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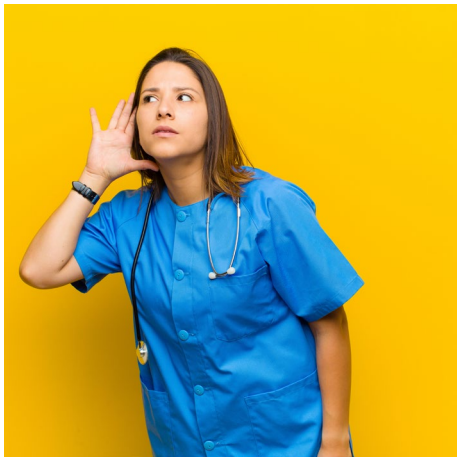
Workplace boundaries





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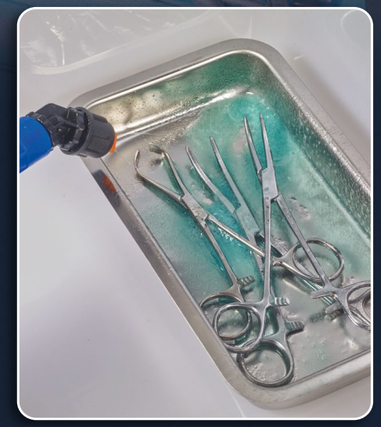

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Under Threat

Medical Journals Receive Unprecedented Inquiries

Medical journals are no strangers to receiving letters. However, one letter that arrived recently at several journals was extremely unusual. The letter was from the United States Department of Justice.

"We were surprised," said Dr. Eric Rubin, editor-in-chief of The New England Journal of Medicine, in an interview with National Public Radio (NPR). Rubin said the letter came from a U.S. attorney for the District of Columbia.

According to NPR, the letter asked about "misinformation, competing viewpoints and the influence of funders such as advertisers and the National Institutes of Health." Such letters were also sent to JAMA, Obstetrics & Gynecology, CHEST, and possibly others. "The public has certain expectations, and you have certain responsibilities," the letter added, with a request for response by May 2. The letter mentioned that the journal has tax-exempt status.

"It does feel like there's a threatening tone to the letter, and it is trying to intimidate us," Rubin told NPR. "We were concerned because there were questions that suggested that we may be biased in the research we report. We aren't. We have a very rigorous review process. We use outside experts. We have internal editors who are experts in their fields as well. And we spend a lot of time choosing the right articles to publish and trying to get the message right. We think we're an antidote for misinformation."

> **"The peer-review system exists precisely to insulate scientific evaluation from external pressures, whether political, commercial, or ideological."**

I find it very concerning that government agencies would attempt to influence or intimidate medical publications through threatening correspondence. Such actions set a dangerous precedent and compromise the objective evaluation of healthcare interventions, treatments and policies. The staffs of medical journals

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ensure that research meets rigorous standards of methodology, peer review, and ethical conduct—there's no need for government agencies to pollute this process.

The peer-review system exists precisely to insulate scientific evaluation from external pressures, whether political, commercial, or ideological. It's not a perfect process, and there have been troubling incidents over time, but these instances are few and far between. We can trust the vast majority of research printed in reputable journals. In these publications, editors and reviewers assess research based on methodological rigor, statistical validity, and contribution to medical knowledge—not on whether findings align with any current political preferences. This independence has enabled medical science to advance treatments for cancer, develop vaccines that have saved millions of lives, and establish safety protocols that protect patients worldwide.

Government threats, such as the aforementioned letters, may chill the research environment itself. Scientists may become reluctant to pursue research or report findings that could attract government scrutiny. Yes, government agencies often have legitimate interest in understanding research findings, but feedback should be shared through appropriate channels such as public-comment periods, advisory committees, and transparent regulatory processes—not through an effort to intimidate publishers.

I hope the medical journals contacted by the DOJ will continue to resist pressure. I imagine they will. Patient lives, public health, and the integrity of American medical science all depend on maintaining the independence that has made American medical journals among the most respected and influential in the world. The leaders of such journals deserve our trust and support.

In far less controversial news (although somewhat related, since we've essentially been discussing boundaries), I hope you'll enjoy our cover story about setting boundaries at work. This piece explores relationships with sometimes-difficult colleagues, bosses and patients. That topic is accompanied by articles that tackle setting boundaries with a different challenge: noise and distractions. This package begins on page 18. Lastly, you'll see a familiar name in one of our editorial departments this issue. Our longtime Infection Prevention Now author Nancy Haberstich's column is filling in for AfterCare's Patricia Raymond while she's on break. Nancy's column is about antibiotic resistance. I wish this topic weren't still relevant, but unfortunately, it is. You can find the column on page 28.

Michelle Beaver

Taking Care of Each Other

Team Bonding Makes for Better Outcomes

By EndoPro Staff

Chelsea Hospital's endoscopy team brings unique expertise to the table and a collaborative spirit that makes all the difference to their patients, according to Lindsey Quinn, RN, BNS, nurse coordinator.

"What truly sets our team apart is our unwavering commitment to excellence in patient care and our deep-rooted culture of support—for both our patients and one another," Quinn said. "Despite being a relatively small team, we are mighty in our impact."

The state-of-the-art facility features 16 pre-operative and post-anesthesia care-unit bays, two procedure rooms dedicated to pain management, and four fully equipped endoscopy suites. The staff includes 25 RNs, 12 per-diem RNs, two admin staffers, and seven surgical-care and instrument-care technicians.

In addition to outpatient services, the team also performs endoscopy and pain procedures for inpatients at Chelsea Hospital. The services include diagnostic and interventional

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procedures such as colonoscopies and esophagogastroduodenoscopies, dilations, banding, tattooing, cauterization, biopsies and snare polypectomies.

But at Chelsea, it isn't just about the services. Quinn said, "Patient safety and well-being are at the heart of everything we do. We take great pride in the quality of care we provide, ensuring that every patient feels seen, heard, and supported throughout their experience with us."

The core of that care is how the team takes care of each other.

"We are more than just colleagues," Quinn said. "We are a work family. Many of us have walked through life's highs and lows together, celebrating milestones and offering strength during difficult times." This bond fosters a resilient, positive and supportive work environment that directly translates into better outcomes for the team's patients.

