FIRST, DO NO HARM

Bullying can have serious consequences … are you contributing to the problem?

Diane C. Fernald RN, JD, and Carol Latter of the MRM Group.

In today’s competitive and stressful healthcare environment, workplace bullying is more common than ever before. The reason? People under a significant amount of stress may vent their frustration by lashing out at others, often for seemingly trivial matters.

Personal and work-related stress often contributes to toxic work environments. Studies have shown that bullying behaviors like insults, threats, or giving someone the “silent treatment” are not only unpleasant but can actually result in serious harm to the victim. Targets of this type of behavior may suffer from depression, anxiety, or sleeplessness, or even substance abuse, as they try to deal with their mounting stress. And according to research, physiological effects can also be serious, including hypertension, fibromyalgia and cardiac disease— even suicide.

There is also an economic consequence for healthcare organizations. Workplaces where disruptive behavior goes unchecked often face decreased productivity, poor employee morale and higher turnover. One study showed that bystanders—who may be sympathetic to the bully’s target but afraid to intervene for fear of retaliation—can also become depressed, feel guilty about their inability to stop the bullying, and witness the harm it inflicts.

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Workplace Cotinine/Nicotine Testing: Considerations for Healthcare Employers

Manoj Moholkar, MD, MPH

Cigarette smoking and the use of nicotine/tobacco products are among the most important modifiable risk factors for adverse health outcomes in the nation. They are a major cause of morbidity and mortality and the leading cause of preventable illnesses and death. The CDC analyzed the National Health Interview Survey (NHIS) data for 2004 - 2010 to describe current cigarette smoking prevalence among currently working U.S. adults by industry and occupation. By industry, age-adjusted cigarette smoking prevalence among working adults ranged from 9.7% in education services to 30.0% in mining; by occupation group, prevalence ranged from 8.7% in education, training, and library to 31.4% in construction and extraction.

Although some progress has been made in reducing smoking prevalence among working adults, additional effective employer interventions need to be implemented, including health insurance coverage for cessation treatments, easily accessible help for those who want to quit, and smoke-free workplace policies. Many state and local governments now require workplaces to be smoke-free. These policies can have a positive impact. In 2006, the U.S. Surgeon General concluded that “workplace smoking restrictions lead to less smoking among covered workers.”

Making the workplace completely tobacco-free can have an even greater impact, as both tobacco user and non-user employees may be helped by such policies. To achieve this, one of the strategies initiated predominantly by employers in the health care industry, is the addition of urine nicotine/cotinine screening in pre-employment testing to eliminate current smokers from being hired.

The Burden and Costs of Smoking for Employers

According to a 2001 study by Halpern et al (Tobacco Control), workplace productivity was increased and absenteeism was decreased among former smokers compared with current smokers. Employers, especially healthcare organizations, have plenty of reasons to consider making the workplace a smoke-free environment.

A study published in Tobacco Control (2013) indicated that smokers cost their employers an estimated additional $6,000 per year compared to non-smokers. In 2007, a study led by researcher Dr. Terry L. Con-
help, and even quit in search of a calmer, happier workplace.

In the healthcare environment, there is another issue that often raises an ugly specter: physicians have been known for being disruptive themselves. Research has shown that people who work in high-stress, high-stakes jobs are more prone to stress-related outbursts in the workplace—and that healthcare workers are at higher risk of on-the-job violence or bullying than other types of employees. OSHA reports that from 2002 to 2013, incidents of injuries requiring days off were four times more common in healthcare than in private industry on average.1

Bullying, whether it is angry outbursts, insults, intimidation or backstabbing, is even more common. According to a study published in the *International Journal of Environmental Research & Public Health,*2 and reported in a June 2016 bulletin issued by The Joint Commission,3 a study of 284 U.S. healthcare workers found that 38 percent reported psychological harassment.

