated. "The COVID-19 pandemic has exacerbated these challenges and contributed to new and worsening mental health concerns, including burnout, compassion fatigue, depression, anxiety, substance use disorders, and suicidal ideation."

NIOSH asked for input on programs and interventions, including "how stigma associated with seeking mental healthcare is addressed, and how health workers are encouraged to participate. In your experience, how does the

workplace benefit from implementing interventions or offering services to health workers to prevent/reduce work-related stress?"

An anonymous commenter to the NIOSH request for information wrote, "We are living in unprecedented times. I never thought I would see the day where nursing would be a profession that is literally shunned. Doctors and nurses walking off of their once-loved jobs due to stress and burnout. I worked frontline at a rural health clinic for over 1.5 years providing rapid COVID tests, and after that, vaccines. Overwhelm[ed] was not even close to how I was feeling. I could not quit because of my financial obligations, but I dreaded coming to work every day. It seemed as if no one cared at all. I was terrified for my safety as well as the safety of my loved ones. Working shorthanded along with stress was not the formula for a happy work environment. I would like to see administration openly appreciate staff and [put] more incentives in place to boost morale. Appreciation goes a long way."

Dennis Smith, a healthcare pastoral care provider, wrote, "Peer support that is prompt, sensitive, and sincere has been helping people to take a few more steps in a better way as we continue through the pandemic. Employee assistance program support is beneficial. The ability of those who are walking with the same moccasins and in real time can be very powerful."

Another commenter, Nolan Wessell, MD, an assistant professor of orthopedics at Colorado University Hospital, cited the expansion of workload and demand for productivity.

"Data suggest that healthcare providers today are tasked with completing three to five times the level of productivity compared with what was asked of them 30 years ago," he wrote. "We need a system that better values all types of healthcare providers and ensures that they can function at the highest level of their training in order to ensure the long-term success of a system that is already overburdened and becoming more burdensome with each passing day." ■

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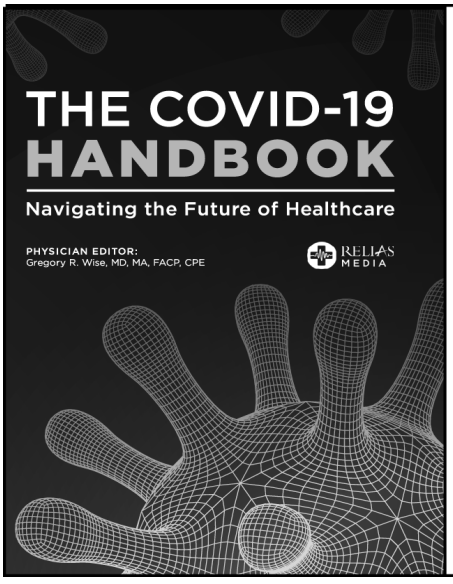

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The COVID-19 Handbook provides a fact-based approach to address multiple aspects of the COVID-19 pandemic, including potential therapeutics, the effect on healthcare workers, and the future of healthcare in a post-COVID world.

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Helping Stressed Employees

Employee health professionals can find a wealth of resources in *Stress First Aid for Health Care Workers*,[1] a compendium of tactics and assessment tools to address the growing mental health crisis.

Published by the Veterans Affairs Administration (VA), the manual and workbook includes many useful tools, including stress and mental health assessments along a continuum from "ready" to "ill":

Ready

- Optimal functioning;
- Adaptive growth;
- Wellness.

Reacting

- Mild and transient distress or impairment;
- Always goes away;
- Low risk.

Injured

- More severe and persistent distress or impairment;
- Leaves an emotional/mental "scar;"
- Higher risk.