Quinn's colleague, Cara Olsen, RN, agreed. "Never have I worked with such a team that works so hard for the patient outcome and experience," Olsen said. "As a team member you are loved the second you walk through the door. It's a work family that is there for you in the good times and the bad. This is a rare find in work environments and what makes this team so great in my eyes."

A few of the elements that make the team effective are the power of consistent communication, an ongoing mutual respect, and a shared commitment to both patient care and team well-being. "We believe that excellence in healthcare starts with a strong, connected team," Olsen said.

Some best practices include:

Prioritizing patient safety and dignity in every interaction, no matter how routine the procedure may seem.

Maintaining open and honest communication through regular team meetings, daily huddles, and informal check-ins.

Fostering a culture of support and empathy, where team members feel safe to speak up, ask for help, and offer encouragement.

Celebrating wins—big and small—and recognizing each other's contributions, which helps build morale and a sense of shared purpose.

Staying flexible and adaptable, especially during times of change or challenge, while always keeping patient care at the center of their focus.

Nicole Richardson, RN, has seen this firsthand. "Being in charge you see how much can change in a single day. Cases will be canceled, added, moved up in time slots, and moved locations. During these changes I get to see so many staff members step up, change assignments, and help others to get the job done."

"Our philosophy is simple," Quinn said. "When we take care of each other, we're better equipped to take care of our patients. That mindset has helped us build a resilient, high-performing team that others can learn from."

That's not to say Chelsea Endoscopy doesn't have its challenges. Quinn cited staffing shortages, increasing patient volumes and the far-reaching impacts of the COVID pandemic as some issues the team has had to sort through. "We've had to adapt quickly and work together to maintain the highest standards of patient care and safety," she said.

The team has faced personal challenges, as well. Kimberly Hicks, RN, said part of the reason she loves her team members is because of the way they "come together when each other is navigating a difficult time in our lives. When it comes down to it, we are family and the support we give each other is beyond any other job I've ever had.

"What I love about our team is how we always pull together when things are crazy to provide the best care to our patients," Hicks added. "Our patients would never know that it may be the worst day on the unit for staff because we mask it so well."

Quinn agreed. "Through it all, we've remained a source of strength and support for one another," she said. "Whether it's covering shifts, offering a listening ear, or simply showing up with kindness, our team consistently demonstrates compassion not only for our patients, but for each other. These shared experiences have deepened our bond and reinforced our resilience. They've shaped us into a team that is not only highly skilled but also deeply empathetic and united by a genuine commitment to care—both within and beyond the walls of our department."

This enthusiasm is shared by Denise Dembinski, RN, who said, "It's good to work with people [who] are all committed to taking the best possible care of our patients. And also provide the best support for each other as we navigate life's ups and downs."

The team also celebrates achievements and milestones such as retirements, graduations and personal accomplishments—the things that make life rich and fulfilling. These celebrations often extend beyond work hours.

The team has gone on department outings such as renting a chauffeured bus to attend an event together, and they even went camping. In addition to social gatherings, the team holds monthly team meetings to stay connected professionally. These meetings provide a space to share updates, discuss improvements, and ensure everyone feels informed and valued. This ability to balance professionalism with genuine connection is a key part of what makes Chelsea's work environment so positive and cohesive.

Quinn concluded, "Our exceptional teamwork, mutual respect and shared dedication make us not only effective but also proud of the work we do every day." EP

Complex and Difficult

How to Clean Flexible Endoscopes Properly

By Nancy Chobin, RN, AAS, ACSP, CSPM, CFER

Flexible endoscopes are complex devices that can be difficult to clean, therefore facility personnel responsible for overseeing reprocessing of flexible endoscopes should review reprocessing practices several times a year and ensure that processing personnel are adhering to the instructions of the endoscope, processing equipment, detergent and cleaning-supply manufacturers.

Cleaning in healthcare facilities is defined as "the removal, usually with detergent and water, of adherent clinical soil (e.g., blood, protein substances, and other debris) from the surfaces, crevices, serrations, joints, and lumens of instruments, devices, and equipment by a manual or mechanical process that prepares the items for safe handling and/or further decontamination" (ANSI/AAMI ST91:2021, p.4).

The Occupational Safety and Health Administration (OSHA) defines decontamination as "the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal" (29 CFR 1910.1030[b]).

The decontamination process involves two steps. The first and most important step is manual and/or automated cleaning. The second step is the application of a chemical disinfection or sterilization process. Although this sounds simple, each step has many components that must be performed correctly to ensure effective processing and the safety and health of employees, patients and the community.

Cleaning, followed by thorough rinsing, is the first—and probably the most important—step in the decontamination process. Without thorough cleaning, items may not be completely decontaminated. Patient deaths and/or infections have been traced back to flexible endoscopes that were inadequately cleaned. Meticulously performing all steps required for cleaning flexible endoscopes, components and accessories is essential to ensure they are safe for patient use.

Cleaning and rinsing remove rather than kill microorganisms. If contaminants such as blood, body fluids and tissue are left behind after cleaning, they can prevent disinfecting and sterilizing agents from contacting all surfaces of the endoscope and possibly create a breeding ground for microorganisms, making disinfection more difficult. And remember: Just because something looks clean doesn't mean it is clean.

Personnel responsible for cleaning flexible endoscopes must wear appropriate personal protective equipment (PPE) to prevent exposure to contaminants such as blood, body fluids and tissue, as well as pathogenic and nonpathogenic organisms. Reprocessing technicians work in a wet environment and are also working with potentially hazardous chemicals such as detergents and disinfectants. The recommended PPE includes a Level 4 barrier gown, face shield or goggles, a fluid-resistant face mask, decontamination gloves, headcover and fluid-resistant shoe covers, per ANSI/AAMI ST91:2021.

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Principles of Cleaning

Designated facility personnel must ensure that the manufacturer's instructions for processing every type of endoscope used in the facility are available and followed. It is important for endoscope-processing technicians to understand that regardless of the facility or the items being reprocessed, the fundamental principles of cleaning remain the same. Certain general principles of cleaning apply to all items being processed. These principles include the following:

- The cleaning solution must contact every surface of the endoscope or endoscope accessory.

