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Geri Amori: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives.

I'm Geri Amori. Today I am joined by Danielle Ofri, MD, Stacy Nigliazzo, RN, and medical defense attorney, Jake Kocienda. Welcome.

Today, we're talking about travel nurses. Good thing, bad thing, do we really need them? Dr. Ofri, as an internist, what has your experience been like working with travel nurses?

Danielle Ofri, MD: Well I would say that I have mostly worked with travel nurses during the height of the pandemic, and they were lifesavers. We, in New York City, in the spring of 2020, would not have survived without our travel nurses, and I'll also include army nurses and physicians who came in.

You know, it's interesting to work with a combination team. A typical team would be, myself, a recently graduated third-year medical student, one resident, a nurse from Ohio, an ophthalmologist, and a urologist. And that's how we took care of the COVID patients. I was thrilled to have them. And had no complaints.

Amori: Wow, that's great. Stacy, as a nurse, have you actually worked with travel nurses and what was that like, for you, from a nursing perspective?

Stacy Nigliazzo, RN: I have worked with travel nurses for the last 20 years. Hospitals have always used them, just to a greater degree during the pandemic. My experiences over that time range from excellent to disastrous.

Keep in mind, this is a specialized group. They're expected to step in and carry the weight of an already-stretched workforce, often in a time of crisis. Traditional nurses receive about 4 to 6 weeks with a preceptor before working on their own. Whereas travel nurses usually arrive and leave within 4 to 6 weeks. They might get 3 shadow shifts with a staff nurse before carrying a full load at the bedside. And this time limit is determined by the agency.

Now, to be fair, the agency also fulfills certain requirements ahead of time: certifications, competency on common charting systems and equipment, but clearly, this is an incredible task that we're asking of them.

These nurses must conform to the highest standard of excellence. And above all, hospitals must ensure a safe environment for patients and all staff, agency or otherwise. And because there's currently such a high demand for help, fees for agency services have risen dramatically. And hospitals have no choice but to pay them.

As a result, suspected predatory, maybe, practices by some of the agencies are an unfortunate reality. For example, let's say an agency has tripled its fee in the face of a higher demand. Ask

yourself, how much are these nurses actually making, and how much is this agency profiting? And do we get to a point where we call this price gouging?

We talk about meaningful legislation to prevent it. We don't allow stores to charge $25 for a bottle of water after a hurricane, right? And think of how demoralizing this is for existing nurses who know this transitory person is making far more than they are for doing the same job.

And keep in mind, if a travel nurse is practicing unsafely, the receiving hospital can usually just cancel the contract and request someone else, but what about the next hospital? You have to remember the challenges of multistate licensing and professional responsibility.

An impaired or incompetent nurse might simply jump from one agency to another, one state to another. And if there's no central mechanism for accountability, what's stopping them? So clearly there are a lot of angles to consider here.

Amori: That sounds like it, it really does. Which leads me to ask Jake then, as a defense attorney, have you seen any risk issues related to travel nurses?

Jake Kocienda, JD: Actually, I have, and I think Stacy kind of touched upon that a little bit. The interesting part of the traveling nurses is really that you don't know who you're going to get, necessarily, when the agencies send them over.

These people could be very unfamiliar with the system there, either the EHRs, but also just the way the hospitals or the location they're assigned functions. One of the things to keep in mind is that medical malpractice, the vast majority of cases often come down to a problem with systems. Either the systems aren't being followed, or there's holes in them.

And so the visiting nurses walking into a system that they're not as familiar with, open up that possibility that things go wrong, not because of bad medical care, but they just don't understand that something doesn't happen or they make some assumptions and things fall through the cracks because of that, leading to a malpractice suit or a claim. And then the next thing you know, the visiting nurse is on their next assignment across the country or in another state and the hospital or the facility is left holding the bag, dealing with the fallout.

There's also the culture problems. They come in, philosophies or the way of doing things, they may not fit. This can really rankle some people. But even from the flipside, from the travel nurse perspective, they leave—perhaps they're there for a week, a month, a couple days—they leave, something goes wrong, they may have provided great care, and then they can become the scapegoat. It's very easy. The one that left is the one who caused it, even though maybe that's not true. And they get brought into the case. But there's no allegiance, there's no loyalty.

The agency may have to deal with something like that. Stacy mentioned at the end there, you don't know who you're getting, what they're good at, it's hard to vet. They may be licensed, they may have insurance, and they may be practicing, but are they traveling because they like the lifestyle or are they traveling because no one wants to employ them full-time because they can't get along with people? Or they're not practicing really well.

These are some of the risks that, especially in an emergency situation, that Dr. Ofri mentioned. You know, you're kind of stuck, and sometimes you don't have a choice, you take who walks through the door. But there are a lot of risks from an exposure liability standpoint that come with it, that maybe the hospitals can't control for anymore or the facilities can't prevent. Or take some prophylactic approach to avoid the problems.

Amori: That's a really interesting point, Jake, and that leads to a really interesting question I'd like to ask you, Dr. Ofri. Have you experienced and do you feel that patients get a different level of care from a travel nurse, that you've worked with, anyway?

Ofri: I would say it's hard to say because travel nurses are as diverse as any group of hospital employees, and some are excellent, and some are not. But what I've noticed in my experience with travel nurses is that there's obviously the pandemic emergency of 2020, that was one situation. But, in nonemergent situations we typically don't put travel anyone in key critical posts. We'd rather put our staff there. And then have those PRN people fill in the less, let them be the vaccine nurse and then put our nurses into the ICU where they can be trained up.