Ill

- Persistent and disabling distress;
- Unhealed stress injuries;
- Clinical mental disorders.[1]

The first aid manual also includes comments from health workers, ranging from deep frustration to positive thoughts and acts. Below are some examples of comments from healthcare workers:

- "The worst part is when you know you're not covered. You can bust your tail and you feel like you're not supported by superiors. That's the worst part."
- "I have made a very conscious effort to keep tabs on myself. The big stress indicators for me are fatigue, having a hard time focusing, being short on the fuse, not exercising, and not doing the things I like."
- "At the end of the day, if we're not comfortable talking to one another or we don't even have the relationship to even care about one another on that level, none of this is going to work."
- "Managers were told to punish workers who weren't wearing protective equipment. Instead, we asked what was going on in the system. We found out that the hospital had bought cheap goggles that don't work and fogged up, and nurses wanted to see patients. They were willing to risk splash to take care of patients. We started a process that resulted in staff feeling supported instead of punished, and a problem-solving dialogue."
- "What makes people calming to be around is genuineness. I tend to try to surround myself with people who are genuine."
- "I consider it preventive maintenance to talk with a trained counselor, to be able to have longevity in this job. People don't mind doing preventive maintenance on [their] cars."
- "I gave my family a general safety briefing so they knew about things at my work that might affect my safety or theirs." ■

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Reconnecting with the Patient in Era of 'Mechanized' Medicine

The healing path leads to therapeutic alliance with patient

Jan Bonhoeffer, MD, comes across as a spiritual physician, one who knows all the exactitudes of the medical profession, but thinks it has profoundly lost its way.

Bonhoeffer is a pediatrician at the University Children's Hospital in Basel, Switzerland. In 2015, he realized the training he received at medical school did not prepare him to experience true healing moments with patients. As a result, Bonhoeffer founded Heart Based Medicine, a global network of healthcare professionals exploring the natural healing potential of the healthcare provider and the patient. Last year, Bonhoeffer published a book on his new approach to medicine and healing.[1]

Hospital Employee Health spoke to Bonhoeffer about his search for a healing path back to the patient, which was inspired partly by an epiphany he experienced with a comatose child. This interview has been edited for length and clarity.

HEH: You talk about making a "compassionate connection" with the patient, something you believe has been largely lost in medicine.

Bonhoeffer: When we talk about compassionate connection between humans, then that is where love comes in. Love as in agape, as in love of God, love of creation, whatever

the culture might be that we grew up in. Whatever the route of access, we have to have something that is bigger than ourselves. In my experience as a clinician, these were the moments in 20 years of bedside care where I was serving life and the patient was serving life. And together, a healing process kind of emerged between us rather than just me being a well-educated professor knowing all sorts of [traditional medicine]."

HEH: Many issues in healthcare are being reconsidered due to the pandemic. Do you see this as an opportunity to integrate some of your ideas about patient care?

Bonhoeffer: If not now, when? What else does it take for us to wake up from our fairly arrogant take on a human-centric, data-centric approach to healing? We have all the fantastic successes that came about through evidence-based medicine, but all of those amazing breakthroughs and successes have led us to forget about the human part of healing.

HEH: Can you give an example of how you treat or view patients differently than before you came to this new concept?

Bonhoeffer: A compassionate connection between the healthcare professional and the patient may actually arise from a sincere interest. Learn from the patient what they actually want and what they actually need. That's not an attitude that we're trained on in medical school. We are kind of trained to ask that question, but it's a bit of a rhetorical question. We're trained to ask an open question; for example, "What brought you to the hospital?" It doesn't actually reflect a heartfelt interest, but it's part of a strategic questioning.

HEH: In the book, you described a profound experience with a patient.

Bonhoeffer: Rebecca, a comatose adolescent child, arrived in the intensive care unit, and we didn't know why she was comatose. We were doing all the things that modern medicine can do to figure out why she's comatose and what may have happened. We couldn't figure it out. Everything quieted down at night and I was alone with her, sitting at the bed, and I was devastated. I was responsible for her at the time, and I was devastated because I didn't know what she actually needed. I sat next to her, pulled my chair up to her, and actually held her hand. She is this unconscious child with all sorts of intensive care support, and I'm just asking her, from the bottom of my heart, "I would so much like to help you." I said that in despair. It was like a prayer, like Lord, make me see what is it that I'm missing here for this girl. In that moment, she actually turned around, opened her eyes ever so slightly, and said, "Really?"

> "THERE'S SOMETHING THAT CONNECTS THE HEALTHCARE PROFESSIONAL WITH THE PATIENT IN A WAY THAT WE'RE CLEARLY UNAWARE OF."

HEH: Maybe part of that was taking her hand and touching her, but it almost is a spiritual moment. That is powerful.