- There must be some type of physical action, such as friction, which enhances the cleaning process. *Friction* is the action of one surface or object rubbing against another. Friction is created by scrubbing, brushing and rinsing all surfaces of the endoscope during manual cleaning and by flushing and rinsing detergent through the lumens of the device.

The following nine factors have an impact on cleaning.

1. Water quality

2. Water temperature

3. Cleaning activity of the detergents (also known as *cleaning chemistry*)

4. Mechanical action

5. Nature and design of the instruments or devices (e.g., simple or complex)

6. Type of soil (e.g., blood versus fatty soil)

7. Human factors/competence (e.g., training, complying with IFUs and using processing equipment correctly)

8. Cleaning verification (checking and documenting the effectiveness of the cleaning process)

9. Quality assurance (monitoring the cleaning process to ensure compliance with IFUs, facility policies and procedures, and applicable standards and guidelines)

When cleaning failures occur, one or more of these factors is involved.

It is important for all endoscope-processing team members to understand that disinfection and/or sterilization will not compensate for poor cleaning. The importance of performing adequate cleaning of flexible endoscopes cannot be overemphasized and is stressed in all professional guidelines and standards related to processing medical devices used for surgery and/or endoscopy. Further, the importance of obtaining and complying with the endoscope manufacturers' IFU cannot be overstated.

The FDA had developed a guidance document, "Reprocessing Medical Devices in Health Care Settings: Validation Methods and Labeling Guidance for Industry and Food and Drug Administration Staff." The purpose of this document was to guide medical-device manufacturers in creating and validating reprocessing instructions that, if followed, will ensure that their devices can be safely used for the purpose for which they were intended. Except for the specific regulatory or statutory requirements mentioned, this guidance document is not regulatory and is not legally enforceable; however, the IFU that manufacturers develop using this guidance document are recognized by the Joint Commission, AAMI, and other accreditation and professional organizations as providing a mechanism for the user to verify that the device can be safely reprocessed.

In addition to following manufacturers' IFU, designated facility personnel must be able to verify the cleaning process recommended by a manufacturer. According to ANSI/AAMI ST58:2024, "Chemical Sterilization and High-Level Disinfection in Health Care Facilities (Annex N):" verification of a cleaning process consists of the following.

a) Visual inspection combined with other verification methods to determine the cleaning of the external surfaces and the internal housing and channels of medical devices

b) Testing the cleaning efficacy of cleaning equipment and

c) Monitoring key cleaning parameters (such as the temperature)

Manufacturers provide such tests so the equipment can be tested efficiently without damaging the devices or necessitating recleaning of the device.

Quality Improvement

Designated facility personnel should ensure that each step in the cleaning process is fully verifiable through personnel training and through observation and that the process can be followed completely, accurately and without variation by all individuals who perform it; they must also provide process controls along with validation and verification methodologies that ensure adequate, consistent cleaning levels.

To define any facility process, designated facility personnel must develop written policies and procedures that identify the steps of the process. The policies and procedures should be based on published professional guidelines and should align with the validated processes described in the manufacturers' IFU.

Designated facility personnel must also ensure that each employee completes an orientation program wherein the employee receives documented education and training about the tasks they will be performing at the facility and that the employee undergoes documented competency verification demonstrating their ability to perform the tasks correctly. After successfully completing their orientation, designated facility personnel should continue to provide education and training of employees as needed and should verify the competencies of each employee at least annually—or more frequently, as needed.

All personnel processing flexible and semi-rigid endoscopes should be certified in flexible-endoscope processing within two years of employment and maintain their certification throughout their employment (ANSI/AAMI ST-91, 2021).

The importance of implementing an effective cleaning process is underscored by accreditation surveyors who have been instructed to request that endoscopy technicians obtain the manufacturer's IFU for a particular endoscope and demonstrate and/or describe the process that should be used to clean the device. This enables the surveyors to evaluate whether the employee is following the correct procedure to ensure the cleanliness and safety of the endoscope.

The manufacturer's IFU for each device should include information about the recommended cleaning and/or disinfecting agents, cleaning implements, and cleaning methods that should be used, as well as instructions about how to disassemble the device for effective cleaning, if applicable.

If a manufacturer's IFU are unclear, inadequate or contraindicated by best-practice recommendations from relevant professional organizations, designated facility personnel should contact the manufacturer for additional information and clarification.

Any information obtained from a phone call with a manufacturer's representative or from a manufacturer's sales representative should be followed by a written statement from the manufacturer confirming the information. It is not acceptable to rely on verbal instructions. All device manufacturers' IFU should be readily available to processing personnel for reference. Failure to comply with the manufacturer's IFU could void the manufacturer's expressed or implied warranty and could result in high-level disinfection or sterilization failures. It is the responsibility of the processing professional to comply with the manufacturer's IFU.

Summary

There are many more steps in the cleaning process and each one is important. It is up to the facility to ensure that staff are thoroughly trained and competent in the cleaning process. Routine observations and audits should be performed to ensure compliance with state policies and compliance with the device manufacturer's current instructions for use (IFU). Some personnel who are responsible for cleaning do not recognize the importance of their job.

It is important to understand that the process of high-level disinfection depends upon the disinfectant reaching ALL surfaces and channels of the device. If the device is not cleaned per the IFU, the disinfection process could be reduced or even nullified. That is simply not acceptable. Although not glamorous, your job is critical to good patient outcomes. The patient depends on you to do the right thing. EP

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Workplace boundaries

Use Them to Decrease Distraction and Increase Joy

By Edward Leigh, MA

Editor's Note

The following package deals with setting boundaries in the workplace, such as boundaries with colleagues, bosses and patients, and against noise and distractions. Boundary-setting is more important than ever, because modern medical settings are more stressful than perhaps ever before, with the exceptions of say, COVID, or times of war. We have limited control over the workplace, but the following articles focus on where improvements might be possible.