But the best travel nurses, I think, are the ones who really kind of ask about the environment. So, I just, an hour ago was delivering monoclonal antibodies to several COVID patients and those are being administered with travel nurses, and they're excellent.

They're really interested in this particular group and knowing how we do it, how we interact. So their sort of curiosity and desire to fit in with our organization makes it really smooth. I think the patients don't know otherwise; they seem like our wonderful nurses.

I really appreciate when they make the effort to know who we are and how we might be different. Well I work in a public hospital and that's different from being in a high-end private hospital. It's a different way of working, and the nurses who really make the effort to integrate in that, do fantastically.

Amori: It sounds like there's a lot of variation based upon the personality of the person who's doing it and their motivations for doing it. Stacy, as a nurse, that's an opportunity, I'm hearing there's good money in it, have you thought about ever doing travel nursing, and why or why not?

Nigliazzo: I've thought about doing it in retirement, potentially. Just as a way to get an RV, pack the dogs up, visit family I wouldn't see otherwise, necessarily, or places in the country where I've always wanted to visit. But I didn't think about it at all during the pandemic because I was very engaged with my local community. As nursing leader, I wanted to see our community through that crisis.

We had a lot of great additional help come in, as Dr. Ofri said. We had the FEMA nurses, we had the agency nurses, we had our own staff who stayed, and we wouldn't have gotten through without all of that help. So, I'm deeply grateful for the good experiences that we have.

Amori: Great. I understand. And it sounds like a great way to spend a post-middle of your lifetime, doing that. Dr. Ofri, do you want to say something about that?

Ofri: Yeah, I will add that I did travel doctoring for about a year-and-a-half after residency. We call it locum tenens and it was an incredible experience. And for me, I had the chance to practice in different settings, completely different from the urban, the Level 1 trauma center kind of setting, that I trained in.

And I met a lot of travel doctors who were not sort of the dregs who couldn't make it anywhere but those who were interested in new experiences and maybe they had, they were skiers, some kind of outdoorsy lifestyle, or they had time. But it really was, I think, people who are curious about different ways to practice medicine, and how can I learn more in a rural setting, in a small-town setting. Mostly, I found it was a great experience.

Amori: That's interesting. So both of you are really commenting on the potential for development and expansion and really kind of creating a global community of awareness by doing that. I love it. That's great.

Jake, you mentioned some risk management issues earlier. Have you actually seen any lawsuits that were targeting a traveler because they were a traveler?

Kocienda: I have not seen a traveling nurse being the target, their care being the focus. However, I have had a couple of cases where their care or their involvement was very, very important to understanding and defending the case. As a witness, they were very integral in the defense. And yet they weren't around.

We had to not only track them down, but also get them essentially willing to cooperate because one of them in particular felt, well, they weren't there, they were there very temporarily, they don't have to be involved. And who wants to be involved in a lawsuit? And so trying to get them to be invested in helping with the defense was very difficult. She wasn't the target, but her care and what she observed, and her encounters and interaction with the patient were extremely important.

So that was effective to the case and something we had to worry about. But I haven't seen anything where their care was actually the focus and target. I think a lot of times, first of all lawsuits are 2 to 3 years, at least in Connecticut, and Massachusetts sometimes even longer, before they come to fruition. So the big surge in traveling nursing over the past couple of years, those cases aren't "due" in the system yet.

But they have been involved as witnesses, and the frustration in defending both the client and myself and getting them involved was clearly something we had to reckon with.

Amori: So what I'm hearing in kind of a general, something new I'm hearing is the potential for development for the healthcare provider or the healthcare clinician of any sort, is really there, and is really a very good possible thing. And on the other hand, while there are risks for the organizations, maybe there's some benefits too.

As we're getting ready to wrap-up here, I'd like to ask each of you from your differing perspectives to tell us the one thing you would like our listeners, both in healthcare and not in healthcare, to take away from today's discussion. Let's start with you, Dr. Ofri.

Ofri: Sure. I think the most important thing for a successful travel nurse or any healthcare provider is a desire to be integral to their environment for the moment and not just act as a band aid but make the effort to be your most professional self for however long, be it an hour, a day, a week, or a year. Because in the end, if you think about it, that your priority is the patient care, it shouldn't matter your setting. And we want to sort of convey that ethic, I think from the agency, and from the healthcare institution, as well.

Amori: Great. Thank you. Stacy, your one point you want everyone to remember?

Nigliazzo: I would just reiterate that as healthcare providers, our currency is human life, plain and simple. Agency staffing is a necessary resource, but we should offer and utilize it responsibly. We must ensure safe practices and fair compensation to protect our patients and our nurses.

Amori: Thank you. And Jake?

Kocienda: I think the main focus or the main takeaway I have is that it's a team effort and that it's not one sided, so no one should be expecting that the hospitals or facilities or the offices who bring in the visiting nurse or clinician, should take all of the responsibility and the nurse just moves on and does what they want.

And the nurse should also be expected to cooperate and try to fit in, as has been mentioned. With that team effort, I think you can work really well. But the fact that everyone, and this has become a much bigger phenomenon over COVID and the pandemic, I think, like anything new, it has to be worked out. But the team-effort approach I think is the best way to avoid liability, exposure, and to make sure the proper good care that everyone expects and is usually delivered, remains delivered.

Amori: Thank you. Well, this has been a really great discussion. And I want to thank our panelists for participating. I hope you, our audience, found this valuable. Thank you for joining us, and until next time, this is *Perspectives 360*.

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