So who are the victims of this kind of behavior? The possible scenarios are almost endless. It can be doctor versus nurse, nurse versus nurse, or senior staff versus medical resident, for example. But whatever form it takes, bad physician behavior in particular has become the stuff of legend, written up in publications ranging from medical journals to *The New York Times.*

One cardiologist who pondered the subject in a semi-humorous medical blog recalled: “I had a roommate in medical school who was a great guy. He studied hard, didn’t party too much, and always managed to put the toilet paper on the right way. Years after we graduated and had gone our separate ways, I had a phone conversation with a physician assistant who’d gone to work for my old roommate. ‘It must be great working for Dr. X,’ I added. A pause on the phone. ‘No,’ he said slowly, ‘he’s a total jerk. Everybody hates him.’”4 Despite his surprise, the author acknowledged, “Rarely do I come across an arrogant doctor who recognizes him—or herself as such.”

Disruptive physicians may mean well, but they may cave under the daily pressure of too many patients, too much red tape, shrinking reimbursements, and too little sleep. Pushed to the limit, a physician who ends up running an hour behind schedule might yell at her receptionist, or a surgeon who runs into procedural complications may take it out on the anesthesiologist.

The repercussions of events like these are often far from trivial. Incivility in the workplace can not only harm your staff but damage the reputation of your hospital or practice, and impact patient safety. As studies have shown, it can also spark a lawsuit by an unhappy patient who decides to sue for a poor medical outcome after a rude or uncaring response by her physician.

So how do you avoid situations like these? As the physician blogger pointed out, there are two rules to remember. First, “it is simply not allowable to be impolite, mean, nasty or snippy with staff or patients, even when you are in a stressful situation.” Second, “whatever is stressing you is probably stressing those around you as much or more. Under those circumstances, you have to go out of your way to be kinder and more understanding. As a doctor, you control the mood in the [medical setting]… even if you can’t control the situation.”

**10 TIPS FOR CREATING A POSITIVE WORK ENVIRONMENT:**

1. Refrain from intimidating or abusive behavior
2. Speak professionally and cordially with staff and patients
3. Avoid degrading, demeaning, personal, or offensive comments
4. Answer phone calls and emails promptly and courteously
5. Avoid gossip about peers, coworkers or patients
6. Actively listen to your patients and colleagues
7. “Count to 10” before responding to a situation that upsets you
8. Apologize for any unprofessional lapses
9. Intercede if you witness someone being bullied
10. Create/adopt a “zero tolerance” policy on bullying

And if you witness disruptive behavior in your workplace? Step in and speak up, experts advise. An April 2016 article outlined a Vanderbilt University Medical Center peer-to-peer program that encourages staff to monitor and report bad clinician behavior, and teaches “peer messengers” to intervene successfully in response to staff-reported complaints. After one year, 71 percent of clinicians who had received “respectful, nonjudgmental, timely feedback” were not named in any follow-up reports.5

William Cooper, director of the Vanderbilt Center for Patient and Professional Advocacy, recommends several tips for interceding: speak to the offender privately, keep the discussion short, and thank the clinician for taking the time to talk. He noted that many people who engage in disruptive behavior have been doing so for years, but “no one has ever told them.”

**And if the offender is you? Take a good look in the mirror. Then apologize.***

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Diane Fernald, RN, JD is a nurse attorney, who not only served as a nurse for 20 years, but was also a medical malpractice attorney for 16 years defending physicians, nurses, hospitals and other providers in a variety of lawsuits and actions, not only in court, but before professional boards and insurance panels as well. She is currently employed as the Vice President of Education and Consulting for MRM Group, LLP, focusing on services and education to healthcare providers in risk mitigation and patient safety improvement.

Carol Latter is a professional writer and editor with more than 30 years’ experience, specializing in the fields of medicine, science and business. She has served as the editor of, and writer for, many professional publications. At MRM Group, she researches and prepares medical education products for live events and web-based presentations. She is an Honors graduate of Carleton University, Ottawa, Ontario, Canada.
Our mission, as occupational medicine professionals in a preventive medicine specialty, is to provide care for generally healthy persons who work in unhealthy environments. The area of occupational medicine most fun for me is the analysis of potential adverse workplace environmental exposures and the development of advice for preventing related injuries and illnesses. Discovery of new occupations and environments to investigate can easily “make my month – or year!” Here’s a doozy!