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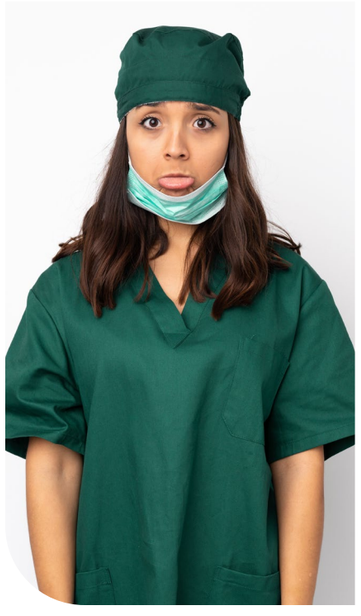
You're having a very busy day with many patients on the schedule. You're documenting information regarding a patient you just interviewed. During your hectic day, a co-worker approaches you says, "I don't think I will have time to finish these calls; could you call these patients?" This same co-worker has periodically asked you to complete tasks that they are responsible for in the workplace. Despite having a full plate of tasks, you agree to help your co-worker.

In the above workplace scenario, what just happened? You think you're helping a co-worker, but this person is repeatedly asking you to do their work. What is happening is a violation of boundaries. Of course, filling in to help a co-worker is fine, but when it becomes habitual, then it's an issue.

What is a Boundary?

A boundary is a limit defining you in relationship to someone or to something. Boundaries can be physical and tangible or emotional and intangible. For example, a physical boundary is a fence, which identifies spatial limitations. Physical boundaries are concrete and easily identifiable. However, emotional boundaries are much less clear, which can make them more challenging to establish and enforce.



A line in the sand is a clear physical boundary. When a person steps over that line, they have violated the boundary. This same analogy can be used in emotional boundaries as well. For example, if a co-worker makes an inappropriate comment, they have crossed a line.

Having effective boundaries will not distance you from others. The boundaries prevent conflict and bring people together because, generally speaking, everyone knows what acceptable behavior is. This article will help you establish boundaries while still maintaining excellent relationships with co-workers.

Causes of Boundary Violations

Emotional Baggage

Everyone enters the workplace with some baggage. When people walk into the workplace, they do not leave their baggage by the door. Baggage brought into the workplace affects interactions with co-workers, potentially leading to significant issues with boundaries. Many factors come into play, including the style of communication each person experienced in their families. Some people come from family situations where nurturing relationships were seen and modeled. Unfortunately, other people come from situations where significant dysfunction was present, and those styles of behavior walk into the workplace. Some people don't realize they are violating boundaries in their communication style because in their environment, such behavior was acceptable.

Presenteeism

This term means that employees are physically present, but due to physical or emotional issues, are distracted to the point of reduced productivity. While absenteeism means they are physically absent, presenteeism means they are physically present, but due to other issues they are unable to functional effectively to complete work-related assignments.

Many of the causes of presenteeism are rooted in psychological issues. For that reason, the workplace needs to have tools to help struggling employees, including stress-management support and, when needed, employee assistance programs. The privacy and confidentiality of such programs must be fiercely guarded—from both other employees and management—or employees will not feel comfortable using them.

Presenteeism leads to weak interpersonal relationships. Combining emotional baggage and presenteeism can lead to workplace toxicity and exacerbate the ensuing boundary violations.

Types of Boundaries

Co-worker Boundaries

Everyone in the workplace has job responsibilities and duties. In the example above, an employee was violating a co-worker's boundaries by continually asking them to do their work. However, boundaries may not be directly related to job responsibilities. For example, a co-worker who often uses crude language or tells inappropriate jokes is also violating boundaries. This employee is violating boundaries of people who expect the workplace to be free of bawdy language and tasteless or insulting remarks.

Patient Boundaries

There are appropriate interactions with patients, and then there are behaviors that cross the line, such as talking to patients about personal issues. Of course, chatting with patients about pets or a new restaurant in town is acceptable, but talking to patients about an abusive boyfriend is not appropriate.

Setting Boundaries

The following will help with the mechanics of boundary setting.

Follow the ABC Rule

ABC = Always Be Courteous. A person can still be friendly while setting boundaries. For example, in my work as a keynote speaker and workshop leader, the person who introduces me sets boundaries regarding mobile phones, and they're always pleasant about it. They kindly advise the audiences to please put their phones on vibrate. There's no need to yell at people about the volume of their phones.

Identify Your Limits

The first step in setting boundaries is determining your limits, which can be emotional, mental, physical or spiritual. You set limits by noticing what you can tolerate and accept, as well as what makes you feel uncomfortable and stressed. These feelings will help you clarify your limits. Your limits are personal and are likely to be different than the limits of other people.

In one of my many boundary-setting workshops, an attendee mentioned a co-worker who had a habit of eating her lunch in front of her computer. The problem is that she liked eating fish and some co-workers thought the smell of the food was bothersome. A co-worker politely mentioned to this person the fish issue. The fish-eating co-worker immediately apologized and mentioned having no idea of the food having a strong odor.

Overall, listen to your feelings; they will tell you if boundaries have been violated. There are certain feelings that often signal boundary violations, including feelings of discomfort, resentment or guilt. These feelings are symptoms of boundary violations.

Clarity

Workplace boundaries must be clearly outlined so people in the workplace know what behaviors are acceptable. Each team member understands what to do, how to do it, and when to do it. This creates an efficient workplace environment. Managers must define and enforce the boundaries.

Passive-Assertive-Aggressive Behavior

Passive Behavior

Passive people are submissive and sometimes have feelings of low self-esteem. They do not stand up for themselves and are often sometimes referred to as doormats, in that other people can step all over them. Since some passive people feel powerless, they may have weak or nonexistent boundaries. They focus on the needs of other people. Even if they're really busy, if a co-worker asks them for help, they will relinquish their own responsibilities to do someone else's work.

Aggressive Behavior

Aggressive people are sometimes arrogant and may have unrealistic feelings of self-importance. Some belittle others and attack those who don't share their views. Some aggressive people are tyrannical and have poor boundaries, since all their attention is on themselves. They focus only on their needs. If a co-worker asks them for help, they may refuse and be unpleasant.

Assertive Behavior

Assertive people are confident and self-accepting. These people have clearly defined boundaries. They focus on meeting their needs and the needs of others in a harmonious fashion. If they're very busy and a co-worker asks them for help, they will politely explain that they can't help now but will give them options to help meet their needs, such as checking back later or suggesting another person who might be able to assist.

Assertive people are comfortable and confident with themselves and have well-defined boundaries. The ideal workplace scenario is to have as many assertive people as possible since these types of individuals create a friendly and productive workplace. See Table 1 for a summary of passive, assertive and aggressive behaviors.

