House Committee on Oversight

and

Government Reform

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Chairman Waxman, Ranking Member Davis, Members of the House Committee on Government Oversight and Reform.

In my oral statement before this committee, I provided a brief synopsis of the severely debilitating experiences I sustained in 1998 and subsequent years, due to healthcare acquired infections. I've little doubt that hospital workplace complacency and inattentive hygienic attitudes by well educated and well trained hospital staff caused my life threatening situation, and subsequent, disabling lifestyle.

As I've prepared to speak with you today, I've given a great deal of thought to how I could possibly convey to you, the degree and scope of suffering and mental trauma I experienced due to avoidable and frankly, preventable healthcare acquired infections.

I'm unsure that I can or will, adequately convey in words, what occurred to me in 1998 which has affected me for the rest of my life. Clearly, my naiveté, unquestioning faith and high expectation that hospitals and those working within them were consummate

professionals focused on their patients, contributed to my misunderstanding of a serious threat I had yet to encounter.

SOME PERSONAL INSIGHT

Through most of my life up until the age of 41 years of age, I'd experienced minimal contact with healthcare professionals other than mostly routine physical examinations, typical dental appointments and as a child, orthodontic care. I was raised with two brothers and despite our having the various, common, childhood illnesses, my family was fortunate in that we all lived relatively disease free until we grew older. Both of my parents were deceased in their 70's, primarily due to serious and chronic illnesses.

As a young adult, my personal, primary health care experiences were associated with my military service and again, most of those experiences related to periodic physical examinations and regulatory compliance issues, none of which I believe, exposed me to healthcare acquired infections.

Because I served many years in overseas assignments, I was not around my family when serious health issues began affecting their lives. I regret I was never with my parents or grandparents when they became seriously ill, requiring hospitalization prior to their deaths.

I believe if I'd spent time with them while they were hospitalized, I would have begun to understand what really occurs in hospital settings, and maybe, I might have been better prepared when I was hospitalized. Perhaps I would have eased some of their pain which now, gnaws on me, knowing what I do about hospitals and the

dangers therein. One major concept I have learned with all my own contemporary hospitalizations and interactions with numerous healthcare providers, is that ***situational awareness is the key to survival.***

MY LIFE CHANGES FOREVER

My life changed in 1990 while I was serving overseas in the Republic of the Philippines. Beginning in the spring of that year, I began experiencing pain in my right leg and my back. The problems intensified and my military health care consisted primarily of an x-ray, some Tylenol and heat treatments. The diagnosis based upon my symptoms at the time, was sciatica.

After months of growing pain, I was sent to Manila for an MRI as the technology didn't exist at our base hospital. Following my return to Clark AB, I recall an orthopedic surgeon reviewing the films and looking at me, stating emphatically, "you're on the next aerovac to the United States. You have a serious spinal problem."

My initial serious surgery and first experience with a healthcare acquired infection occurred at the military hospital at Lackland AFB in San Antonio. The spinal surgery, what could be done, was "successful." The neurosurgeons did their jobs well, and I later walked out of the hospital. However, I recall in the post-operative period of my recovery, I contracted some type of infection which extended my hospital stay for a limited period.

I returned to the Philippines for a month long, rest and recovery period. I wasn't working at the time, but I did occasionally go to the

office after hours. I was a branch chief with seven criminal investigators under my supervision. There wasn't any question I couldn't abandon my duties merely because I was "resting and recovering."

The Air Force returned me to the United States for follow-up treatment in late January, 1991. What occurred between February and early June, 1991, was my participation in a cutting edge, developing treatment called Proton Beam Radiation.

I received nearly 7900 rads of radiation at the Lawrence Berkeley Laboratory, at the time, state of-the-art technology for my extremely rare, cancer. I handled the treatment well and actually commuted between the lab and Fairfield, California, two to three times per week. I was billeted temporarily, at a hotel near Travis AFB.

My return to Clark AB in early June, 1991 was preempted by the eruption of Mt. Pinatubo, a volcano that had been dormant for approximately 500 years. I actually arrived at the base on the last incoming military aerovac before non-essential, flight operations ceased due to the volcanic threat.

Within five days, I was required along with around 15,000 others to relocate to Naval Air Station Subic Bay. After 11 days, my wife and family departed and a week afterwards, I departed on the USS Midway, ultimately arriving at Fairchild AFB, Washington State.

When advised of the plans to leave Subic by ship, I enlisted the aid of a senior non-commissioned officer who had worked with me, to assist me with my two bags during our return to the Continental

United States. You see, I was unable to carry anything heavy because of my recent surgery and post-operative radiation.

I was reassigned to San Antonio, Texas because of the extensive, healthcare facilities in the military community.