Quite a bit of momentum is developing in the commercial, nonprofit and governmental sectors toward interplanetary travel, with the most likely initial destination being Mars. Some believe that it is possible that we will have humans working on Mars within the next decade. This isn’t science fiction anymore. This is for real – today. Some engineering challenges remain but most expect these challenges to be overcome quickly. What about challenges more specific to the human? What are the physiologic challenges inherent in interplanetary travel? Before we can address physiologic challenges we must assess the interplanetary work environment. As occ docs, how can we begin to assess the general environmental exposures likely existing for these workers?

At initial glance, there are the fairly obvious problems due to lack of oxygen, lack of gravity and lack of ambient pressure (a vacuum). As you think more deeply about it, you realize that there will be exposure to radiation and a lack of dermal sunlight exposure. Also, prolonged confinement and isolation could be problems. You have heard that many astronauts feel sick for the first few days in space. Research also shows that past interplanetary workers will face. You surmise that workers in the Antarctic and submariners probably receive very little dermal sunlight exposure and have to deal with some degree of confinement and isolation. You wonder if submariners have prolonged exposure to elevated carbon dioxide levels. Medical crew on air ambulances, commercial fishermen, frequent business travelers and others have to deal with motion sickness. You wonder if this type of motion sickness is similar to what is encountered in space.

You realize that interplanetary workers will have exposures which may have terrestrial occupation parallels that you are familiar with but are likely at a depth and level of complexity far beyond what you have dealt with before. You also guess that some exposures may be totally unique to anything which can be experienced on Earth or near to Earth. How will human physiology respond to these exposures?

For more information on human physiologic response to interplanetary travel come to the NECO/MAAOHN Annual Conference 2016, “Integrating OEM in the Workplace and Beyond”, December 1-2 at the Boston Newton Marriott Hotel in Newton, MA. To register, visit www.necoem.org. We’re looking forward to seeing you there!

Dr Luna is a fellow of both ACOEM and the Aerospace Medical Association. He is a former aerospace medicine residency director and was Associate Dean of Aerospace Medicine for the US Air Force School of Aerospace Medicine. Dr Luna is in independent practice in occupational and aerospace medicine in Portland, Maine.
The CDME session at AOHC highlighted the fact that performing DOT exams is still a challenging task, in spite of our being trained and certified, with many questions arising in the wake of the updated forms and still varying perspectives over how to address individual problems. This is complicated by the lack of clear guidance regarding many of the myriad presentations faced by examiners. Unfortunately, some CDMEs have faced the loss of clientele when they follow the guidelines.

**Overarching Guidance**

Cancer and the DOT Driver: When asked for recommendations regarding the driver undergoing cancer treatment, she answered it by referring back to the above advice. Consider the condition, the treatment, the treatment side effects, and complications. One physician audience member reminded us of the side effects of cancer medication, which can include for examples, severe fatigue, cardiac disease, peripheral neuropathy, and anemia. She recommended more frequent CMV exams.

CDME/MRO Separation of Responsibility: When the CDME evaluates a driver and provides a CMV certification, but later, as the MRO, deals with the same driver having a positive drug screen, does the CDME go back change their certification? Per Dr. Hartenbaum, you do not change your certification opinion, but you may use this data upon repeating an exam on this driver in the future.

Interested in writing an article for the newsletter?

Want to be a “published author” without needing a direct academic affiliation or requiring an extensive review process?

Our newsletter welcomes your personal expertise as well as your connections to those who can contribute an article. Topics can be varied, but must be related to the field of OEM in some way; examples include 1.) personal interest in a particular issue 2.) how you managed a difficult case 3.) developments in clinical care 4.) hot topics and controversial issues in the field 5.) medical practice of OEM 6.) difficult DOT or MRO cases 7.) your life as an OEM doctor and 8.) news of member activities. You do not need to be an expert in journalism – the editorial board will assist you in editing your article for publication. FMI: Please contact D. Plantamura at NECOEM@comcast.net or the editors: Susan Upham at supham@roadrunner.com; Abhijay Karandikar at dr_abhik@yahoo.com; Thomas Luna at TLunam4@gmail.com.  