Handling Boundary Violations

Language

I suggest using "I" language and avoiding "you" language. "You" language can sound threatening, while "I" language comes across as pleasant, yet firm. For example, let's say you have been asked to do excessive work and you're feeling overwhelmed. These are two possible responses:

- "You" version: "You're giving me too much work. You have to stop this!"
- "I" version: "I'm feeling overwhelmed. Let's talk about solutions to manage the workflow."

The "I" language version focuses on the sender's feelings and is not accusatory. The response also blends in a solution-oriented perspective.

I also suggest avoiding "why" language. For example, a co-worker has not been completing assigned tasks. You have been forced to cover for this person and you're feeling frustrated. You have reached a point where you have to say something. These are two possible responses:

- "Why" version: "Why aren't you getting your work done?"
- "What" version: "What's going on that's leading to your assignments not being done? I notice this has been happening more often. Let's talk about the situation."

The "what" version is more friendly. The response also blends in a solution-oriented perspective.

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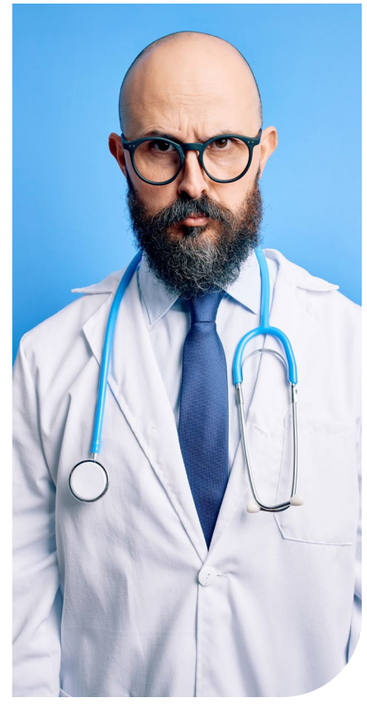

Get It in Writing

There should be clearly written guidelines for employee job-related tasks and guideless for interpersonal behavior to avoid boundary violations. Having clearly written guidelines moves the conversation from subjective to objective.

Two-Way Street

If you want people to respect your boundaries, then you must respect their boundaries. Be conscious of what you are asking of others. Is it reasonable?

Balance

We want clearly defined boundaries, but we must also allow for some flexibility. Our boundaries may need to vary based on the situation.

Get People Back on Track

People sometimes get distracted and go on tangents and need help getting back to the task at hand. The details of your co-worker's vacation may be fun, but excessive discussions can take away from job responsibilities, hence violating your boundaries of completing assignments. In this situation, it's important to respond gracefully, such as by saying, "Your vacation sounded wonderful. I need to complete this documentation, but let's chat at lunch and you could fill me in more."

Boundaries with Patients

Healthcare professionals must use caution when talking to a patient about their personal lives. The patient's role is not to be that of a counselor. Only share limited and general information about life outside the workplace. However, some information can be shared if there is a benefit to the patient, such as an encouraging statement. If you had the same medical issue and are doing well, that type of discussion is certainly acceptable.

The actions of patients trigger emotional reactions among professionals. These feelings include sadness, anger and protectiveness, among many other feelings. It is normal to feel such emotions, but caution must be used in how these feelings are expressed. Emotional reactions can interfere with boundaries, including becoming too attached to certain patients while ignoring others. Becoming aware of these emotional reactions is the first step to looking at how they affect working with patients.

Terms of Endearment. Using terms of endearment can initially appear to be a gentle and kind gesture but can create issues. Calling a patient "sweetie" or "honey" may appear to be comforting to that patient, but it may also suggest a more personal interest than intended. It might also suggest favoritism to other patients who are not called by those nicknames. Some patients may find such endearments offensive or patronizing.

It is a good practice to avoid using these terms, as doing so could blur the clarity of a professional's role in the life of the patient.

Burnout. Caregivers must learn to care for themselves. Providing care to frail and vulnerable patients is deeply rewarding, and sometimes deeply draining. The kind of giving that leads to burnout tends to involve behaviors done outside of the boundaries of one's job. Being aware of the boundaries of one's role and striving to adhere to those boundaries helps protect the caregiver from the destructive impact of burnout.

Gifts and Favors. Giving gifts to a patient or receiving gifts from a patient can blur the line between a personal relationship and a professional one. Have written guidelines for employees to determine what is acceptable as a gift. The same rules apply to favors, such as staying after work hours to "do a favor" for a patient.

Secrets. Do not keep secrets with patients. Do not share personal secrets with a patient and ask them to keep it a secret. Do not agree to keep secrets patients tell you. Secrets are different from confidentiality. Confidential information is shared with a few other members of a team providing care to a patient. Personal secrets compromise role boundaries.

Putting It All Together

Boundary issues will always be a part of the workplace due to a variety of factors, such as the communication skills and personal histories people bring into the workplace. A healthcare environment is a therapeutic milieu. To keep the environment therapeutic, boundaries must be established and implemented.

Through the strategies discussed in this article, you can minimize boundary issues. When equipped with the right set of skills, you can set boundaries while simultaneously creating positive workplace relationships that will benefit both your co-workers and your patients. EP

Edward Leigh, MA, is the founder and director of the Center for Healthcare Communication, a healthcare consulting firm focusing on employee and patient engagement.

Overstimulated at Work?

Boundaries to Protect Yourself

By Ryan Young

More and more people in today's fast-paced working environment feel perpetually on edge: unable to focus, plagued by a nonstop stream of notifications, and exhausted before the day even ends. This is due in part to overstimulation, which, in the healthcare setting, can be worse than almost anywhere else.

Overstimulation is when the brain becomes overwhelmed by too much sensory, cognitive and emotional input—in other words, far more than it can efficiently process. Overstimulation may result in irritability, exhaustion, lowered productivity and, finally, burnout. The modern workplace, with its open-concept offices, constant digital communications, and the demand for employees to be "always on," has become a prime contributor to this growing problem.

Overstimulation is different from stress. Overstimulation is the state one goes through after being put through excessive use of information or sensory input in a short period of time. This could include noise, bright light, constant meetings, or multitasking in the hyper-connected world. When overstimulated, the brain can't filter distractions and is unable to focus on the processing of emotions or any meaningful work.