Bonhoeffer: It was one of those moments where I learned that I scientifically cannot explain what happened. We can hypothesize, but I can't really explain this. But what I learned from it is that there are things we don't understand. There's something that connects the healthcare professional with the patient in a way that we're clearly unaware of as [providers]. It was unplanned, it was a non-strategic communication with the patient — just showing up as a full human being with all humbleness and not knowing, and this actually helped her to find the path toward the healing that followed.

HEH: Can you practice this form of medicine without the pressures of turning over patients, making money, and all the bureaucracy inherent in the U.S. healthcare system?

Bonhoeffer: It's been part of my training with residents for many years that taking time with the patient in the beginning saves time and money. If we're strategic and we're trying to save time, we're busy with ourselves, we're basically trying to meet our own needs, standards, and all the hospitals requirements — standard operating procedures, financial targets, you name it. When we're actually sitting with the patient and really take genuine interest in what they need, and what they are expecting, we create a therapeutic alliance that creates trust. Trust not on a head level but on a heart level, they feel, "This person really cares for me." It saves hours of unnecessary diagnostic work, chasing the results, requesting specialist consultants to show up and give their opinion on top of everybody else's opinion. It saves tremendous resources.

HEH: Another section of the book describes self-care tips and reconnecting with your values. Are these applicable to healthcare workers?

Bonhoeffer: Very much. In several ancient traditions — let's

say, Ayurveda or traditional Chinese medicine — there are forms of medicine where self-care is an integral part of being a healthcare professional. In corporate medicine today, it's not. We have been objectifying patients, we have been objectifying disease, and we have taken the healer out of the equation. The healer has become a broker of medicine and surgery. If you want to learn how to play the violin, would you go find somebody who knows everything about the history of the violin, the way they're built, and the harmony and the theory behind it — but they've never played a violin? You wouldn't — why would you?

But here, it's OK. In healthcare, we get away with it. Look at the health of the healthcare professionals, with their depression and burnout rate at 50%. Every second, every fourth healthcare professional is actually in need of healthcare. Look at the rate of suicide and depression among healthcare professionals. We know it's very high. It is [the result] of being in a highly stressful environment. It's being in a quite inhumane environment. It's being driven into a profession that has become more and more objective and [has less appeal] as a life's purpose. More than 90% of healthcare professionals start enthusiastically, but at the time of final exams, 50% have signs of burnout. At the end of their career, 70% of healthcare professionals advise their children not to enter the profession. That doesn't sound like a healthy profession to me. In the book, we make a few very simple first proposals for healthcare professionals to integrate self-care so that they learn about what it means to be on a path of healing themselves, and they can respect and support their patients.

HEH: How do you start your day on this path of healing?

Bonhoeffer: For me, the day starts with meditation or prayer. There are many different variations on a "heart-opening" practice, whether it is meditation, sitting in silence, just letting the mind settle, letting the dust settle, to actually opening up to something that is bigger than myself and to be in service of this creation, rather than to impose my own little ideas on it. ■

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CDC Warns of Severe Flu Season Despite Mild Season in Southern Hemisphere

Will more healthcare settings mandate flu shots?

Flu is nothing if not unpredictable, thus the adage, "If you've seen one flu season, you've seen one flu season."

On the one hand, public health officials are warning a possible severe influenza season is on the horizon, partly because COVID-19 shutdowns and precautions led to a historically low flu season in 2019-2020. On the other hand, Johns Hopkins epidemiologists reported a mild flu season in the Southern Hemisphere, which generally is predictive of a similar season for the Northern Hemisphere. But influenza is a mutable virus, and the vaccine sometimes does not match a strain that becomes predominant.

"It appears that the 2021 Southern Hemisphere influenza season was largely similar to 2020, which is an encouraging indication that the Northern Hemisphere could face a similar trend," Johns Hopkins Outbreak Observatory reported. "But the circumstances, both in terms of COVID-19 epidemiology and protective measures, are not necessarily conducive to mitigating seasonal influenza transmission. It is critical that public health officials and healthcare systems effectively implement plans for slowing community transmission as much of the world's already-limited health system capacity has been absorbed by the COVID-19 pandemic."[1]

The problem with a historically mild flu season in 2019-2020 is so few people were infected they now have little residual immunity.

