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## Accountability for Nosocomial Infections

*Hospitals must not rationalize their inability to deal with nosocomial infections.*

**Q.** *The development of a nosocomial (hospital-acquired) infection is a classic example of an iatrogenic incident in hospitals and nursing homes. Within my organization, I suspect some patients are not informed that the infection is unrelated to their admitting condition, unless they are already debilitated, and are unaware of the additional length of stay it causes. What are the ethical, legal, and financial issues that this topic raises, and how should they be addressed?*

**A.** This complex problem has only recently begun receiving the attention it deserves. More than five years have passed since the Institute of Medicine reported that up to 98,000 patients die each year in hospitals due to clinical errors. Yet this large number did not include all of the estimated 88,000 deaths that occur as the result of nosocomial infections, which affect approximately two million patients annually. Because a third of these infections are the direct result of acts of commission and omission, they should be viewed as clinical errors as well.

Ironically, some perverse financial benefits often accrue to the organization when an infection happens. In more than 100 DRGs, a hospital-

acquired urinary tract infection causes the patient's care to be classified as "complicated." Consequently, although hospital-acquired infections are mostly preventable, reimbursement to the hospital can almost double when they occur.

One of the most frequently omitted actions by caregivers is the simple act of hand washing. According to the CDC and the U.S. Department of Health and Human Services, strict adherence to hand-washing procedures alone could prevent the deaths of 20,000 patients each year. When the implementation of basic, inexpensive measures can have such an enormous impact, there is no excuse for not taking immediate action. We have the ability to prevent many infections from occurring and others from spreading, for example, methicillin-resistant *S. aureus* infections. Failing to do so is ethically indefensible. What inhibits hospitals and caregivers from ensuring that everyone is more vigilant?

### Organizational Barriers

Historically, a variety of organizational barriers, as well as human nature, have impeded more rapid progress in reducing nosocomial infections. These include:

- **Denial and rationalization**—It is relatively easy to avoid taking strong action when the problem either is not acknowledged or is viewed as one of the unavoidable risks of being hospitalized.
- **Failure to establish a culture of safety**—Unless organizations empower employees, physicians, and even patients and families to identify the risks of infections, important and indeed essential allies will have been ignored in dealing with this continuing challenge.
- **Culture of blame**—As opposed to a culture of safety where emphasis is placed on teamwork and preventing harm to patients, a culture of blame focuses on individuals and reprimands them for causing the harm. When this happens, out of fear of retribution, staff members are much less likely to acknowledge a mistake and suggest what can be done to avoid a recurrence.
- **Fear of liability**—Reticence to identify deficiencies is a classic component of a culture of blame, and this reticence is reinforced when there is a fear of punitive action in the form of legal action against the organization or the individual.
- **Inadequate education and training**—While everyone should be aware of the benefits of hand washing, providing repeated reminders about its importance helps achieve compliance. In addition, staff involved in the care of high-risk patients (for example, those in intensive care units) need to be carefully trained in the handling of intravenous lines and the changing

of dressings to prevent infections. (For a case study in reducing catheter-related bloodstream infections, see page 20 of the March/April 2005 issue of *Healthcare Executive*.)

- **Resistance to change**—It is human nature for people to adopt habits or ways of performing their jobs that are convenient for them. These individuals are often unenthusiastic about modifying their behavior, particularly if they view the changes as interrupting their normal pattern of activity.
- **Deficient physical plant design**—Hand washing should be easy to do, especially now with alcohol-based hand rubs. However, sinks, alcohol-based hand rubs, and hand-washing solutions are often not close to the site of patient care and not readily convenient for use by caregivers.
- **Resource constraints**—Outmoded facilities, substandard staffing, and budget limitations make it more difficult to isolate infected and immunosuppressed patients, permit staff to follow and monitor proper infection control techniques, and purchase required equipment and supplies.
- **Lack of leadership and accountability**—Ultimately, the largest organizational barrier—as is usually the case with addressing any critical program—is the failure of administrative and clinical leaders to insist that this issue must be a high priority.

### Resolving the Dilemma

A number of studies have now confirmed the obvious: Patients and their

families recognize that even very competent staff members are fallible and make mistakes, but patients and their families do not understand, nor will they tolerate, cover-ups. Fortunately, they can be very effective allies in the patient care process. For example, asking staff members (physicians, nurses, or others) if they have washed their hands before conducting examinations, changing dressings, administering medication, and drawing blood can and does produce a marked improvement in hand-washing compliance.

Effective January of this year, the Joint Commission on Accreditation of Healthcare Organizations instituted new standards to cause facilities to focus more intensively on infection control procedures. All hospitals now must demonstrate compliance with hand-washing practices established by the Centers for Disease Control and Prevention. Providers are also required to report as a sentinel event, and submit a plan of correction for, each identified case of unanticipated death or major, permanent loss of function associated with a nosocomial infection.

Acknowledging a mistake or problem has occurred, genuinely apologizing for it, describing precisely what measures have been taken to avoid or minimize recurrence if the probable cause is known, and—when suitable—offering some reasonable compensation are steps in a response that has two distinct advantages. First, it is the most ethically appropriate response, at least in part because this is the manner in which you or a member of your family would want to be treated in a similar situation. Second, unless

legal counsel advises to the contrary, it is most likely to reduce the likelihood of a lawsuit and the financial costs associated with defending a potential malpractice case.

Any adverse event affecting a patient's treatment and/or length of stay is lamentable. Discussing the event in a timely and forthright manner with the patient is an ethical imperative that is also a legally and financially sound practice, and it should be included in every organization's policy on disclosing clinical mistakes.

Now and in the future, we must continually ask ourselves why patients must suffer not just from injury or disease but also from their treatment. Only by having everyone focusing on preventing harm from occurring to patients will the incidence and sad consequences of preventable nosocomial infections be eliminated. ▲

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