Overstimulation occurs when incoming information, interactions and sensory experience combined outpaces the brain's capacity to process. A 2023 study in The Journal of Neuroscience reported that sensory overload complaints had increased 40% from pre-pandemic levels; this may well be a shift exacerbated by a return to office spaces and a surge in digital communication.

The Modern Work Environment

We work a lot differently now than we did just 15 years ago, and many of the innovations in the modern workplace—well-intentioned to help people collaborate and work more efficiently—surely serve to increase overstimulation. Here's how:

The Open-Office Dilemma

Open-concept offices were once lauded as the future of collaboration. In reality, they're often a sensory minefield of conversation, ringing phones, clacking keyboards, and impromptu meetings—making it nearly impossible for workers to focus. In that way, they're not all that different than your typical nurse's station or surgery center office. Researchers at Harvard Business Review found that, due to noise and distraction, employees in open offices experience a staggering 15% loss in productivity.

The average worker gets 121 emails a day and countless messages, texts and notifications. And with the expectation of immediate response, employees are constantly switching between tasks, leading to cognitive fatigue. According to a study by the University of California at Irvine, it takes an average of 23 minutes to refocus after an interruption, making digital overload one of the biggest contributors to overstimulation in the workplace.

Back-to-Back Meetings and Multitasking

Most employees find themselves caught in a vicious circle of back-to-back meetings, leaving little or no time for deep work. The compulsion to multitask—doing emails while on calls or messaging during meetings—prevents full engagement and increases cognitive strain.

The "Always-On" Culture

With the introduction of remote and hybrid work, the line between personal and professional life has continued to blur; people may feel obligated to check emails after hours or respond to late-night messages, leaving little time for actual mental recovery.

What Employers Can Do to Reduce Overstimulation

Creating a healthier work environment isn't just about reducing stress; it's about rethinking how we structure work to minimize cognitive overload. Employers can make a difference by instituting changes that protect mental well-being while sustaining productivity.

1. Normalize Quiet Spaces and Flexible Work Zones

While collaboration is invaluable, employees also need spaces where they can work without interruptions. Quiet rooms, soundproof pods, and "focus hours" can help temper the sensory overload of open offices.

2. Rethink Communication Overload

Organizations should set norms around communication to limit unnecessary digital interruptions. Encouraging scheduled check-ins rather than constant instant messaging, and implementing email-free focus periods, can make a big difference.

3. Prioritize Meaningful Breaks

Brief, intentional breaks throughout the day—say, walking outside, meditating or simply looking away from screens—reset the brain and prevent overstimulation from building up.

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4. Create Meeting-Free Time Blocks

Companies like Shopify and Asana have successfully introduced "meeting-free days," allowing employees uninterrupted time for deep work. Limiting meetings to specific time blocks can give employees more control over their schedules.

5. Encourage Separation of Work and Personal Life

Employers should model healthy boundaries by not intruding on employees' time outside of work. Simple things, such as discouraging after-hours emails and setting clear expectations around availability, can prevent the always-on mentality that contributes to overstimulation.

What Employees Can Do to Protect Themselves

While organizational change is crucial, employees can also take proactive steps to manage overstimulation in their daily routines. These tips include:

Identify your triggers. Notice where and when overstimulation usually occurs, such as a noisy office, constant email pings, or back-to-back meetings.

Set boundaries with your digital tools. Turn off nonessential notifications, batch and check emails, and set "do not disturb" on during your focus time.

Take a sensory break. This may be breathing exercises, time away from screens, or sometimes just closing one's eyes for a few moments—anything to help the nervous system reboot.

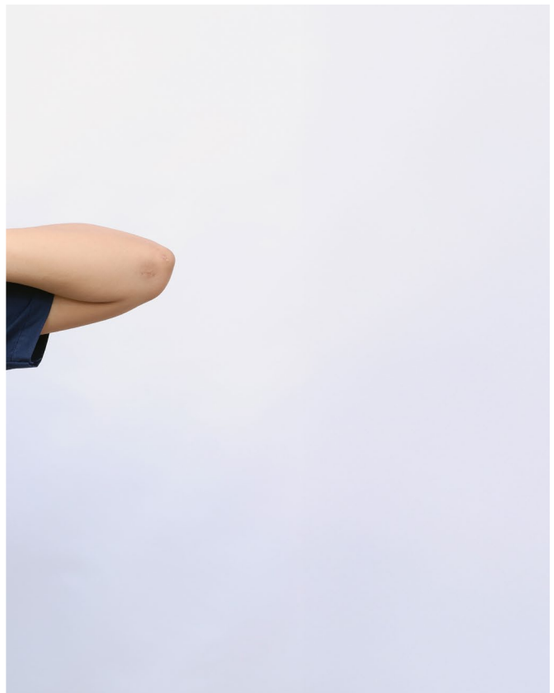
Express need. People are different. If some of the factors that are overstimulating you can be improved, talk with your manager or anyone else who may be able to help.

The Future of Work Deserves Smarter Spaces

Overstimulation is a challenge that calls for meaningful steps toward healthier, more sustainable work environments. It means rethinking building layouts, digital communication habits, and workload expectations to create a space where employees don't just survive the workday but thrive in it. Taking proactive steps to reduce overstimulation isn't just about productivity; it's about creating a culture where employees can bring their best selves to work without the constant burden of mental overload.

Healthcare practitioners have no shortage of stress, and the job has some degree of overstimulation built in. However, reasonable steps can be taken to reduce overstimulation, and the changes will benefit both practitioners and the patients they care for.

Ryan Young is a mental-health advocate and serves as marketing and social media manager for Give an Hour, where Ryan employs storytelling and community engagement to foster connection and hope, providing mental-health resources for those in need.



The Battle Against Workplace Noise

By Chris Berdik

From drug-infusion pumps to heart-rate monitors to low-battery warnings to bed alarms firing off for routine body shifts, the number of alarms calling out to clinicians has skyrocketed in recent decades. Hospital audits have tallied hundreds of alarms per patient per day, most of them inconsequential or false. The resulting "alarm fatigue" not only contributes to clinician burnout but can degrade patient care, according to the American Association of Critical Care Nurses.

It's a vicious cycle of noise, as each new alarm must get itself noticed above the prevailing din, and one of the big topics I cover in my book "Clamor: How Noise Took Over the World—And How We Can Take It Back" (Norton, May 2025). I zero in on the problem of signal overload and potential fixes in hospitals and elsewhere in the chapter, "All the Machines That All Go Beep."

