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Picking Up an Infection in the Hospital

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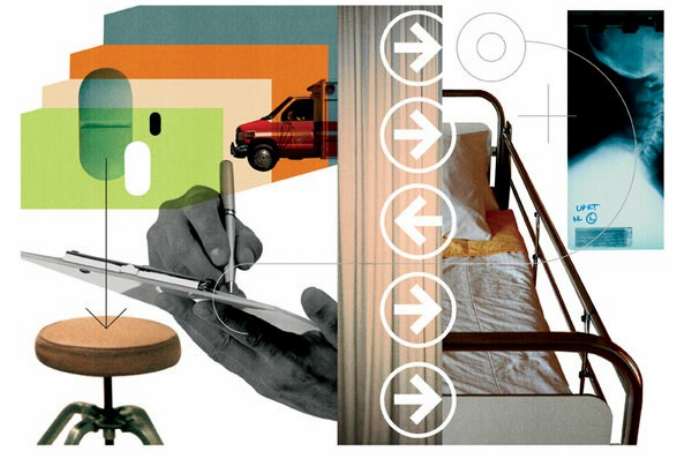

Stuart Bradford

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When the emergency room doctor pulled the blanket aside, looked at my elephant-size inflamed leg and said, “Whoa!” I knew that wasn’t a good sign.

Nor was the reaction of the emergency room nurse, who glanced down at my bizarrely swollen extremity, then started nervously backing away.

Health care practitioners are trained not to show their feelings, but there are clearly times when things look so bad that even they can’t hide their reactions.

I was in the emergency room at Los Robles Hospital in Thousand Oaks, Calif., because a few days earlier I had undergone what was supposed to be a relatively straightforward outpatient procedure to remove a skin growth on my leg. A couple of days after the surgery I felt fine. The surgeon told me I could drive whenever I was up for it, so we took our grandchildren to the Magic Castle in Hollywood. Running from room to room to see the different sleight-of-hand acts, I no longer felt fine. Now I felt a searing knife-like pain in my leg, which soon began to swell in size.

I went back to see my surgeon, who looked a little concerned. You have an infection, she said. Take these two antibiotic pills, schedule a Doppler scan for the next day, and all should be well.

That night, my leg got even bigger; from the waist down one side of me looked like I weighed 350 pounds (I’m not even half that.) My wife and I spoke to the surgeon, who was vague. “You could go to the E.R. if you want,” she said. “Or wait.”

I went and was admitted immediately. That night, a Doppler study showed no life-threatening blood clots. With no beds available, I was kept in the emergency department overnight, taking catnaps while trying to blot out the screams and moans from down the hall, before being given a room, and intravenous antibiotics, the next morning.

“This is very serious,” said Dr. Barry Statner, the infectious disease specialist who came to see me the next day in my hospital room. “We’ll cure you,” he said while firing questions at me about my medical history. “But you need to know, this is very serious.” I wondered if I was going to lose my leg.

For the first time in my life, I had entered the world of the powerless sick. Like most people, I had long heard about the dangers of contracting infections in hospitals or surgical centers, but

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I never took them seriously. I assumed that, except for the worst cases, such as those caused by improperly disinfected scopes and other instruments, they were little more than a minor annoyance.

In fact, infections kill, and they do so regularly, even to people who are otherwise healthy.

“There are diseases that can take a regular healthy person and destroy them within hours,” Dr. Statner told me. “You don’t get a second chance. People don’t realize how rapid and lethal infections can be.”

In the United States in 2014, one in 25 patients contracted a hospital-borne infection on any given day, according to the Centers for Disease Control and Prevention. Some 722,000 Americans developed such infections in hospitals in 2011, and about 75,000 died during their hospital stay.

I count myself as somewhat lucky. My wound was infected with a relatively run-of-the-mill strain of Staphylococcus aureus, and after a week in the hospital, followed by two weeks hobbling around the house, where a nurse visited daily to pack my wound with prodigious amounts of gauze, I was on the road to recovery. I was fortunate it wasn’t one of the more serious infections that lurk around hospitals, like MRSA, a “super bug” strain of Staph that is resistant to most antibiotics, or C. difficile, which can cause months of relapsing and severe diarrhea.