"When there is active flu one year to another, then we have more people — not just who are vaccinated — but people who were actually sick and have built up some protective immunity," said **Rochelle Walensky**, MD, director of the CDC. "That immunity actually helps us, especially those who have not been vaccinated."[2]

Another signal of more circulating flu virus in the 2021-2022 season is the early, unseasonal appearance of respiratory syncytial virus (RSV), she explained at an Oct. 7 press conference held by the National

Foundation for Infectious Diseases (NFID).[2]

"We have had a large amount of RSV in the last couple of months, which is atypical for this seasonal virus," Walensky said. "We did not see some of these respiratory viruses last year because we were taking those prevention and mitigation strategies [for COVID-19]."

CDC surveillance conducted at Vanderbilt University confirms this unusual emergence of RSV, said **William Schaffner**, MD, professor of preventive medicine at the school and medical director of the NFID.

"We have seen an unseasonal increase with RSV, and that's continuing," Schaffner said. "Is that a harbinger of a worse influenza season? We don't know, but we certainly don't want a 'twindemic' of both COVID and influenza. Let's get vaccinated against both."[2]

Flu Shots Mandated?

With mandated COVID-19 vaccination in healthcare settings now subject to a federal presidential order, there is some thought that more hospitals may mandate flu immunization. For example, the Johns Hopkins Hospital policy requires flu vaccination, but allows medical and religious exemptions, requiring "everyone who has not received the influenza vaccine [to] wear a mask within 6 feet of a patient during the flu season. The mask must be worn during the time period from Nov. 19, 2021, to May 15, 2022. Vaccinated staff will receive purple ID badge clip."[3]

The CDC reported 80.6% of healthcare workers stated they took the flu vaccine during the 2019-2020 season, similar to immunization level the season prior. "Coverage was higher among healthcare personnel who were required by their employer to be vaccinated (94.4%) than among those whose employer did not require vaccination (69.6%)," the CDC noted.[4]

> "COVERAGE WAS HIGHER AMONG HEALTHCARE PERSONNEL WHO WERE REQUIRED BY THEIR EMPLOYER TO BE VACCINATED (94.4%) THAN AMONG THOSE WHOSE EMPLOYER DID NOT REQUIRE VACCINATION (69.6%)."

Flu vaccination has faced historical resistance from people who fear or simply refuse the shot, much as with the COVID-19 vaccines. For those who can overcome the misinformation and see the benefit is much greater than the risk, the shots for flu and SARS-CoV-2 can be given at the same time.

"We can give flu vaccine and COVID vaccine on the same visit," said **Patsy Stinchfield**, RN, MS, CPNP, president-elect of NFID. "You don't need to separate them, but usually we will administer them in separate arms."[2]

In a recent NFID survey, 44% of U.S. adults said they are unsure or do not plan to take the flu vaccine during the 2021-2022 flu season.[5] In another troubling finding, 23% of people at high risk of flu complications said they were not planning to take the vaccine. People at higher risk of flu complications include pregnant women, children age 5 years and under, those age 65 years and older, and those with chronic conditions such as diabetes, lung conditions, or heart disease. The CDC recommends everyone 6 months and older be vaccinated against influenza.

Those survey findings caused alarm, but "the pandemic does seem to be driving changes in some prevention behaviors," Schaffner said. "For example, 54% of U.S. adults plan to wear a mask during flu season. Forty-five percent say the pandemic will make them more likely to stay home from work or school if they are sick. That's good news."

'That Dog Won't Hunt'

Reasons for not taking the vaccine included the age-old "I never get the flu," and the vaccine is not effective. Another long-imploded myth came up after an unidentified reporter asked: "How do we really know the flu vaccine does not cause flu?"

"You cannot get flu from the flu vaccine. That's an old myth — please, you can't do that," an exasperated Schaffner said. "Virtually all the vaccines are made up of only parts of the virus, so there is no way that they can recreate the virus in your body to give you influenza. [No one] can hide behind that as a reason not to get vaccinated. As we say in Tennessee, 'That dog won't hunt.'"

Since the discussion was breached by serious misinformation, Schaffner explained why the live, attenuated nasal spray vaccine also does not cause flu.