The chapter explores alarm management, technology solutions and quiet times. It also argues for paying closer attention to the sounds themselves, to make them more helpful and less distracting, which is part of the story (excerpted below).

Fighting Sonic Inertia

The battle against alarm fatigue is not simply about volume control but also about revamping hospital soundscapes to better support clinicians and patients. Momentum for this larger cause continues to build on multiple fronts.

Among those working to extricate hospitals from the noisy trap of their own making is Yoko Sen, a sound designer and composer of breathy ambient electronic music in New York City. About a decade ago, after an extended hospital stay, she co-founded Sen Sound with her husband. Through countless interviews and workshops with patients, clinicians and medical-device makers, Sen and her team encourage people to think expansively beyond the beeps, not only focusing on the hospital noises they want to escape but also considering how to create a better soundscape for healing.

During Sen's hospitalization, she lay surrounded by machines beeping with unflagging urgency, and she thought about a neuroscience study she'd read, which suggested that hearing is the last sense to go before we die. Would this piercing chorus of beeps be her final sendoff? It seemed so tragic. At one point, an alert on her bedside monitor sounded so shrill and persistent that her husband flagged down a nurse for help.

"Oh, don't worry," the nurse reassured him. "That thing just beeps."

Telling this story, Sen laughs at the notion of a machine that "just beeps," without meaning or apparent purpose beyond sounding its unceasing electronic yawp. But the vignette also captures the neglect of the wider soundscape that lies at the heart of alarm overload. Its cacophony is a result of the decades during which hospitals accumulated sound-emitting technologies with little regard to the mounting cognitive burden they might place on staff and patients. In 2018, for example, a lead product developer at Philips, a prominent medical device company, contacted Sen after watching a talk she gave and invited her to work with his team. He admitted that his company had largely ignored the alarm sounds their patient monitors made, despite devoting decades of engineering and countless dollars to research and development of the machines' other aspects. Eventually, he traced the current alarm sounds to a cassette tape dating from 1981.

This is an example of "sonic inertia," and it wasn't surprising to Sen. Constant beeps might keep patients awake and anxious, and they might stress out busy nurses and doctors, but as long as they successfully snagged clinicians' attention, they worked, and the sounds they made were left alone.

Sen's first challenge, therefore, was to raise expectations of alarms beyond basic functionality.

Collaborating closely with the Philips product-design team, she played the company's then-current alarm sounds to gatherings of doctors and nurses and asked, "If the patient monitor was a person, who would it be to you, based on these sounds?"

"A drill sergeant," somebody said. Others suggested a dictator, an ignored boss, or a petulant toddler.

When asked what they might prefer, the clinicians said they wanted the monitor to sound more like a coach, a friend, or some other helpful and supportive person.

"I wish it to be a colleague," one doctor ventured, "with the same interests as myself: to do what's best for the patient."

The next step was a series of virtual workshops to solicit broader thoughts on hospital alarms from both clinicians and laypeople in a dozen countries. The project team dissected the transcripts of these sessions, clustered common themes, and ultimately distilled eight criteria for a successful alarm. Half of them related to "functionality," such as being simple to learn and locate in space, easy to distinguish amid background noise, and quick to stimulate a response. The other half were measures related to "sensibility," including how startling, aggravating, fatiguing or distracting the current sounds were.

With these criteria as a guide, Sen Sound and Philips's product designers started reworking the sounds for low-, medium- and high-priority alarms. Clinicians had said they wanted the low- and medium-priority alarms, which they heard most often, to

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be less aggressive, so the team slowed the pacing of the beeps and made them softer and "rounder," more like chimes with lingering notes. Medium-priority alarms were distinguished from low-priority ones by making them a bit more percussive and higher pitched, "like a gentle tap on the shoulder."

High-priority alarms kept the original pacing of beeps, but the timbre was tweaked to make it less shrill and harsh—clinicians said they wanted to be "warned without being jolted."

The project team then gathered feedback via two rounds of online surveys embedded with sounds—first they tested a handful of alternative alarms against each other and then pitted the winning alternatives for low-priority, medium-priority, and high-priority alerts against the originals. They asked listeners to give their preferences and to rate the alarms on the eight criteria.

This led to a surprising discovery. Everybody had expected significant tradeoffs between functionality and sensibility. They assumed that the acoustic qualities that grab attention and prompt immediate action would be opposite in nature to those that make sounds softer, gentler, warmer or smoother. Yet survey respondents mostly ranked their preferred sounds higher in both functionality and sensibility. And they preferred the new sounds to the originals overall. Philips adopted the redesigned sounds in 2023.

Solutions to hospital noise that have staying power will move beyond squashing problem sounds and proactively consider the bigger sonic picture: soundscapes matter for healing.

As a coda to Sen's time in the hospital, she composed a "final sound" mix of music and spoken word (recordings from people she'd ask to describe the final sounds they'd want to hear in this life).

The voices talked about the sounds of water as a source of life, a transformative force, or the reassurance of breaking waves reaching out from a vast, unfathomable ocean. Others spoke about hearing the voices and laughter of loved ones, a chorus of birds that could kindle a "feeling of the morning when I'm waking up to something new," or simply a rhythmic beat strong enough to "carry me to whatever's next."

For nearly five minutes, the piece echoed with final sonic wishes.

Not one beep could be heard among them.

Chris Berdik is a science journalist and a former staff editor at The Atlantic and Mother Jones. He has written for numerous publications, including New Scientist, The Boston Globe, The Washington Post, and The San Diego Union-Tribune. He lives in Boston.

Antibiotic Resistance

How Do We Slow the Rise?

By Nancy Haberstich, RN, MS

Antimicrobial stewardship is an important mission for healthcare, a mission built on the "it takes a whole village" idea. Read on to see the big picture and how to contribute to the success of this global endeavor.

The Miracle Drug

Penicillin was discovered by Alexander Fleming in 1928. It was further developed for medicinal use by Drs. Howard Florey and Ernst Chain of Oxford University, just in time for treating soldiers in World War II. Penicillin was quickly dubbed a "miracle drug" and is considered one of the greatest contributions to health in the 20th century.

