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Dirty Business: Legal Prophylaxis for Nosocomial Infections

Robert Steinbuch¹

“[F]IRST, do no harm” expresses one of the most basic maxims that medical students learn.² It serves as a constant reminder to doctors that they must consider the ramifications of both their actions and inactions.³ Additionally, the phrase acts as notice to physicians that good intentioned medical decisions may produce undesirable results.⁴

Notwithstanding this fundamental medical precept, however, hospital patients seeking treatment for one set of ailments too often wind up contracting other, even worse, medical conditions from health-care workers. The problem of hospital-acquired, or medical-worker-spread, infections (HAIs)—present throughout the history of medical science—has not been restricted to fringe cases. For example, President James A. Garfield died as a result of several factors including a HAI.

On July 2, 1881, Charles Guiteau, a rejected ambassadorial applicant, shot the newly elected president.⁵ Over the next few months, bickering doctors repeatedly probed President Garfield with unclean hands and instruments. Unaware of the infections that they were transmitting, these doctors ultimately contributed to the President’s untimely and unnecessary

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² Ben A. Rich, *Postmodern Medicine: Deconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77, 91 n.70 (1993).

³ See *id.*

⁴ See, e.g., Segev Shani & Zohar Yahalom, *The Role of Pharmaceutical Industry Disseminating Pharmacovigilance Practice in Developing Countries*, 63 FOOD & DRUG L.J. 701, 701 (2008) (discussing the prevalence of unwanted, harmful effects of drugs).

⁵ Amanda Schaffer, *A President Felled by an Assassin and 1880’s Medical Care*, N.Y. TIMES, July 25, 2006, at F5.

death.⁶ Indeed, compounding the tragedy, President Garfield's death could well have been prevented based on the medical science available at the time.

Approximately thirty years before President Garfield's death, Dr. Ignaz Semmelweis, "The Father of Infection Control," realized that women whose babies were delivered by medical students had much higher mortality rates when compared with those women employing midwife trainees.⁷ Dr. Semmelweis realized that medical students were spreading infections from cadavers to patients.⁸ Dr. Semmelweis had the medical students disinfect their hands,⁹ and the results were staggering.¹⁰ The mortality rate of this patient cohort dropped dramatically.¹¹ Dr. Oliver Wendell Holmes Sr., father of the noted U.S. Supreme Court Justice, Oliver Wendell Holmes Jr., made similar findings in 1843.¹² And, between 1865 and 1869 Dr. Joseph Lister, a British surgeon, invented an antiseptic spray composed of carbolic acid to use on patients.¹³

Notwithstanding that the discoveries of these great doctors were well documented and the results of adopting improved procedures were dramatic, the medical establishment pursued changes in the way health-care workers addressed the spread of infections with tragically slow speed.¹⁴

The ground-breaking conclusions of these doctors along with many subsequent studies have demonstrated conclusively that the best method to reduce the risk of the contraction of HAIs, including super-bugs such as Methicillin-resistant *Staphylococcus aureus* (which can survive for weeks on surfaces in a hospital),¹⁵ is simple hand washing and other inexpensive

6 *Id.*

7 M. Best & D. Neuhauser, *Heroes and Martyrs of Quality and Safety: Ignaz Semmelweis and the Birth of Infection Control*, 13 *QUALITY & SAFETY IN HEALTH CARE* 233, 233 (2004); see also S.Y. Tan & J. Brown, *Ignaz Philipp Semmelweis (1818–1865): Handwashing Saves Lives*, 47 *SING. MED. J.* 6 (2006).

8 Best & Neuhasuer, *supra* note 7, at 233.

9 *Id.*

10 *Id.*

11 *Id.*

12 John M. Boyce & Didier Pittet, Center for Disease Control, *Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force*, MMWR RECOMMENDATIONS AND REPORTS, Oct. 25, 2002, at 1, 1, available at <http://www.cdc.gov/mmwr/PDF/rr/r5116.pdf>.