"It is a miracle of modern science that the virus can stimulate your immune system but it cannot get down into your chest," he said. "It can't multiply there. It's 'cold adapted,' as we call it, and cannot multiply at the slightly higher temperatures down in your lungs. Even that live attenuated virus cannot give you the flu."

Stinchfield said unequivocally, "It is not possible to get influenza from the flu vaccine." She then added an artful analogy that vaccination is like practicing before a game or performance.

"When your kids are saying they don't want to get the flu shot, tell them you practice for your sport, you practice for choir and band," she said. "This is practice for your immune system. You give it a little bit of a vision ahead of time so when the real virus comes your way, your immune system is ready."

The 2021-2022 influenza vaccine protects against four strains of flu, with immunity in place about two weeks after vaccination. However, the vaccine does not protect against other viruses.

"It is not uncommon during respiratory season that someone would get the flu vaccine and a week later get a cold," Walensky said. "We need to make sure that people recognize that is not the flu vaccine."

Regarding efficacy, the flu vaccine is made every year to match the circulating viral strains. Sometimes, it is more effective than others. However, even in an imperfect year, the flu vaccine can prevent hospitalization and death, Walensky said. For example, a record 199 children died of flu during the 2019-2020 season in the United States. "Consistent with findings from other seasons, about 80% of those children were unvaccinated," she said.

Co-Infection with SARS-CoV-2

If flu returns in force, there also is a risk of co-infection with COVID-19, which could prompt a serious inflammatory immune response. The viruses can present with similar symptoms of fever, cough, and shortness of breath, but there are tests to discern between the two or identify a co-infection.

"I have seen a couple of cases who had both infections simultaneously," **Jamie Rutland**, MD, CEO of West Coast Lung in Newport Beach, CA, said at the NFID conference. "Those individuals were taken care of at home, but when they presented to the ER, they were positive for influenza A and SARS-CoV-2. The inflammatory response of the immune system is going to be activated, which, quite frankly, is what we are all afraid of."[2]

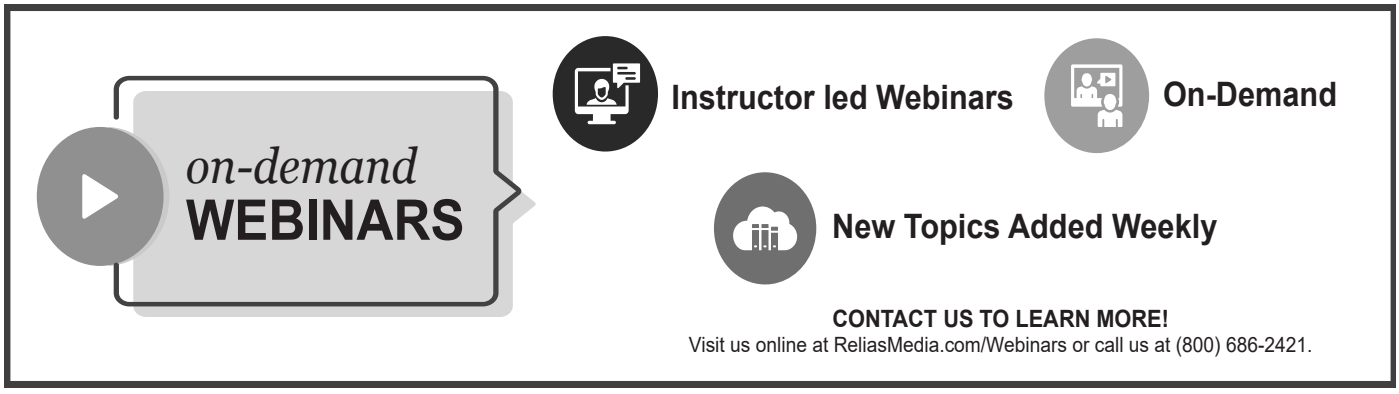
"It's another reason to get vaccinated for both, and we may see more co-infections because there will be more flu this year," Schaffner added.

Both influenza and SARS-CoV-2 are serious infections during pregnancy, so the safety of vaccines for both viruses was emphasized to protect mother and child. There also are effective antiviral treatments for influenza, and pregnant women were urged to contact their provider at the first sign of symptoms.