Penicillin bolstered human life expectancy by 27 years and allowed people more normal lives without the perpetual worry of common infections such as strep throat, pneumonia or sexually transmitted infections.

Undoubtedly, antibiotics like penicillin revolutionized healthcare and continue to save lives. However, with the near-indiscriminate use of the miracle drug—understandably fueled by vivid and morbid memories of overwhelming infections—antibiotic resistance followed on the coattails of overuse, complacency and misuse. This resistance threatened to diminish the progress made in the fight to control infectious diseases.

There is no single factor to blame for the development and expansion of antibiotic resistance. Rather, it was a combination of medical advances:

- Overuse and misuse of antibiotics
- A tremendous increase in the size of immunocompromised populations
- A higher frequency of invasive medical procedures, longer hospital stays and more ICU days
- Individuals with chronic debilitating conditions living longer

Science showed that resistance to antimicrobials was inevitable, but there are measures to slow this resistance, ideally to a more manageable pace. At the core of this endeavor is an essential need to understand and respect these drugs.

Antibiotic Resistance

An antibiotic is a selective poison, targeting bacterial cells and killing the pathogen while avoiding or minimizing damage to the human cells and human host. Different types of antibiotics affect different bacteria and act in different ways. For example, an antibiotic might inhibit the ability of the bacterium to turn glucose into energy, or by attacking its cell wall, as

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penicillin does. Penicillin attaches to a cell's wall and destroys a key part of it, which causes the cytoplasm to spill out, killing the bacterium.

The antibiotic does not technically cause resistance but rather allows it to happen. This is an evolutionary process, and sometimes evolution is relatively rapid. Any population of microbes naturally includes variants with unique traits; these might include an ability to withstand an attack of the drug. (We learned that with COVID-19.)

When a patient takes an antibiotic, the drug kills defenseless bacteria and leaves behind those that resisted it. This is called "selecting." The surviving bacteria then multiply, increasing their numbers a millionfold in a day, and the variant becomes the predominant microbe.

A patient can develop a drug-resistant infection, either by exposure to an already resistant microbe, or by creating a resistant microbe in their body once undergoing antibiotic treatment.

Pathogens resist antibiotics by interfering with the drug's mechanism of action. Bacteria that survive an antibiotic assault can make changes in their own structure and pass the information to their "offspring." Bacteria can also transfer genes by swapping DNA packets known as "plasmids." In the healthcare environment where bacteria are challenged by antibiotics, genes that confer resistance become available to bacterial populations and create a perfect storm for resistance.

Stewardship

Resistance spreads fast, necessitating a plan to slow the pace, because there is no going back. The plan is a series of programs known as "antimicrobial stewardship." Since these programs are used to control a variety of microbes (e.g., bacteria, yeasts, microscopic fungi) from developing resistance, "antimicrobial" is a preferred term (rather than antibiotic) to be more inclusive. "Stewardship" is a fitting word, as it implies responsibility in overseeing and protecting something worth caring for and preserving. The term also indicates positivity and comprehensive understanding of the microbes, the drugs, human behaviors, and alternatives to infection prevention.

The core elements of an antimicrobial stewardship program are accomplished by the entire community of health professionals and directed through healthcare organizations. Here's the outline:

1. Prescribing and using antibiotics appropriately and only when necessary (for both humans and animals) by ensuring:

- Antibiotics are prescribed only for confirmed bacterial infections and only when truly needed
- The appropriate antibiotic is prescribed at the proper dose and for the proper duration
- That prescribed antibiotics are used until the full antibiotic course is finished

> **Science showed that resistance to antimicrobials was inevitable, but there are measures to slow this resistance, ideally to a more manageable pace. At the core of this endeavor is an essential need to understand and respect these drugs.**

2. Preventing infectious disease by:

- Washing hands
- Avoiding cross contamination with appropriate personal protective equipment (PPE) when contact is unavoidable
- Keeping current with vaccinations
- Improving hygiene and sanitation

3. Promoting and monitoring infection prevention and control measures via surveillance and reporting to combat the misuse of antibiotics.

Prior Authorization

Some facilities restrict the use of certain antibiotics based on the spectrum of activity, cost or associated toxicities. Furthermore, some facilities ensure that intended use is reviewed by an antibiotic expert before therapy is initiated. This intervention requires availability of expertise in antibiotic use and infectious diseases, and its authorization needs to be completed in a timely manner. This function is managed by clinical pharmacists who can communicate directly with prescribing physicians.

Know Your Role

Nurses and technicians do not prescribe antimicrobial drugs, but they play a role in stewardship. Nurses can assure that cultures are performed before starting antibiotics. They also collect specimens for culture and therefore contribute to an accurate diagnosis. In addition, nurses review medications as part of their routine duties and can prompt discussions of antibiotic treatment, indication and duration.

Antibiotic "time outs" are another key area in being a good steward. Antibiotics are often started empirically in hospitalized patients while diagnostic information is being obtained. However, providers often do not revisit the selection of the antibiotic after more clinical and laboratory data (including culture results) become available.

An antibiotic "time out" prompts a reassessment of the continuing need and choice of antibiotics when the clinical picture is more clear and more diagnostic information is available. All clinicians should perform a review of antibiotics 48 hours after they are initiated and answer these key questions:

- Does this patient have an infection that will respond to antibiotics? If so, is the patient on the right antibiotic(s), dosage and route of administration?
- Can a more targeted antibiotic be used to treat the infection (de-escalate)?
- How long should the patient receive the antibiotic(s)?

Patient Education

Every facility or healthcare organization should have an antimicrobial stewardship program and should provide regular updates on antibiotic prescribing, antibiotic resistance, and infectious-disease management that address both national and local issues. Pay attention to these updates and any directives that include your role.

Nurses and pharmacists are responsible for educating patients and family members about the importance of the drug in treating the patient's infection and the details of administration that will insure effectiveness. Remind them to not save unused antibiotics for another time when they feel sick. Emphasize the importance of compliance and communication with their prescribing clinician if side effects threaten that compliance with the full course of the drug. Be sure to emphasize that antibiotics do not work on viruses like the common cold.

Please teach and train your family on these important matters, too. It takes a whole village to manage the challenge of antibiotic resistance. EP

Nancy Haberstich, RN, MS, (retired) is a seasoned infection preventionist and an avid writer.

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