

## **Doctors Must Wash Hands**

By Betsy McCaughey on 12.29.04

NEW YORK -- Bradley Moore of Washingtonville, New York, was taken to the hospital with a head injury. He managed to survive swelling and damage to his brain, but while he was in the hospital he contracted an infection. "It was the infection that killed him," Patricia Moore explained, after burying her son. "I am only one voice, one mother, but I know that hospitals can lower their infection rates by implementing simple practices such as handwashing. This problem has been ignored too long."

Ignored? Kept secret is more like it. You've seen the advertisements imploring you to use this hospital or that hospital because it has the best doctors, or the latest equipment. The one fact you don't see advertised is the number of patients who get an infection while there. Hospitals are doing their best to prevent their infection rates from being disclosed. It's no wonder. Every year, more than two million hospital patients in the U.S. contract infections, and nearly 100,000 die from them. The death toll is higher than from AIDS, breast cancer, and auto accidents combined.

Statistics don't convey the suffering. Patients who manage to survive a serious infection sometimes go through months of pain and repeated surgeries to cut out infected tissue. That's what happened to Eunice Babcock of Connecticut, who went in for bypass surgery and got a staph (*staphylococcus aureus*) infection. She was so close to death that doctors had to surgically remove her sternum, leaving her disfigured and unable to stand up ever again.

### **Doctors' Dirty Hands**

This suffering is tragic, because infections are largely preventable. No scientific breakthrough is needed. The single most effective way, according to the federal Centers for Disease Control and Prevention (CDC), is to get doctors and other caregivers to clean their hands in between treating patients. Doctors clean their hands before treating a patient only 48 percent of the time, on average, research shows. "Even at the best hospitals" the rate is only 60-70 percent, points out Dr. Beth Raucher, an infection expert at Beth Israel Medical Center in New York City. It's not unusual to be able to trace the bacteria in a patient's wound directly to the bacteria on a particular health care worker's hands, she explains.

Patients "are dying from germs their physicians and nurses give them," warns Elizabeth Norman, head of New York University's doctoral program in nursing and an outspoken critic of the poor hygiene in hospitals.

Contaminated equipment, such as wheelchairs, bedrails, stethoscopes, and blood pressure cuffs also allow dangerous bacteria to be transmitted from one patient to another. Patients

with staph actually shed the bacteria in little flakes from their skin that are then carried on equipment and floor dust. Intravenous (IV) and urinary tract catheters -- tubes that enable liquids to enter or leave the body -- are also extraordinary transmitters of infection.

A few hospitals in the U.S. are showing how possible it is to reduce infection. Latter Day Saints Hospital in Salt Lake City, which already had an infection rate below the national average, reduced its rate by 50 percent, largely by improving pre-surgical procedures. Mercy Hospital in Oklahoma City lowered the risk of infection after cardiac, colon, and hysterectomy surgeries by 78 percent. Forty-four hospitals in the Pittsburgh region have reduced catheter-related bloodstream infections by nearly half, and a pilot program at the V.A. Hospital there has virtually wiped out a deadly type of infection, methicillin resistant staph.

Yet the overall hospital infection rate in the U.S. is at least as high as it was three decades ago, and there is some evidence that it may actually be increasing. Most hospitals are dirtier places than they used to be. New York University's Elizabeth Norman remembers that in the mid-20th century, when she and nurses of her generation trained, her hands were red and raw from scrubbing, and cultures were routinely taken from underneath the fingernails of hospital staff to make sure bacteria were not being spread. Sadly, she has "watched the abandonment of simple practices that were once routine."

A liberal reliance on antibiotics has replaced scrupulous attention to hygiene. That has led to new danger: infections that almost no drugs can cure. One of the most feared infections is MRSA (methicillin-resistant staphylococcus aureus) because most antibiotics do not tame it. Yet it can be virtually eradicated. Hospitals in Holland and Denmark have done it by insisting on hand hygiene, decontaminating equipment such as beds and wheelchairs after patient use, and isolating patients who carry the germ -- precautions people assume are taken everywhere. In addition, non-emergency patients in these two countries are tested for MRSA before coming into the hospital, and those who test positive are treated to eliminate the bacteria -- a process that keeps new germs out of the hospital.

These precautions are not taken by many American hospitals. The result? A frightening 57 percent of hospital staph infections in the U.S. are antibiotic resistant (up from 2 percent in 1974), and the problem is spreading. Denmark and Holland have brought that figure down below 1 percent.

### **Drugs or Hygiene?**

On July 8, the Infectious Diseases Society of America called on Congress to provide incentives for companies to develop new drugs against antibiotic-resistant infections. That's the wrong tactic. It merely perpetuates a race between scientists and germs that are constantly morphing to resist antibiotics -- a race we may not always win. Strict hygiene will curb the spread of infection, no matter how germs evolve. It's time to make hygiene a central part of medical care again.

The British are beginning to do that. British medical care falls far short of American care by almost every measure, but hospitals there now are rushing to make infection control a

top priority. Why? Because a MRSA epidemic has evoked such fear and outrage that the public is demanding action. Newspapers run frontpage stories about patients who went into the hospital for routine surgery, contracted MRSA, and died or suffered terribly. Under political pressure, Prime Minister Tony Blair issued an edict that the British National Health Service must reduce infection.