"It is really helpful to call early, because your oxygen level can't go too low before it starts effecting the baby," **Laura Riley**, MD, obstetrician and gynecologist-in-chief at NewYork-Presbyterian said at the NFID conference. "We want to know if you are having those symptoms, even if they seem mild. Most pregnant women we don't even test. If we think it's flu, we are going to give you medicine. That's how serious we take it."

The CDC has rigorous safety systems in place for both flu and SARS-CoV-2, which in terms of adverse events allows detection of "needles in haystacks when they occur," Walensky said. "We have seen extraordinary safety with the flu and COVID vaccines in pregnancy."

There is some thought the pandemic will change the way people respond to respiratory viruses, and measures like masking, social



distancing, and avoiding crowded indoor settings will become more common in future flu seasons. Given the social division over COVID-19, all bets are off on people for the current flu season.

"There are probably two groups out there, one being the very careful who are following this thoughtfully," Schaffner said. "The data from the NFID survey [indicate] that these people will put on masks and do a little more social distancing when they encounter influenza in their community. There are other folks, as we know, who are still pretty cavalier about influenza and probably won't take those precautions."

In addition to emphasizing vaccination for both viruses, the utility of masking and other mitigation measures will be a recurrent public health message, particularly for those at high risk of complications if infected with either — or both, Schaffner said. ■

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Screening Ineffective for Identifying HCWs with Respiratory Illness

Ubiquitous employee temperature screening and symptom questions upon entry during the pandemic have not yielded much success in identifying sick healthcare workers (HCWs) and reducing the long-standing problem of presenteeism, according to **David Kuhar**, MD, of the CDC's Division of Healthcare Quality Promotion.

"When I say presenteeism, I mean the act of attending work while ill and potentially infectious to others," Kuhar said at the IDWeek 2021 virtual meeting, held Sept. 29-Oct. 3. "Presenteeism among healthcare personnel is actually very well reported in the literature."

For example, during the 2009 H1N1 influenza A pandemic, one facility reported 65% of HCWs reported working with symptoms of influenza-like illness.[1] In a recently published Swiss study conducted over two flu seasons that included 152 HCWs, 68% reported working with symptoms of influenza at some point.[2]

The reasons HCWs come to work sick are complex. "It can depend upon the job of the employee, their social status in the organization, and the care demands of their work," Kuhar said. "Commonly identified reasons include local [work] culture, an unwillingness to disappoint colleagues, even a fear of consequences for taking days off. Are you going to develop a reputation for leaving work to colleagues? Someone's individual work ethic can affect this."

There might be financial pressures if the institution does not grant paid sick days to HCWs. "If you're going to miss a paycheck when you stay home, people aren't going to stay home," Kuhar said. "In the same vein, for facilities that have policies with combined vacation and sick days — people are pulling from one pool of days they can use — people don't want to replace a vacation day with a sick day. Really, any policies that limit time off due to illness can discourage people from taking time off when they're ill."

Yet among HCWs, there is a lack of perceived risk, with many thinking their symptoms are not a threat to patients or colleagues. "Many [sick workers] are highly contagious and can actually cause severe illness," Kuhar said. "Roughly a third of community-acquired pneumonias can be from respiratory viruses or viral pneumonias. Depending on the population you look at, it could actually be up to half of them. That is a large number. Viral infections can predispose people to bacterial superinfections. They can also cause severe illness, especially among those who are predisposed to it — immunosuppressed people, those with pulmonary disease, cardiovascular disease. The very people who are often [receiving] healthcare."

With other viruses circulating and seasonal influenza historically causing 9 million to 36 million cases annually, infected HCWs have caused hospital outbreaks or been infected during them.

"There are numerous reports of outbreaks in healthcare, such as in long-term care settings, where even the common cold, like a rhinovirus, can cause outbreaks, [including] some associated with severe illness among their residents," Kuhar said.

During the COVID-19 pandemic, a common ritual at facility entry is checking temperatures and assessing symptoms for respiratory illness.

"Perhaps surprisingly, there are very few publications about the ability to detect cases among healthcare personnel [during the pandemic]," Kuhar noted. "However, we received anecdotal reports from professional societies, state and local health departments and facilities, that temperature screening was just not identifying many cases, if any cases at all."

