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COMMENTARY

Patient Safety and Ethical Implications of Health Care Sick Leave Policies in the Pandemic Era

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CASE

Ms. F is an employee of a hospital-affiliated nursing home (NH) where she develops cough, shortness of breath, and malaise while working her shift. She presents to the emergency department (ED) at the same hospital for evaluation of these symptoms after finishing her shift. Ms. F has a history of asthma and has been working during an outbreak of coronavirus disease 2019 (COVID-19) that occurred at the facility where she is employed.

Dr. H evaluates Ms. F in the ED, determining that she is stable and does not require inpatient treatment, and recommends testing for COVID-19. She is agreeable with testing until Dr. H informs her that she must stay home from work awaiting test results. Ms. F becomes visibly upset. When prompted, she reports both a sense of duty to her patients and a fear of financial hardship. She does not have any remaining sick leave, and her husband has been out of work during the pandemic. She declines testing and leaves the ED stating her intention to return to work in the NH.

COMMENTARY

Great strides have been made since the beginning of the pandemic, but sudden acute respiratory syndrome coronavirus-2 (SARS-CoV-2) continues to circulate in the community.¹ Although vaccination efforts are evolving to include hard-to-reach communities, individuals susceptible to infection remain, and the future impact of more transmissible SARS-CoV-2 variants of concern remains unknown.² As long as community transmission persists, unvaccinated older adults and those with comorbidities are at particularly high risk of severe disease.³ Physical distance remains a cornerstone in limiting disease spread, with documented major outbreaks associated with confined living spaces.^{4,5}

Patients in the congregated living arrangement of NHs, often with advanced age, significant comorbidities, and inability to care for themselves, are especially vulnerable and have experienced particularly devastating outcomes when infected with COVID-19.⁶ Patients and employees of NHs

represent a significant percentage of all COVID-19 deaths in the United States.⁷ With the generally limited mobility of NH residents, it is likely that the major route for illness introduction is through employees, when visitation is restricted.

This case involves consideration of the factors influencing employee illness behavior, the ethical responsibilities of the leadership of the health care system to its workforce and patients, and how local policy influences the risk of nosocomial illness transmission.

PATIENT SAFETY CONSIDERATIONS

An employee who becomes sick is immediately presented with two options—stay home and recover or report to work while feeling ill. Literature shows that multiple factors influence this decision, including individual attributes such as job title and socioeconomic status, workplace characteristics such as culture and sick leave policies, and, finally, federal and state regulations mandating paid sick leave.^{8,9}

Prior to the COVID-19 pandemic, it was well-documented that presenteeism—continuing to work despite illness—was widespread overall and very common among HCWs, with as many as 80% of medical providers continuing to work despite symptoms of an influenza-like illness.^{10–13} HCW presenteeism risks the transmission of illness to vulnerable patients and puts fellow HCWs at risk.¹⁴ HCW-to-patient transmission has been implicated in local outbreaks during the COVID-19 pandemic,^{15,16} with infected HCWs continuing to work for a median of two days after symptom onset in one study.¹⁶

The underlying motivations for working during illness can vary by individual and by circumstance. Some HCWs may report to work while sick from a sense of duty to their patients and colleagues.¹¹ Among others, presenteeism may result from the estimation that the financial harm one experiences from staying home is greater than the perceived harm to others of working while sick. Employees with the most tenuous hold on economic stability and with the highest perceived risk of losing their job for not coming to work report the highest likelihood of presenteeism during a pandemic.¹⁷ Workplaces with a high perceived threat of discipline are also associated with increased likelihood of working while sick.¹¹

Not surprisingly, employees who do not have paid sick leave, or who have run out of available sick time and would be required to take unpaid leave, are also more likely to work while ill.¹¹ This observation has important implications for health care, as the rate of presenteeism is lower in organizations with paid sick leave policies, and these facilities benefit from lower rates of infection transmission both to patients and among staff.^{18,19} Accordingly, health care facilities that enact restrictive sick leave policies with the intention of maximizing per-employee productivity could reasonably expect the imposition of barriers to be associated with increased presenteeism. For these reasons, the Centers for Disease Control and Prevention (CDC) recommends sick leave policies for HCWs that are nonpunitive and flexible.²⁰

Among physicians, those most vulnerable to coercion due to their educational or training status report the highest impact of external factors on their decision to present to work while ill.^{21,22} Special consideration must be paid when crafting policies regarding medical student and resident physician sick leave to mitigate the risk of these groups feeling undue pressure to work despite illness. Among more senior physicians, both a culture of wariness of burdening colleagues and a feeling of overwork may contribute to presenteeism.^{11,21,23} There also appears to be a belief among physicians that by taking adequate precautions they are able to minimize the risk of illness transmission, thereby resolving the ethical conflict between the duty to care for their patients, the desire not to impose on their colleagues, and the duty not to harm.²¹ This may in part explain the high rate of presenteeism seen among physicians and can inform strategies to encourage physicians to stay home when sick.

