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Perspective

The Next Asbestos

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Every year in this country, two million patients contract infections in the hospital. Until recently, infection was considered the inevitable risk you faced if you were hospitalized. That is changing: there is compelling evidence that nearly all hospital infections are preventable when doctors and staff clean their hands and adhere to other low-cost infection prevention measures. These findings put hospitals in a new legal situation. The assumption that infections are unavoidable shielded hospitals from liability for decades. But not in the future. Hospital infections could be the next asbestos.

Infections are raging through most American hospitals, affecting one out of every 20 patients. The danger is worsening because, increasingly, these infections cannot be cured with commonly-used antibiotics. In 1974, two percent of staphylococcus aureus infections were methicillin-resistant (MRSA). By 1995, that figure had soared to 22 percent, by 2003 to an alarming 57 percent, and now 60 percent and still rising. A few hospitals in the United States are proving that these dangerous, drug-resistant infections can be nearly eradicated. For example, the University of Virginia Medical Center and several hospitals in Pittsburgh, including the Veterans Administration Health System, Allegheny General Hospital, and the University of Pittsburgh-Presbyterian Hospital, have reduced MRSA infections by 85 percent to 90 percent in pilot programs. Twenty nine health care institutions in Iowa eradicated another deadly drug resistant infection, vancomycin-resistant Enterococcus (VRE). How did they do it? Through rigorous hand hygiene, meticulous cleaning of equipment and rooms between patient use, testing incoming patients to identify those carrying MRSA and other bacteria on their skin, and taking the precautions needed to prevent the bacteria from spreading to other patients on gloves, hands, lab coats, uniforms, wheelchairs, stethoscopes and other equipment. These success stories are documented in a new report, "Unnecessary Deaths: The Human and Financial Costs of Hospital Infections" (available at: www.hospitalinfection.org).

In 2003, a committee of the Society for Healthcare Epidemiology of America (SHEA) urged hospitals everywhere to implement these proven precautions. The Committee to Reduce Infection Deaths (RID) issued a similar call. We have the knowledge to prevent infection. What has been lacking is the will.

Public disclosure may help change that. Seven states — Florida, Illinois, Missouri, New York, Pennsylvania, Virginia, and Connecticut — recently enacted laws to publicly report risk-adjusted hospital infection rates. Thirty more states are considering similar legislation. In the future, patients who have to be hospitalized will be able to find out which hospitals in their area have the worst infection problems.

The New York reporting law, signed by Governor Pataki on July 19, 2005, as an addition to chapter 284 of the Public Health Law, requires hospitals to report annually to the state health department certain types of infections that patients develop in the hospital. The state Health Department will collect the data, risk-adjust it to be fair to hospitals that treat cancer, HIV, and organ transplant patients who succumb to infection easily, and then make comparative data available to the public, probably by 2008. The Committee to Reduce Infection Deaths had proposed that none of the data could "be used in litigation against an individual hospital," but key lawmakers said such a provision would have amounted to a "poison pill" preventing the bill's enactment.

Secrecy has allowed the infection problem to fester in the past. Though every hospital has an infection control program, "there is little evidence of control in most facilities," the SHEA committee reported. Hospitals that continue on this course will face embarrassing public comparisons and numerous lawsuits as well.

Most victims who sue will not be able to prove precisely how the bacteria entered their body while they were hospitalized. Soon, it may not matter. Jurors will be told that the hospital failed to enforce hand hygiene rules and implement necessary infection prevention practices and consequently, should be deemed negligent and held liable, even strictly liable in some cases, for patients' infections.

Many questions will be raised by these lawsuits. At least half of hospital infections could be prevented if caregivers clean their hands immediately before touching patients. Most hospitals tell doctors and nurses to clean their hands, yet doctors break this fundamental rule 52 percent of the time, on average. When hand hygiene rules are not enforced, infections are foreseeable. A few hospitals are devising sanctions, such as suspending admitting privileges or curtailing operating room time to discipline chronic offenders. Will hospitals that fail to do this be deemed negligent and held liable for the infections their patients contract?

Astoundingly, most U.S. hospitals don't routinely test incoming patients for MRSA. Seventy to ninety percent of patients carrying MRSA are never identified. Knowing which patients are sources of infection is key to stopping the spread. If you're placed in a semi-private room with a patient carrying MRSA, you're at increased risk of infection. Also, as a new study in *Infection Control and Hospital Epidemiology* documents, if you're placed in a room previously occupied by a patient with MRSA, your risk of infection increases, because the bacteria linger on floors and furniture long after the patient who had it is discharged. Will hospitals that fail to test incoming patients and isolate those testing positive be deemed negligent and held liable when a patient contracts a deadly MRSA infection?