13 S.W.B. Newsom, *Pioneers in Infection Control—Joseph Lister*, 55 *J. HOSPITAL INFECTION* 246, 249 (2003).

14 Best & Neuhasuer, *supra* note 7, at 234; see also Newsom, *supra* note 13, at 249.

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The prevalence of [Methicillin-resistant *Staphylococcus aureus*] (MRSA) in hospitals in the United States has been steadily increasing, and shortly after the turn of the century, the frequency of methicillin resistance among

hygienic procedures.¹⁶ The Centers for Disease Control (CDC) confirms that basic prophylaxis significantly diminishes the likelihood of contracting HAIs: thirty-six percent of infections are preventable merely by the adherence of health-care providers to existing cleanliness guidelines.¹⁷ Indeed, for this reason health-care agencies have recommended basic hygiene protocols for at least the last half century.

For example, in 1961, the U. S. Public Health Service suggested that health-care workers wash their hands before and after contact with patients.¹⁸ In both 1975 and 1985, the CDC published written guidelines on hand-washing practices for hospitals, and in 1988 and 1995, the Association for Professionals in Infection Control (APIC) published similar guidelines.¹⁹ Also, in 1995 and 1996, the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommended the use of either antimicrobial soap or a waterless antiseptic for hand cleaning “upon leaving the rooms of patients with multi-drug-resistant pathogens.”²⁰ Although

S aureus isolates in U.S. hospitals surpassed 50%. Not surprisingly, strains of hospital-acquired MRSA have spread to nursing homes throughout the United States. Community-acquired MRSA was first described in the United States in Detroit and Boston in the 1980s among intravenous drug abusers, many of whom were taking oral antibiotics in an attempt to prevent staphylococcal skin infections at their injection sites. In the 1990s, outbreaks of staphylococcal disease due to community-acquired *S aureus* were described among the Aboriginal populations of Australia. The first real problems with CA-MRSA in the United States surfaced in the late 1990s with a description of 4 fatal infections among Native American children in Minnesota and North Dakota. In the past decade, CA-MRSA has exploded throughout the United States. . . . A report from the National Naval Medical Center in San Diego clearly documents the striking increase in CA-MRSA that occurred there between 2001 and 2004 and mirrors what has been described in most of the rest of the country. . . . Although most infections caused by CA-MRSA are non-life-threatening infections of the skin and soft tissues, a recent study documented that between July 2004 and December 2005, a significant number of cases of serious invasive MRSA infections in 9 locations in the United States . . . were caused by CA-MRSA.

Robert C. Moellering Jr., *A 39-Year-Old Man With a Skin Infection*, 299 J. AM. MED. ASS'N 79, 82, (2008) (footnotes omitted).

16 See, e.g. Paul D.R. Johnson et al., *Efficacy of an Alcohol/Chlorhexidine Hand Hygiene Program in a Hospital with High Rates of Nosocomial Methicillin-resistant Staphylococcus aureus (MRSA) Infection*, 183 MED. J. AUSTR., 509, 514 (2005); see also LiveScience Staff, *Spotlight on Prevention, Deadly Bugs Survive for Weeks in Hospitals*, <http://hospitalacquiredinfections.blogspot.com> (follow “Deadly Bugs Survive for Weeks in Hospitals” hyperlink) (Dec. 2006).

17 *Spotlight on Prevention, An HAI Primer (Exhaustive Overview)*, <http://hospitalacquiredinfections.blogspot.com> (follow “An HAI Primer (Exhaustive Overview)” hyperlink) (Mar. 2007).