I retired in 1993 from the Air Force and my wife and I relocated to Northern Virginia. I was employed in a new career when my medical situation became active again

Between 1991 until late, 1997, I regularly had semi-annual MRIs to monitor my health situation. Fortunately, the recurrence of my illness was identified before it got out of hand in September, 1997.

CONTEMPORARY HOSPITALIZATION & EXPERIENCES

In February 1998, I was hospitalized at one of two large, New York hospitals. My physician, a neurosurgeon with specialized spinal skills, operated on my spine twice that month. I believe I was in a recovery mode for several weeks before being transferred to a different hospital for physical therapy.

The committee is aware of my general medical experiences during this period, thus I won't repeat them in this statement. However, it was during the physical therapy period that I was initially diagnosed with what I later learned was MRSA.

I received treatments for the infection and eventually, was discharged in May to return home. I couldn't walk when I left the hospital, although I had expectations I would eventually.

At home, I soon began suffering more pain and as I've previously reported to the committee; I was hospitalized locally for a

serious abscess, and soon rehospitalized in NY. I remained hospitalized in NY for another 3 ½ months, undergoing three major back surgeries in an attempt to resolve the infection problem which was now identified as Vancomycin Resistant Enterococcus (VRE) and Osteomyelitis, a bone infection.

Since my wife lived in Virginia, I only saw her periodically, on every other Saturday. She'd exhausted her all leave during my initial hospitalization from February to May; she had a job and couldn't take an indefinite leave of absence but even if she could, hotel costs in NYC were cost prohibitive to us.

THE "UNOBVIOUS" PROBLEMS AFFECTING PATIENTS IN A HEALTHCARE ENVIRONMENT

Being alone in the hospital was what I discovered to be the first serious threat to my well being. How do I describe to you how it felt lying in a hospital bed with serious, life threatening resistant infections? True, I was monitored by the nurses; I received medicine and the doctors made their rounds. From an outsider's perspective, it appeared that I was receiving the care and attention I needed, and so I thought.

When my mother visited me for two weeks during my second hospitalization in 1998, I soon realized how fortunate it was she came to be with me. Besides uplifting my spirits just by being there, she soon observed several anomalies. She initially observed that when the bed sheets on my bed were routinely replaced by some of the

nursing staff, the clean sheets were literally dragged upon the dirty floor while the bed was being made.

Because some nursing assistants were shorter in height, they'd lower my hospital bed in order to be able to reach across it. Because of my wounds, I couldn't get out of bed, thus, I'd be forced to roll from one side to the other during the sheet replacement process. I never saw what was occurring because I was always facing the opposite wall, holding onto the bed rail, in pain and on medication.

When making my bed, the partially unfolded, clean sheet, hanging over the side of the bed, would drag on the floor. It would be lifted eventually during the process and some of it was tucked under the mattress while I lay on the remaining portion. Were it not for my mother, I don't know how long or how often this process of dragging clean sheets on the floor would have continued and there I was, trying to recover from infected back wounds! (I also never knew for how long this occurred prior to my mother's visit.)

During her visit, my mother asked me several times why the linen bag in my room, used for dirty linen, was not emptied daily. Once during her visit, there were so many dirty sheets and towels in the bag, the smell became discomforting. I asked my 72 year old mother to drag this heavy bag out of my room and leave it in the hall. I figured someone would find it and maybe, they would get the message! I don't remember anyone ever coming into the room and asking about the bag in the hallway.

I absolutely believe any patient has a better chance of survival, merely by having a trusted family member or friend in the room. From my experiences, it became very apparent that the adage, "you

can't see the forest because of the trees," was a reality among hospital staff when it came to hygienic procedures and my care.

In 1998, I recall that my room was visited by housekeeping personnel who would spray some type of fluid on hard surfaces of my room, apparently to disinfect them. I never knew what they were using nor did I even know whether the cloths or towels they used were clean ones, or if they'd been used in another patient's room. Frankly, both my physical and mental conditions were so debilitated; I never thought to ask the question.

I can't speak to the frequency of the housekeeping visits; however, I recall that one woman who came to my room was always in a hurry, often completing her duties seemingly in seconds. In and out so quickly, I recall she would typically drag the cloth across the window sill or possibly, a bed rail before departing the room.

There are many surfaces in a hospital room which are easily and routinely contaminated on a daily basis. I believe if I'd seen the checklist of the housekeeper's duties in my room, I would have noted the shortcuts I believed she was taking.

I don't know how to clearly explain how difficult it is to be a patient on a crowded and busy, hospital ward, and report an anomaly or problem to an attending physician or nurse. I never felt they were interested to avail themselves of additional, impromptu issues, especially when it involved a colleague.