Airports have widely implemented screening among passengers, but modeling estimates show they are missing at least half the cases, Kuhar said. Another healthcare report indicated that among patients who were admitted with SARS-CoV-2 with positive tests, only 16 out of 68 had a fever.[3]

"Temperature screening during the pandemic has not efficiently identified cases, and it is not likely an efficient strategy for detection of other respiratory illnesses," Kuhar said. "We know that people can have influenza and not have fevers, [even though] there may be pre-symptomatic [viral] shedding."

Symptom screening looks for more data points, such as a sore throat, shortness of breath, and cough. "You're able to cast a wider net," Kuhar said. "The biggest cons are that it is not objective, and symptom screening really is only ever as good as people are aware of [symptoms] and willing to share them."

Some hospitals started using electronic reporting of symptoms to speed the process and allow those with no symptoms to enter quickly. "There are minimal reports of symptom screening alone detecting infected healthcare personnel, which I found a little surprising," he said. "However, from anecdotal reports, we heard from many facilities as well as health departments that very few cases were being identified with symptom screening at all, with some places reporting none."

That does not necessarily mean there is no value to symptom screening, Kuhar added, noting it still might discourage presenteeism. "Active screening may end up discouraging personnel with symptoms from even testing the [facility] doorway and just staying home," he said.

This can be complemented by more passive approaches, like encouraging workers not to report to work if they are ill. "There are a lot of limitations for temperature and symptom screening," Kuhar said. "I can't help but keep going back to focus on the underlying causes of presenteeism."

One of the biggest problems is the culture of a facility, which must be set by the hospital administration. "Only leadership can really affect facility culture and effect change," Kuhar said. "Without it coming from the top, it's generally not going to happen."

For example, leadership can remove barriers to taking sick days, like providing pay for those days to remove the financial pressure that drives presenteeism.

"Create policies that require restriction from work when ill," he said. "It's very different when the message is 'We don't want you to come to work when you are sick' vs. 'If you're not feeling well, you don't have to come to work.' It's really a different message when it's clearly, 'Do not do this.'"

Another option is for employee health to provide rapid-access medical evaluations for staff. "Have someone make the determination — 'This may be a contagious disease and you should go home,' or 'We feel very good that it's not [contagious] and you can proceed to work,'" Kuhar said. "This could prevent people from working when sick, while allowing some people who might have taken a day off to come in."

The current challenge of staffing certainly is a factor, but there always has been some element of threadbare resources and limited backup in many facilities.

"There are actually reports of healthcare workers coming to work when ill — even with respiratory symptoms — and they have paid sick days that they simply haven't taken," Kuhar said. "If there's no backup, if there's no person to cover their job, people are going to be much less likely to stay out of work when they're sick." ■

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CE QUESTIONS

1. **Which of these statements regarding healthcare worker well-being during the pandemic is correct?**

   a. Nationwide, nursing was well staffed and supplied before the pandemic.
   b. The pandemic exposed a few hospitals that had neglected stocking personal protective equipment.
   c. Nurses were predisposed to mental health problems that became a crisis during the pandemic.
   d. Vaccinated nurses have not experienced the stress and fear of their unvaccinated colleagues.

2. **Which is not a reason cited by David Kuhar, MD, that healthcare workers come to work sick?**

   a. Financial pressures if the institution does not grant paid sick days to healthcare workers.
   b. Workers know they can reduce fever with medications to get past check points.
   c. Workers perceive less risk, with many thinking their symptoms are not a threat to patients or colleagues.
   d. Symptom screening only works if people are willing to report symptoms.

3. **Jamie Rutland, MD, said the primary concern in patients who are co-infected with influenza and SARS-CoV-2 is:**

   a. it increases the likelihood of long COVID.
   b. an inflammatory response of the immune system.
   c. the viruses might exchange genetic material.
   d. antiviral treatment for flu exacerbates the SARS-CoV-2 infection.

4. **The problem with a historically mild flu season in 2019-2020 is so few people were infected they now have:**

   a. the perception they do not get the flu.
   b. less interest in taking the flu vaccine.
   c. little residual immunity from being infected.
   d. less reaction to antivirals if they become infected.