Surgery patients can reduce their risk of infection by bathing or showering with chlorhexidine

soap daily before their operation. Will a hospital that fails to advise patients to take this precaution be deemed negligent and held liable when a patient develops a surgical site infection?

Will a hospital be deemed negligent and held liable if the staff forgets to administer a prophylactic antibiotic within an hour of the incision, the standard of care in most cases, and the patient subsequently contracts a surgical site infection? What if the staff shaves a patient before surgery, contrary to best practices, and the patient comes down with an infection?

Even where there is no evidence that a hospital overlooked infection prevention measures, the plaintiff's attorney could argue that infection is evidence enough that the hospital breached its duty. Every law student learns about the barrel that fell out of a merchant's second-story window, injuring a customer below. The merchant was held liable because the accident was itself definitive evidence of negligence, a textbook example of *res ipsa loquitur*. Similarly, trial lawyers will claim that an infection "speaks for itself" and shifts the burden onto the hospital to offer evidence that it was not negligent.

Res ipsa loquitur already has played a prominent role in medical malpractice cases in New York. What will be new is its applicability to hospital infection. For example, in 1997, the Court of Appeals granted a new trial for a plaintiff who had undergone a hysterectomy and subsequently found an 18-by-18-inch laparotomy pad left in her abdomen. The Court of Appeals ruled that the jury should have been told that the error speaks for itself: once the plaintiff proves that "the event was of the kind that ordinarily does not occur in the absence of someone's negligence, that it was caused by an agency or instrumentality within the exclusive control of the defendant, and that it was not due to any voluntary action or contribution on the part of the plaintiff, a prima facie case of negligence exists." The Court of Appeals also explained — and this is key to future litigation based on infection — that "to rely on *res ipsa loquitur* a plaintiff need not conclusively eliminate the possibility of all other causes of injury. It is enough that it is more likely than not that the injury was caused by the defendant's negligence." *Kambat v. St. Francis*, 89 N.Y.2d 489.

A rapidly growing body of new evidence shows that almost all hospital infections are preventable if hospital staff are trained in the correct procedures and required to follow them. Had the plaintiff in *Hoffman v. Pelletier et al.*, 6 A.D. 3d 889 (3rd Dept. 2004), presented such evidence, the trial court probably would not have granted summary judgment for the defendants. The plaintiff had developed a staph infection following cervical surgery, and sued her surgeon and the hospital. The trial court granted summary judgment for the defendants. "Since plaintiff offered no proof that such infections do not occur in absence of negligence, *res ipsa loquitur* was inapplicable," reasoned the court. Though such evidence was already available in 2004, it is far more plentiful and well documented in medical journals now. Even the federal Centers for Disease Control and Prevention have indicated that they will soon be releasing new guidelines for infection prevention in hospitals, based on this new evidence.

What must hospitals do to avoid liability for infections? That's still unknown. Courts will decide, "probably moving from common law negligence to the eventual establishment of strict liability," according to Sanford Young, a New York lawyer. In the early cases, plaintiffs may have to point to specific departures from best infection control practices, such as shaving patients before surgery, to prevail. Exactly how the legal precedents will develop is unknown.

What is known is that most hospital infections are preventable with certain simple precautions.

Is it feasible for hospitals to take these precautions? Can they afford to? The stunning fact is that they can't afford not to. Infections erode hospital profits, because seldom are hospitals paid fully for the many extra days of care when a patient develops an infection. The measures needed to stop infections require no capital outlays by hospitals and yield a financial return of at least ten to one, making hospitals more profitable even in the short run. For example, Dr. Carlene Muto reduced MRSA by 90 percent in a medical intensive care unit at the University of Pittsburgh. To do so required \$35,000 per year extra on labor and improvements such as gowns and lab tests, but averted about \$800,000 in treatment costs by sparing patients from infection.

Saving lives and improving profitability should be sufficient motivation for hospital managers to improve infection control. If not, the looming threat of litigation is one more incentive. That's unfortunate. Lawsuits are not the best way to improve patient care. They often result in unfair verdicts, and few truly injured patients have access to legal remedies (as few as two percent, according to the Harvard Medical Practice Study). Nevertheless, hospitals that act decisively will have the best insurance against costly damage awards: clean, safe care.

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