I will acknowledge that everyone assigned to a ward is generally very busy, but their focus on patient related tasks often, seemingly missed the inherent necessities of safe and proper, hygienic protocols.

Ultimately, in the case of the housekeeper, I was forced to write a letter to the hospital administrator explaining my observations; I then rewrote it in my journal to insure I had a copy. I don't recall who I asked, but someone assisted me in getting my letter to the hospital administrator. The housekeeper was eventually replaced, and for the next week or two, several nurses assigned to my ward, challenged me for "unnecessarily getting their friend in trouble."

The bigger issue which I later learned was a serious problem in hospitals, pertained to hand washing. I can seldom recall medical staff physically washing their hands before checking my wounds or administering an injection or some other treatment. The scenario then, as it is today when I have local, medical appointments, is for medical personnel to reach into an open box and put on their hands, **non-sterile gloves,** which typically sit on a shelf in a patient's hospital room or a doctor's examination room.

I've learned over time that those gloves are not worn to protect the patient; they are worn to protect staff from exposure to a possible contaminant from a patient, even if the patient has no such diagnosis.

So what is done to specifically protect patients? The answer is simply, nothing!

Why should anyone be surprised when the CDC publishes their reports such as their March-April 2001 report entitled, *Feeding Back Surveillance Data To Prevent Hospital-Acquired Infections*, which states in part, "Hospital-acquired infections affect approximately 2 million persons each year?"

In 1998, I wasn't well informed on the issue of healthcare acquired infections. I hadn't researched the subject nor had anyone briefed me in advance on the dangers I was about to face.

MY PROACTIVE ACTIONS

In 2004 when I was rehospitalized, I was more informed and prepared to deal with the conditions I knew I'd face. I actually physically feared going back to the same hospital I'd been in previously, but my doctor had privileges there, and thus, I had no choice.

Before being admitted, I contacted The Joint Commission, defined by **Wikipedia**, an online encyclopedia, as "a private sector, US-based non-profit organization," whose mission is "*To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.".* [http://en.wikipedia.org/wiki/Joint_Commission]

I was seeking any available information on their findings and observations regarding the hospital's Infectious Disease Surveillance and Training Programs, along with the findings of any Joint Commission inspections within the prior two or three years.

Despite the fact The Joint Commission's publicized mission statement states that it "evaluates and accredits more than 15,000 health care organizations and programs in the United States," to "*To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related*

services." [http://www.jointcommission.org/AboutUs/Fact_Sheets/joint_commission_facts.htm], the information provided to me was substantially lacking in specifics. Moreover, when I telephoned The Joint Commission and specifically inquired about health acquired infection rates; the nature of the hospital's surveillance program or how it administered training to staff regarding healthcare acquired infections, I was told the information was either "unavailable" or "not releasable to the public."

So much for transparency in reporting by this non-profit agency, whose 29 member Board of Commissioners, is comprised primarily of members of the health care industry.

When I was admitted to the hospital, I personally hand carried a case of sterile gloves and this time, I didn't allow anyone to touch me unless I knew they washed their hands with soap and water; and occasionally, I prepared the sterile gloves for their use! Imagine being hospitalized in a neurosurgical ward, generally alone and without family by your side, having to instruct healthcare providers to do their job safely.

In 2004, I wasn't afraid to confront a nurse or resident about whether they understood the danger they subjected me to when they grabbed the non-sterile gloves to inspect my back wound. Admittedly however, I wasn't as aggressive with my doctors. I was more discreet with any admonishments, but on several occasions, I did ask them to wear my clean gloves and absolutely not those contaminated ones, sitting in the open box!

Prior to this hospitalization, I'd coordinated with the hospital's Infectious Disease Office to have a dedicated, blood pressure cuff unit assigned to my room. I didn't want my vitals routinely taken by equipment that was commonly utilized on the ward for many other patients, all with various illnesses and potential, bacterial infection.

Once, around 5:30 in the morning, I was awakened by a medical technician literally taking my blood pressure with a unit he'd brought into my room and not the one sitting 18" from my bed. When I challenged him, he said he knew nothing about the dedicated unit.

I told this technician that he'd better review my charts; that I was at risk for infection and he was seriously endangering my life. About an hour later, he returned to my room, apologizing and acknowledging he hadn't read the documentation before administering the morning test!

Additionally, I'd requested that the number of medical students accompanying the residents during their daily rounds be limited to two students when visiting my room. I sought a reduction of unnecessary personnel in my room that could inadvertently and unintentionally, transmit bacteria onto my person or any of the furniture, putting me at greater risk.

I even coordinated with the hospital to prohibit the newspaper lady on Sunday mornings from bringing the papers into my room. Newsprint is very dirty and I recalled in 1998 that when the paper was delivered, it was often placed upon my bed or on the table where my food tray was delivered.