***Author deadline for next newsletter – February 17.***
Interpretation of Tests

When a person reports the use of nicotine replacement products and is no longer smoking, the urine cotinine may be positive. The employee typically indicates the use of these products prior to the test. How can the MRO confirm that the test result is due to nicotine replacement products? They can order a test for anabasine, an alkaloid, which is present in tobacco but not in commercial nicotine replacement products. If a sample tests positive for anabasine, then the person is still using tobacco products.

Even though the half-life of cotinine is about 24 hours, it can be detected several days after cessation of tobacco use. When an individual stops using tobacco and nicotine products, it can take more than 2 weeks for the blood level of cotinine to drop to the level of a non-tobacco user and several weeks more for the level to decrease to a “very low” concentration.

In general, a high level of nicotine or cotinine indicates active tobacco or nicotine replacement use. A moderate level indicates a tobacco user who has not had tobacco or nicotine for two to three weeks. A lower level may be found in a non-tobacco user who has been exposed to environmental smoke. Very low to nondetectable concentrations are found in non-tobacco users who have not been exposed to environmental smoke or in tobacco users who have refrained from tobacco and nicotine for several weeks. Passive inhalation is not an acceptable explanation for a positive test and the test cut off makes the adjustment for passive inhalation.

Regarding other potential etiologies for false positives, there is some evidence that pesticides may be involved, but current research is not convincing.

Nicotine Testing and the Law

The National Conference of State Legislatures (NCSL), however, reports there are at least 29 states and the District of Columbia with statutes that protect employees from adverse employment actions based on their activities outside of work, which include smoking. Only MA and VT allow the testing in New England. As an employer, you must be careful to comply with these laws in your pursuit of a smoke-free workplace. However, under the Americans with Disabilities Act, nicotine addiction is not a protected disability like conventional drug testing.

Final Points

The cost is around $20/test. Also, it is important to keep in mind that cotinine testing does not determine a person’s ability to perform a specific work-related task. Remember that this test only determines the presence of nicotine and this can include non-cigarette forms of nicotine including nicotine patches and gum.

One Employer Comments:

“As a large healthcare provider our greatest asset is our workforce. As we looked at opportunities to impact the health and well-being of our workforce and our communities we identified tobacco use as a key concern. Part of our mission is to nurture the health of the people in our communities and to create and maintain a healthy workplace while inspiring our employees to achieve their own level of health and wellness.”

To best support the above we made the decision to add cotinine to our post offer employment drug test panel and to not hire anyone who tests positive for cotinine. However, they get a second chance after 3 months and if they test negative, they are hired.

As a healthcare provider we value and respect our current employees who do use tobacco and recognize that tobacco is not illegal. The use of tobacco/nicotine products on our premises is already prohibited. The decision to not hire tobacco users takes this to the next level and aligns with precedents set by other leading health care systems.”

Sources:
Morbidity and Mortality report, 9/30/2011/60: 1305-1309
Benowitz N. Johns Hopkins University School of Public Health. Cotinine, biomarker for tobacco smoke exposure

Dr. Moholkar was originally a physician in India; he then attended the Residency in Internal Medicine at UMASS Memorial Health Care (Worcester) followed by the Mount Sinai Medical Center (NYC) Fellowship in OEM. He now is an Occupational Health Physician/Medical Director at Reliant Medical Group.
THE REALITY OF RECYCLING AND OUR OVERABUNDANT LIVES

Downsizing – What do I do with all this stuff?

By Kris Arnold, MD, MPH, FACOEM

THE DILEMMA OF TOO MUCH
Raising children in a nice big house with plenty of room for playing and toys; travelling and collecting memorabilia from around the world; taking pictures of the family and adventures (pre-digital); not liking to be a part of the “throw-away” society, you know, “buy good quality so it lasts”... And then the kids are out of the house and it’s time to get more footloose and mobile for more adventures in life. Ahhh, woops, that means selling the nice big house with the oversized garage and moving to something smaller. Uhh, yeah, smaller, as in less space to put all the wonderful, potentially useful stuff. That should be easy, right?