No one knows how my infection happened. It was the first, and only, case of this type of infection at the surgical center that year, I was told by Dr. Richard Hoberman, the medical director and the anesthesiologist who had put me under general sedation during my surgery. Clearly shaken by what happened to me, he unexpectedly popped in to my hospital room early in my stay to apologize.

My infection resulted in my being “the subject of several very uncomfortable meetings with the hospital administration” and a five-page written report, Dr. Hoberman said. (They passed on sharing a copy of that report with me.)

Hospitals are anxious to reduce hospital-borne infections, to reduce deaths and improve their reputations. There are also immediate financial incentives: Medicare may penalize hospitals for infections acquired in the facility.

The medical center I’d gone to for my surgery, associated with Los Robles Hospital, practices all the well-known standard forms of infection prevention: constant washing of hands; sterilizing equipment; giving patients preoperative antibiotics; cleaning operating room surfaces and thorough cleaning at night. In addition doctors are not allowed to enter the operating room wearing the same scrubs they wear in the street. To prevent the spread of microbes, cellphones and jewelry are banned, as well as ties.

But infections still happen. While most infections happen at the time of surgery, according to Dr. Statner, they can occur in the hospital room as well. A break in the skin, a lapse in the handling of a paper surgical cover, lackluster cleaning, intravenous lines or catheters that remain in too long — all can result in infection.

In the end, stamping out infections depends on the vagaries of human behavior. “Medical care is done by people. There can be gaps in quality. People must remember to do certain things,” said Dr. Arjun Srinivasan, the associate director for health care associated infection prevention programs at the C.D.C.

“Far too many Americans get sick in the hospital,” said Dr. Thomas R. Frieden, director of the C.D.C. “The importance of making care safer cannot be overstated.” One limitation is that the C.D.C. can only recommend, not mandate, practices to reduce infection, he said. And because hospitals are owned by various corporations, it can be a challenge to know how effectively patients are being protected in any one hospital. If a patient is moved from one hospital to another across town, he said, it “can cause problems,” given that one hospital may have less rigorous infection-reduction policies than another.

Hospitals are experimenting with new disinfection techniques. For example, some disinfecting machines using ultraviolet light are so powerful that no one is allowed in the room when they are in operation. And routine measures like thorough hand washing, and having patients thoroughly shower using chlorhexidine before surgery is helping bring infection rates down in the United States in recent years. In the three to six years before 2014, depending on the type of infection, the rate of surgical-site infections has dropped by 17 percent, C. diff by 8 percent and hospital-borne MRSA by 13 percent, according to the C.D.C. However, there was no change in the rate of urinary tract infections caused by catheters between

2009 and 2014.

Infection rates have dropped even more steeply in Britain, where total MRSA reduction from 2004 is now 80 percent, according to Dr. Mark Wilcox, the head of medical microbiology at Leeds Teaching Hospitals and the head of the C. difficile task force for Public Health England. Leeds Hospital used to see 15 to 25 MRSA infections per month; now it gets five per year, he said.

Dr. Wilcox attributes their success in part to having a coordinated, single health system for the entire country. To encourage hygiene, National Health Service hospitals post current infection rates on boards that can be seen by doctors, patients and visitors. Hospitals are “obsessional” about hand hygiene, Dr. Wilcox said. To do the best cleaning job, health workers must be “bare below the elbows,” with no watches on the wrist. Lab coats, while making a doctor look professional, are also banned, as they can brush up against patients and transfer bacteria from one patient to the next.

Hospitals that fail to meet infection reduction targets are visited by a “hit squad improvement team” that demands a new plan, Dr. Wilcox said. Those that fail lose the right to decide how to spend some of their annual budget.

“A decade ago, people would say that only a small proportion of infections are preventable,” said the C.D.C.’s Dr. Srinivasan. “Now we know that a large proportion are preventable. We’ve turned that paradigm on its head.”