

AARP Bulletin

Dirty Hospitals

Two million patients are infected in hospitals each year and 90,000 of those Americans die.

By Katharine Greider

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Of every 20 people who go into a U.S. hospital, one of them picks up something extra: an infection. It's a lousy card to draw. Infection stalls recovery, sometimes requiring weeks of intravenous antibiotics or a grueling round of surgeries to remove infected tissue. And for 90,000 Americans a year, the infections are a death sentence.

A growing number of hospitals are working harder to stop infections, but as more bugs become resistant to antibiotics, it's an uphill struggle. Some 2 million patients get a hospital-acquired infection every year. In Pennsylvania alone, more than 19,000 infection cases occurred in 2005—up from 11,600 in 2004—out of 1.6 million admissions to 168 hospitals, according to a report issued in November by the state's Health Care Cost Containment Council. Pennsylvania, the first state to provide infection data collected directly from its hospitals, reported that nearly 13 percent of patients who got infections died, compared with slightly more than 2 percent of patients who didn't have infections.

Nationwide, hospital infections are the eighth-leading cause of death. One person who didn't recover was Dorothy Etheridge, a no-nonsense New Hampshire resident who raised five children and worked for 30 years as a mental health counselor. Etheridge had lung surgery in 2004 to remove an early-stage cancer, and doctors predicted a full recovery.

But within days, the normally robust Etheridge took a sharp turn for the worse. She had contracted a nasty antibiotic-resistant germ known as methicillin-resistant *Staphylococcus aureus*—MRSA—and she spiraled into respiratory failure. Through eight months of rehabilitation, bedsores and recurring infections, Etheridge fought back. "She was, to put it mildly, stoical and compliant and did everything and anything that she could to get herself home again," her daughter Lori Nerbonne says.

And get home she did. But after a week her temperature spiked. She was admitted to another hospital, where she died, at age 73, of a brain hemorrhage.

Left with painful memories of their mother's last months, Nerbonne and one of her sisters set to writing letters and testifying before the state legislature, joining a burgeoning nationwide movement that aims to stop infections in hospitals.

A leading light of that movement is Betsy McCaughey, a health policy expert and former lieutenant governor of New York. She founded the nonprofit Committee to Reduce Infection Deaths—RID—two years ago after hearing the story of Brad Moore of Washingtonville, N.Y.

In 2002 Moore was mugged. He survived brain trauma—but got an infection in the hospital and died at age 28. McCaughey recalls sitting with his mother, Pat, in her kitchen. "We looked through her family albums: Brad as a little boy. And then Brad's funeral. It was impossible not to be very, very saddened," she says. "I thought, enough is enough."

Now McCaughey pushes and cajoles hospitals to prevent the spread of infection. The necessary measures, she says, are simple and well documented in medical literature. Yet they're not consistently practiced or explained to patients. "A very good example," she says, is to tell patients to "shower with chlorhexidine soap if you're going in for surgery ... it's so easy. And you get it in the drugstore."

In fact, job number one for advocates like McCaughey is to debunk the notion that infection in the hospital is like bad weather—unfortunate but inevitable. Administrators, they insist, have set the bar way too low, content to keep their hospitals' infection rates to national averages—for example, a wound infection for one of every 24 surgical patients and a urinary tract infection for up to a quarter of those requiring a catheter for a week or longer.

"There's this culture that says that when people are old or immunocompromised, they're just going to get infections," says Lisa McGiffert, who heads the Stop Hospital Infections campaign at Consumers Union, the nonprofit publisher of Consumer Reports. "Well, they aren't 'just going to get infections.' If you're careful, they won't."

Generally speaking, there's little debate about what it takes to check the spread of infection in hospitals, from giving patients antibiotics before surgery to avoiding overuse of catheters and intravenous lines. But hospitals are busy places, and the foe is invisible. Research suggests that more than half the time, health care workers even fail to wash their hands as recommended—a critical bulwark against infection identified 160 years ago.

"These bacteria are largely spread through touch," says McCaughey of the RID committee. "In the old days," she says, "nurses and doctors were trained not to touch doorknobs, cabinets, curtains and blood pressure cuffs once they scrubbed and/or gloved. But all of that training really went by the wayside in the early '70s, when the liberal use of antibiotics replaced that attention to rigorous hygiene."

Not coincidentally, those same years brought a galloping increase in germs you can't knock out with standard antibiotics. In 1974 only 2 percent of staph germs in the United States were drug-resistant. By 2004, fully 63 percent—including the lethal one that attacked Dorothy Etheridge—proved impervious.

One outcome of the crisis is that more hospitals are working harder to stop deadly infections. In early 2005, for example, the nonprofit Institute for Healthcare Improvement in Cambridge, Mass., enlisted 3,000 hospitals to practice interventions proven to save lives. One approach targeted ventilator-associated pneumonia (VAP), a deadly infection that strikes about 15 percent of patients who have a breathing tube inserted. Hospital workers washed their hands frequently, closely monitored incision sites and raised patient beds to at least 30 degrees to prevent stomach fluids from backing up into the lungs—measures that enabled more than 30 hospitals to report no VAPs for at least a year.

Pittsburgh's Allegheny General Hospital is also waging war on infections. In the past few years, says Richard Shannon, M.D., who until recently was chairman of Allegheny's Department of Medicine, the staff has reduced the rate of bloodstream infections caused by large-vein catheters by 90 percent and ventilator pneumonias by 85 percent. Shannon demonstrated that devoting resources to controlling infection saved the hospital \$1.2 million over two years. He and his team reported in a supplement to the November-December American Journal of Medical Quality that eliminating a single bloodstream infection case pays for nearly a year's worth of measures to stop the infections.

The savings to patients and insurers are more obvious. The November report on Pennsylvania's hospitals noted that the average charge for infection cases was \$185,260, compared with \$31,389 for noninfection cases. Reducing infections is a win-win situation, says Shannon. "You not only make human beings better, you actually eliminate a huge amount of waste" in money and time.

How did his hospital do it? By studying quality-control techniques of the industrial production line. One example: Signs everywhere remind workers to wash their hands. "You have to make it so it's second nature, you don't have to stop and think about it," Shannon says.

When an infection does happen, the treatment team meets to figure out what went wrong. In one case they identified a mistakenly reinserted, kinked IV line as a probable cause and explained their conclusions to the patient's family.

In most hospitals, patients won't get such a thorough review and disclosure about the source of an infection. Moreover, in most parts of the country, it's virtually impossible to find out how well hospitals are doing at infection control overall.

But that's changing, too, with Pennsylvania and California among the states leading the way. In the past three years, 14 states have passed laws requiring hospitals to report information about infections to the public.

Public reporting not only informs consumers, it motivates doctors and nurses to work for better results, says Joyce Dubow, associate director at the AARP Public Policy Institute. In 1989, when New York state started publishing hospitals' death rates after bypass surgery, the hospitals conducted internal reviews, hired new personnel and pushed out surgeons with the highest death figures. Statewide mortality dropped like a stone, by 41 percent in four years.

"Nobody wants their deficiencies published," says Dubow. "And places that do well take pride in their good work."

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