In addition to organizational policies, workplace culture plays a role in reporting to work while ill, and in some settings this may be a normalized behavior.¹¹ In this way presenteeism, although it violates stated policies, may propagate. Supervisors can increase the likelihood of presenteeism during illness whether through pressure on employees not to use sick leave or by questioning the legitimacy of sick leave requests.¹¹ It is the responsibility of the leadership of the health care organization to establish a culture of safety that includes using sick leave during illness. A health care organization that fosters a culture of workplace safety, valuing the protection and well-being of employees over their productivity, tends to engender trust, which in turn is associated with reduced presenteeism.²⁴ Trust is engendered before and during a pandemic by clear, frequent, and honest communication on the part of health care leadership.²⁵

The burdens borne by HCWs who become ill will be most harmful to those least equipped to handle the challenges incurred by illness. The lowest paid, those with the least status and having the least agency, are those least prepared to adjust to the challenges of staying home during illness. This unequal burden should not be borne by these individuals but rather by health care organizations.^{26,27}

ETHICAL CONSIDERATIONS

In addition to the patient safety benefits of flexible sick leave policies, a number of ethical principles support their adoption. Given the risk borne by HCWs in caring for the sick during a pandemic, it is recognized that society must adequately address the needs of HCWs.²⁸ At the level of the health care system, this includes mitigating the risk of illness contraction and the harms encountered if it occurs. The principle of reciprocity, in addition to supporting adequate personal protective equipment, vaccination, and provision of antivirals, requires that health care facilities address the potential loss of income due to home isolation with the provision of accessible paid sick leave. Holm advocates for the compensation of self-isolating sick individuals during a pandemic, in part supported by reciprocity.²⁹ Indeed, with anxiety prevalent early in the COVID-19 pandemic, HCWs expressed the need for these and other reciprocity-based measures as a way for their organizations to support and care for them.³⁰ Society benefits from reduced disease transmission when those experiencing illness isolate and should ensure compensation in recognition of this contribution. For employed individuals, the employer is the natural agent to execute this compensation by way of paid sick leave.

The ethical response to a pandemic requires the public be protected from harm.²⁸ At the level of the health care facility, this requires policies that recognize and mitigate the factors influencing presenteeism. Such policies respect the autonomy and inherent dignity of all employees while avoiding coercion.

At the individual level, working despite illness and risking disease transmission in a health care setting is in contradiction with the ethical principle of nonmaleficence, the obligation not to harm others, a cornerstone to medical practice. This individual decision must be considered in the broader context of the environment in which it occurs, as external factors exert significant influence on presenteeism.³¹

Internal tracking of employee illness is needed to monitor the health of the facility's workforce, detect nosocomial outbreaks, and make forward-looking plans. However, this consideration needs to be balanced with patients' right to privacy. Whenever possible, internal reporting of HCW illness should be anonymized to respect employee privacy.²⁸ When disclosure of private health information is required, it should contain the minimum information necessary and be shared with the fewest people possible. For example, a disclosure might reasonably include, in addition to local public health authorities, the employee's supervisor and a member of either infection control or employee health to perform internal contact tracing and follow-up.

It should also be noted that, despite adequate planning and well-conceived policies, a respiratory pandemic may threaten shortages of trained personnel due to either illness or an overwhelmed health system. In this crisis sce-

nario, the harms of a severe shortage of HCWs could be more severe than the harms of HCWs with mild symptoms continuing to care for likewise infected patients. These circumstances may necessitate crisis standards of care, which should prospectively consider equity.^{32,33}

In summation, the disparate ethical principles that gird the pandemic response are linked by trust—that society will protect the individual, that individuals will protect each other, and that health care facilities will protect their patients and employees.²⁸

CONCLUSION

Sick leave policies that are flexible and nonpunitive are essential patient safety and ethical components of a health care facility's strategy to reduce the spread of illness due to presenteeism. With an organizational pandemic response that includes these policies, Ms. F would not experience loss of income in going home, a course of action that would be in line with the culture of safety supported by her supervisor, and she would not be putting her patients and HCW colleagues at risk.

Conflicts of Interest. All authors report no conflicts of interest.

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