Britain's Broomfield Hospital was one of the first to act. It reduced overall infections by two-thirds and eliminated MRSA entirely from its orthopedic wing by improving hand washing, barring nurses from wearing jewelry, prohibiting visitors from sitting on patients' beds, ensuring that doctors changed white coats frequently, testing all patients for infection before they were admitted, and isolating patients carrying infection.

### **Fighting Infection Saves Money**

Can American hospitals afford to take these precautions? We can't afford not to. An infection after surgery more than doubles the cost of a patient's care. Hospital infections add an estimated \$20 billion to \$28 billion a year extra to the nation's health spending, enough to fund two-thirds of the cost of the new Medicare drug benefit.

Who pays? We all do. Patients pay. Employers who foot the bill for workers' health care pay. Insurers pay. Taxpayers who fund Medicare, Medicaid, and other government health programs pay.

Infection prevention saves money. Shadyside Hospital in Pittsburgh spent \$114,320 extra treating 12 patients because they became infected with MRSA. Then the hospital instituted rigorous infection-prevention procedures similar to those in Holland and Denmark. The result: no new MRSA infections in the next five months. The cost of prevention during that period: \$9,984. Numerous similar studies prove infection prevention is cost effective, but hospital administrators still claim they can't afford it.

They also insist on secrecy, arguing that publicizing comparisons of hospitals' infection rates would be unfair to hospitals treating AIDS, cancer, and organ transplant patients who succumb to infection quickly. Fair enough, but reports can be risk-adjusted to reflect these differences. What is unfair is keeping the public uninformed. Pat Moore said about her son's death, "If I had known the hospital had a serious infection problem, Brad would never have been taken there. We would have chosen another hospital with a better record."

If you need an operation, wouldn't you want to know which hospital in your area had the lowest infection rate? Good luck getting that information.

### **Secrecy Allows the Danger to Continue**

Twenty-one states require hospitals to report infections that lead to serious injury or death, but most of these states have acceded to the hospitals' demands to keep infection reports secret. The federal CDC collects infection data from several hundred hospitals around the nation, but also promises hospitals not to disclose their infection rates. That's an outrage.

Patient advocates are calling for state governments to make that information public. Pennsylvania and Missouri enacted laws this year for hospital infection report cards, but nearly everywhere else in the hospital industry is proving a formidable adversary. In December 2002, the Vermont legislature considered a bill to make hospitals report annually on several quality measures, including infection rates. "It was ripped to shreds by the hospital association," complained Jeanne Keller, a Vermonter, health care consultant, and supporter of report cards. With report cards, hospitals that look bad "will be embarrassed at least, and may be forced to improve."

She's right. Hospital report cards work. New York State proved it. Though New York doesn't disclose hospital infection rates, in 1989 New York became the first state to publish information on how hospitals compared in another area -- risk-adjusted mortality rates for cardiac bypass surgery. The results? Deaths from bypass surgery dropped 40 percent, giving New York the lowest mortality rate in the nation for that procedure. Critics of report cards speculate that deaths went down in New York because hospitals avoided treating the sickest patients, fearing that high risk operations would bring down the hospital's grade. The evidence proves that's untrue. Deaths declined for a different reason: hospitals forced their worst performing surgeons -- those with low volume -- to stop doing the procedure. It's a good thing. Patients of the 27 barred surgeons were more than three times as much in danger of dying during surgery. In technical jargon, the 27 surgeons had an average risk-adjusted mortality rate of 11.9 percent, compared with a statewide average of 3.1 percent.

Wisconsin also found that report cards motivate poorly performing hospitals to improve, according to a 2001 study of 24 hospitals there.

The British also see it that way. In England, infection rates are now conspicuously posted at hospital entrances and in newspapers. Patients in the U.S. deserve the same information.

Sadly, even when politicians discuss health care, they stick to the same old script, talking about the uninsured. Eighteen thousand people a year die prematurely because they lacked health insurance, the Institutes of Medicine estimate. That's tragic, but five times that many people die from infections they contract in the hospital. Most of these victims have insurance.

The question has to be asked: What could the President Bush do about the huge fatalities from hospital infection? Plenty. Federal health programs such as Medicare pay 46 percent of the nation's hospital bills. They have real market clout. Astonishingly, Medicare pays the same fees to hospitals with the best care as it does to those with high infection rates. It pays top dollar for dirty care. Washington has been looking for ways to pay for Medicare's drug benefit. The president should instruct Medicare to stop doing business with hospitals that have an infection rate double or triple the norm.

A few large employers and insurers are taking a new approach. They are paying higher rates to hospitals that provide better care. Recently, the Bush administration has shown

some interest in wielding Medicare's market clout, though not specifically to reduce infection. On July 19, 2003, Medicare announced a "pay for performance" experiment in which a small number of hospitals would be eligible for a 2 percent bonus if they proved that they are providing superior care for heart attacks, pneumonia, and certain other illnesses. The American Hospital Association responded predictably, cautioning that "pay for performance" could become punitive. Let's hope so. "Pay for performance" should be expanded to reward hospitals that substantially lower infection.

Holding hospitals accountable is no different from holding public schools accountable. Just as no child should be trapped in a failing school, no patient should be treated in an infection-ridden hospital.

The good news is that the war against infection is winnable. What has been lacking is the will to fight it.

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