First you need to go through all the stuff. Most of us have heard about professional declutters and home organization consultants who help with moving preparation or with general home organization. They don’t come cheap – you pay about $80 an hour to be told information that is already on a number of free websites. Fortunately, we had access to one who is a friend of a friend and who also runs a consignment store. In exchange for a few items to put in her store, she provided a list of different agencies who are in the business of collecting donations, along with commentary on their reputations in terms of the portion given directly to end users versus sales to other endpoints along the donation stream. This was not a straightforward process. I quickly learned that some of the best-known organizations to which people commonly donate, such as Goodwill, are so well known that they receive far more than their store space allows... So, I decided to try, as much as possible, to get my donations directly into the hands of people who really needed help.

I had several categories of items to downsize out of my house in preparation for its sale, with the plan to put a large portion into storage until we decided what we were going to do next in terms of housing. Of course, there was clothing, but also toys, many in serviceable condition, kitchen utensils, some furniture, records, including my parent’s collection of 78 rps, several years of National Geographic and books... sooo many books!

Next, phone calls were made and internet research was performed to help determine the most direct ways to get items to needy end users.

TOYS Toys were one of the hardest classes of items to recycle. For reasons of hygiene and concerns over lead paint on toys from China, most agencies will not take them. Upon reflection, it seems like it could be a good education for children if the toys were actually going to be given to a child whose family was unable to afford them. I am old enough and grew up in a small town where churches conducted toy drives accompanied by direct donation to other churches serving the areas of town with needy families. That was then, though.

HOUSEHOLD GOODS AND CLOTHING My research led to my finding some organizations that specialized in providing household goods and clothing to families transitioning out of homelessness. However, after carting several boxes of perfectly usable, but older, non-electric kitchen utensils to a couple of these sites, only to have them tell me that they could not give people many of the out-dated items, I was totally discouraged. Fortunately, many of these items were mostly made of metal. As luck would have it, I met an enterprising character who collects items from people’s garbage and either finds places to sell them to be used or breaks them down to components that he can sell into the recycling chain. So, here was a resource better than my garbage for some of the “too old” kitchen items.

78 RPM RECORDS Ahh, old 78 rpm records should be of archival interest to either a library or music school. Disappointment again. The Boston Public Library said thanks but no thanks...same answer at Berkeley School of Music. All the titles are available in digital format. I checked even for some really cool big band foxtrot from the early 1940s. Surely some collector somewhere might be interested. But, even eBay prices showed that there was not enough of a market to make it worth posting, certainly not with a looming deadline for the house to go on the market. I couldn’t bring myself to throwing these away. So, the records ended up in a box in storage to be dealt with later. Thank goodness we don’t pay by the pound.

BOOKS Then there were the books. Like I said, sooo many books - from children’s books to foreign language books to my old medical textbooks, some dating back to med school in the 1970s. What was I thinking, not having gotten rid of these long ago? ...More internet searching until I found an organization that works with troubled youth by running a used book business that the youth help manage. By the time I found this organization, I learned that many organizations accept donations, but simply sell them off to other organizations for various purposes - from donation, to sales, to recycling.

In an attempt to get some of the children’s books to places where they would really fill a need, I ended up contacting some of the family shelters in the Boston area and delivering directly to them along with a few toys, since the shelters were not inundated with donations. At one, an adolescent resident who loved reading was invited to look into the box I was dropping off. She was extremely happy to find 3 Harry Potter books.

DONATION PROBLEM As the process continued, my web searches led me to finding articles about the “problem” of donations, particularly clothing. A July 2014 article in The Atlantic cited that Americans were buying 5 times more clothing than in 1980 and that only 15% of discarded textiles were donated, with the remaining 85% representing around 21 billion pounds of “post-consumer textile waste” per year, according to the Council for Textile Recycling (http://www.weardonaterecycle.org/about/issue.html). As I spoke with more and more staff from different organizations in the Boston area, I heard a recurring theme. Many of them received more clothing than they could use for their target population. Thus, they would sell materials to “re-purposing” firms. Some of these would sort clothing, passing on that which seemed least worn to other organizations who would put it to sale or direct donation, and then sell the rest to companies that shred the textiles to be used in new products from car seats to carpets.