18 Boyce & Pittet, *supra* note 12, at 2.

19 *Id.*

20 *Id.*

the majority of hospitals have adopted these various guidelines, health-care worker compliance remains terribly low.²¹

In one study, the CDC estimated compliance with disinfecting procedures at a mere forty-eight percent.²² Unfortunately, observance of these simple and basic health guidelines actually went down when the need for hand hygiene went up.²³ Thus, health-care workers showed a greater failure to abide by hand washing and antisepsis protocols in intensive-care units compared with internal medicine wards, during procedures that carried a high risk of infection, and when the intensity of patient care was high—perhaps due to the appearance of lower urgency of mundane hand cleaning in the context of life-threatening illnesses.²⁴

In England, the medical community has gone even further to reduce the risk of health-care workers transmitting HAIs. Last year, the British “National Health Service instituted a new dress code, banning ties and asking doctors to wear short sleeves.”²⁵ The rule is designed at reducing HAIs because “shirt sleeves and ties are known to accumulate germs as doctors move from patient to patient.”²⁶ In the United States, however, hospitals do not generally have specific rules about ties and long sleeves because—notwithstanding the presence of germs on these articles of clothing—there is no *conclusive* evidence that banning these garments would lower infection rates.²⁷ Moreover, some medical professionals

²¹ *Id.*

²² *Id.* at 22.

²³ *Id.*

²⁴ *Id.*

²⁵ Tara Parker-Pope, N.Y. Times Well Blog, Do You Really Want to See Your Doctor's Elbows?, <http://well.blogs.nytimes.com/2008/09/08/do-you-really-want-to-see-your-doctors-elbows/> (Sept. 8, 2008, 11:50 EST).

²⁶ *Id.*; see also Shaoni Bhattacharya, *Doctors' Ties Harbour Disease-Causing Germs*, NEWSIDENTIST, May 24, 2004, <http://www.newscientist.com/article/dn5029-doctors-ties-harbour-disease-causing-germs.html> (“Nearly half the neckties worn by 42 doctors at the New York Hospital Medical Center of Queen’s (NYHMCQ) contained bacteria which can cause dangerous conditions like pneumonia and blood infections, the researchers found. . . . [P]revious studies have shown that doctors’ stethoscopes and cellphones are also germ reservoirs.”).

²⁷ Parker-Pope, *supra* note 25. Implicit in the objection to adopting the English policy on ties and long-sleeved shirts on the ground that there is no *conclusive* evidence that banning these garments would lower infection rates is the notion that all actions or products are presumed safe until proven otherwise. This approach, of course, is far from novel. For example, for years tobacco companies argued that since there was (at that time) no published proof that cigarettes were dangerous, they, therefore, should not be regulated. The presumption of safety, however, distorts scientific methodology. Products and behavior should not necessarily be presumed either safe or dangerous. We need to balance the need for innovation with the recognition that in today’s technologically advanced world, novel products and services can have dramatic effects—sometimes negative. Addressing such complexities means that we need to develop a more nuanced approach to how the legal system tackles potentially dangerous products and behavior, both pre-hoc and post-hoc.

unfortunately consider as a competing concern the fact “that most patients want their doctors to look professional and prefer a doctor in a white coat.”²⁸ These modest sartorial changes of behavior, even if they merely possess the *potential* to reduce risk, are essentially costless. Moreover, such moves signal a continuing commitment to improving health care, no less create an environment that actually may do so.²⁹ Creating or expanding a culture of constantly striving to increase positive outcomes by reducing exposure to pathogens within health-care organizations is the first step to reducing morbidity and mortality in those institutions.