My primary doctor considered my initiatives contrary to the interests of the hospital as a "learning institution" for medical students.

I responded that I considered it my responsibility to protect myself from the kind of serious problems and risks I'd previously experienced in the hospital.

A PERSONAL RECOMMENDATION

If I were a hospital administrator, I would require my infectious disease unit to periodic, 100% bacteria samplings of the open boxes containing gloves in every room in every ward in my hospital. Starting with these test results, I believe I could influence personnel working in the wards or any other hospital environments involved with patients, about the importance and necessity of hand washing vs. the use of non-sterile gloves.

WE POSSESS THE SOLUTION TO THE PROBLEM

In preparing for this hearing, I extensively reviewed many government documents and past media articles. I am sure this committee is well acquainted with the countless, detailed US Government reports on the history of healthcare acquired infections and their existence which go back decades. I searched the CDC website using the term, "healthcare *acquired* infections," and received a response with 3,140 hits.

Clearly, there is no shortage of detailed information on this subject, including countless articles on the importance of hand hygiene, but sadly, most of it is written in such complicated terms, it appears these reports and studies have been written by rocket scientists. Who can understand such complex documents, except other rocket scientists, or perhaps, the engineer who invented my VHS remote control?

I possess one CDC report dated October 25, 2002, entitled, "Guideline for Hand Hygiene in Health-Care Settings," and it puts forth recommendations by a US Government, hand hygiene task force. **The document is 56 pages in length – all this to explain the fundamentals of hand washing**, something we routinely teach our children.

It's no wonder that healthcare practitioners either don't or can't comply, or even make a minimal effort to follow government regulations or recommendations. The recommendations either can't be understood, or many are so complex, they would take hours to read and decipher.

Our government employs or contracts countless thousands of medical experts in all facets of the profession, who for decades, have been explaining in minutia, the threat to our nation which seemingly, is being ignored. Yet how many expert **trainers** does the government or our nation's hospital administrators employ, insuring practitioners thoroughly understand and comply with their workplace procedures, including hygiene protocols?

HAVE WE REALLY CONNECTED THE DOTS

Following the September 11th, 2001 attacks, there was an outcry in our nation about why no one allegedly "connected the dots," which many allege, contributed to so many deaths and the economic and infrastructure disaster our nation experienced.

It seems to me that with respect to healthcare acquired infections, the dots have been repeatedly connected and documented over the years by many medical experts and Members of Congress. Countless reports have been commissioned and publicized, yet the threat and more importantly, the recurring deaths and financial consequences in our national war on healthcare acquired infections, continues, unabated!

In 2004, the CDC published their annual report entitled, "Deaths – Leading Causes." http://www.cdc.gov/nchs/datawh/statab/unpubd/mortabs/lcwk9_10.htm

This report lists the top 15 causes of death in America that year, and of those listed causes, only five exceed the estimated 99,000 healthcare acquired infection related deaths, that CDC also estimates, occurred in America.

All but suicide, 11th on the list, were non preventable causes. Healthcare acquired infections ARE preventable!

The CDC, in its many published, however complex documents, emphasizes great attention and concern about this national threat. Even its website has an extensive and well documented "campaign," encouraging "Increased awareness of the problem of antimicrobial

(*infection related*) resistance in healthcare settings." [http://www.cdc.gov/drugresistance/healthcare/default.htm

However, the website hasn't been updated since September 15, 2005, or so it states. What has the CDC been doing the past three years to expand and reinforce its campaign?

In its' March-April 2001 Special Issue entitled, "Feeding Back Surveillance Data to prevent Hospital Acquired Infections," cited earlier, the CDC report states in part:

> "The Centers for Disease Control and Prevention (CDC's) National Nosocomial Infections Surveillance (NNIS) system has been serving as an aggregating institution for **30 years**. The NNIS system is a **voluntary**, hospital-based reporting system established to monitor hospital-acquired infections and guide the prevention efforts of infection control practitioners."

Why would this serious national issue, acknowledged for decades as an indiscriminate killer of thousands of Americans, be left up to the *voluntary* cooperation of our nation's medical practitioners who manage and operate the very same facilities where this horrific enemy hides? Clearly, any surveillance system in America ought not to be voluntary and more importantly, findings ought to be public, just like countless other mortality data.

I urge this committee to connect **all** the dots; to take the appropriate steps and enjoin not only our national leaders, but our national healthcare administrators and practitioners in a proactive, collaborative, 21st Century effort, to truly fight and end healthcare acquired infections in our country. We possess the knowledge and capabilities to fight this enemy; we possess the educational and

professional expertise to overcome and destroy it. The only question is whether we have the will to fulfill the mission!