TECHNOLOGY ...And then there were the 4 laptop computers, 3 desktop ones, two servers, several monitors, two large cathode-ray televisions and assorted electronic items. Anyone remember Palm
Pilots? Of course, my town trash will take these with a call for a special pick up, however, I discovered that there are a couple of local programs that teach kids about computers by tearing them apart and trying to get some to work, if deemed at all worth the salvage effort.

“SERVED ITS USEFUL LIFE” ITEMS Sadly, some materials were destined to the garbage. Although one can recycle VHS and Betamax video cassettes, music tape cassettes, and CD/DVD discs, I could not find sites that would do it for free. All of the cassettes end up needing to be dismantled to enter the recycle chain. Also, I became very familiar with the category of “served its useful life.” I still have a pile of items that are primarily metal behind my garage that I plan to take to one of the metal recycling outfits in Boston. I might make enough to pay for the gas to drive there.

IRONY: CONSCIENCE v CONSUMERISM Around the world, economic discussions focus on encouraging the public to consume more in order to solve international economic woes. Trying to downsize with a sense of social responsibility is not an easy task and it puts one face-to-face with practical and philosophical issues related to consumerism. This has been a real adventure and an education.

RESOURCES I did not mention individual agencies throughout this little narrative since readers are not all in the Greater Boston area and I did not want to give the impression that agencies I ended up using might be the only or “best” ones in any category. Below is a list of a few that I found. It is by no means all-inclusive and the absence of any organization in this list does not imply any disfavor based on my research. These all have websites.

(Continued from page 6)

The Biggies:
- Goodwill Industries
- The Salvation Army
- St. Vincent de Paul

Children-Oriented:
- Cradles to Crayons
- Big Brother/ Big Sister

Household Goods:
- Household Goods
- Mission of Deeds

Computers:
- Solutions at work
- Computers4Cancer
- National Cristina Foundation
- World Computer Exchange

Books:
- Cambridge Public Library website has a list of organizations – this was how I got the idea of going directly to some of the family shelters.
- Boomerangs (owned & operated by AIDS Action Committee)
- More Than Words

After 41 years of Occupational and Emergency Medicine practice, Dr. Arnold is now also downsizing personally and taking his professional activities on the road to pursue his interests in international health care development.

NECOEM BOARD PLANS FOR THE FUTURE
The NECOEM Board of Directors convened for a retreat at the Liberty Mutual Office in Hopkinton, MA on 9/24/16. This all day event was spent analyzing the status of our organization, its strengths and weaknesses, clarifying its vision and mission, and defining its goals for the future. Several issues will be of particular focus for the board as we look to the near future. This includes 1.) performance of an educational needs assessment survey, 2.) exploration of how to optimize the use of our website, 3.) development of a web enabled dinner meeting and 4.) improving strategies for onboarding new members and conference attendees. Thanks go out to all those involved, including the planning committee (David Diamond, Ron Blum, Matt Lundquist, Glenn Pransky, and Dianne Plantamura), Glenn Pransky and Liberty Mutual for allowing us to use their facility, and Bob McClellan who led the retreat.
WHAT IS IT?

These process diagrams use a chemical that is used in the manufacture of resins. What is it? Can you identify the end resin product? The chemical causes a well known effect on hands and forearms of workers employed in production and cleaning the reactors. What is the effect?

Please send responses to Abhijay Karandikar, MD, at dr_abhik@yahoo.com Readers who send in correct responses will be identified in the next issue. The correct answer will be published in the next issue of the NECOEM Reporter.

“What Is It” features a series of trivia, facts, figures, etc. related to the field of occupational medicine. If you have any such interesting or fun-filled material, please e-mail it to the associate editor at dr_abhik@yahoo.com. All material should be related to the specialty of occupational and environmental medicine and have an educational, inspirational, historic or other relevant value.