This is particularly salient when we recognize that in the United States alone scientists estimate that roughly two million patients contract nosocomial infections each year, resulting in costs exceeding twenty billion dollars annually.³⁰ Tragically, HAIs double the mortality and morbidity risks of patients and result in over 90,000 deaths annually in the United States alone.³¹

The problem of poor hospital hygiene is particularly crucial given that the “bugs” infecting patients are stronger than ever, which is “an unintended consequence of our use (and overuse) of antibiotics.”³² “Hardy organisms like MRSA evolve to withstand the drugs; then, through vectors like the unwashed hands of health care workers, they hitch a ride from patient to patient, hiding like terrorists among the natural bacteria that all humans harbor.”³³

28 *Id.*; see also Shakaib U. Rehman et al., *What to Wear Today? Effect of Doctor's Attire on the Trust and Confidence of Patients*, 118 AM. J. MED. 1279, 1285 (2005) (“Patients and visitors to an internal medicine clinic in this study were overwhelmingly in favor of doctors wearing professional dress, i.e., more formal attire with a white coat. We recommend that general internists consider wearing more formal attire with a white coat during patient care encounters, because it may favorably influence trust and confidence-building in the medical encounter.”).

29 *But see* Parker–Pope, *supra* note 25 (claiming that “[o]ne concern is that focusing on clothing distracts from the best way to prevent infection spread: regular hand washing”).

30 SpotlightonPrevention:HospitalAcquiredInfections, <http://hospitalacquiredinfections.blogspot.com/> (follow “Hospital Acquired Infections” hyperlink) (Mar. 2007).

31 *Id.*; see also Manoj Jain, *The Germs Are Potent. But So Is a Kiss.*, N.Y. TIMES, Aug. 5, 2008, at F5. For a more general discussion of medical-caused deaths see Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 683 (2006) (“In a 1999 report, the Institute of Medicine (IOM) estimated that between 44,000 and 98,000 Americans die each year as a result of preventable medical error. Others have suggested that the number may be twice as high.” (footnotes omitted)).

32 Jain, *supra* note 31.

33 *Id.*

Contact isolation is part of the battle plan to control the spread of drug-resistant organisms. And it is effective, as long as everyone complies. Remember SARS? In that case, respiratory and contact precautions were credited with stopping the epidemic. Sadly, studies show that nearly 30 percent of health care workers don't comply. . . . Unlike other treatment,

The law has an important role to play in addressing these HAIs. Tort law generally requires negligence for medical providers to be held liable for patients' injuries. Under the negligence standard, health-care workers become liable for a patient's injury if the health-care workers fail to meet the established standard of care.³⁴ Some courts have come to recognize that the spread of disease through failures to meet basic hygiene standards do not meet the current standard of care and, therefore, give rise to medical malpractice liability.

Moreover, given that agency law generally imposes liability on hospitals and other employers for the unclean hands of their employees (such as doctors, nurses, and technicians), hospitals face the legal challenge of taking the appropriate precautions to prevent their employees from transmitting diseases to or among patients.³⁵ Determining the right level of precaution is far from easy, and courts have often shown deference to hospitals when they have been both lax and stringent in their establishment of safeguards. Indeed, courts have gone so far as to approve of the prophylactic removal of a surgeon's operating privileges because he was HIV positive, holding that "any" risk of transmission of the disease was sufficient to warrant this precaution.³⁶ The other side of the equation, however is the subject of this discourse, i.e., hospitals and their employees not doing enough to protect their patients from opportunistic infections.

Anecdotes of HAIs are plentiful. Examples include the potentially devastating situation of medical-care practitioners working with rhinovirus-caused acute coryza in an Intensive Care Unit (ICU) rather than taking sick leave, working in a different unit, or employing the most basic infection-

contact isolation does not benefit the patient in isolation; rather, it benefits other hospitalized patients and the community. Our goal is to contain the spread of the resistant organism from one patient to another, through health care workers.

Id.

34 See GEORGE D. POZGAR, *LONG-TERM CARE AND THE LAW: A LEGAL GUIDE FOR HEALTH CARE PROFESSIONALS* 42 (1992); see also Bruce Hugman, *Tort, Error and Talk: What Can We Learn from the Litigation Crisis?*, 19 INT'L J. RISK & SAFETY MED. 75, 76 (2007) ("With no regard for pursuing a definition which would survive exhaustive legal scrutiny, malpractice is: . . . bad or unskillful practice by a physician or other professional in which the health or welfare of the patient . . . is injured . . . the patient must prove the healthcare provider did not comply with [accepted standards of practice] in their speciality." (alteration in original) (quoting Legal Definitions, *Medical Malpractice Overview*, <http://www.legal-definitions.com/health-law/medical-malpractice/medical-malpractice-overview.htm> (last visited Jan. 22, 2009)).

35 *Santa Rosa Mem'l Hosp. v. Superior Court*, 174 Cal. App. 3d 711, 725 (Cal. Ct. App. 1985). Interestingly, in the law the term *unclean hands* has a definition wholly unconnected to medicine. It essentially means that if someone commits fraud, he cannot assert certain claims against the person he harmed. Thus, while unclean hands in the law bars recovery, unclean hands in medicine results in recovery.

36 *Estate of Behringer v. Med. Ctr.*, 592 A.2d 1251, 1283 (N.J. Super. Ct. Law Div. 1991).

control procedure of wearing a mask. Others involve the transfer of infections through pulse–oxygen monitors moved from the finger of each patient to that of the next patient without disinfection, notwithstanding that these fingers have the unsurprisingly nasty habit of finding their way into various bodily orifices, across lesions, or in contact with pruritic dermatitis.³⁷

But when it comes to reported court opinions concerning nosocomial or hospital–acquired infections, there are only a few. Indeed, eight years ago, in an excellent piece on this topic, Pamela Nolan described that “[d]espite the overwhelmingly large number of people who die from hospital–acquired infections each year, there are virtually no instances of successful litigation against doctors or hospitals.”³⁸ Nolan ascribed the lack of such cases to the difficulty of proving the cause of the infections, as well as the continued judicial and medical acceptance of the notion that nosocomial infections are inevitable.³⁹

Aptly dissatisfied with this situation, Nolan offered two solutions: First, she suggested that jurisdictions adopt the “multiple causation theory,” which would require a plaintiff “only [to] prove that a high infection rate substantially increased the likelihood of harm.”⁴⁰ Nolan noted that while New York has adopted this approach—a state with no shortage of hospitals, no less—other states have not.⁴¹ Second, Nolan recommended applying the doctrine of *res ipsa loquitur* in the context of HAIs, such that courts will infer negligence in cases of nosocomial infections—with that inference able to be rebutted.⁴²

These were bold proposals nine years ago, and remain deserving of further investigation. They might be highly useful tools to address the crisis of HAIs. But before we examine expanding the law in the ways suggested by Nolan, we should analyze the application of existing legal principles to address HAIs. Indeed, the existing landscape of medical–malpractice law has provided for a few, albeit limited, cases employing traditional notions of negligence law to ascribe liability to health–care providers for HAIs.

37 “Blood pressure cuffs are never washed and rarely sanitized. In the hospital, it’s a good idea to ask for a disposable one that they will leave in your room. Oximeters aren’t usually washed, either. I’d wash my hands after someone put one on me (from shared equipment). You’d be shocked at where some patients will put their hands and what is under their fingernails and on their fingers.” Posting of Reader to Tara Parker–Pope, N.Y. Times Well Blog, Doctor, Did You Wash Your Hands?, <http://well.blogs.nytimes.com/2008/04/03/doctor-did-you-wash-your-hands/> (Apr. 3, 2008, 15:50 EST).

38 Pamela Nolan, *Unclean Hands: Holding Hospitals Responsible for Hospital–Acquired Infections*, 34 COLUM. J.L. & SOC. PROBS. 133, 136 (2000).

39 *Id.* at 143.

40 *Id.* at 145, 147.

41 *Id.*

42 *Id.* at 148–49.

One particularly instructive case, *Kimberly F. v. Mary Hitchcock Memorial Hospital*, involves an expectant mother in a maternity ward.⁴³ Upon entering the hospital, the patient had no history of herpes.⁴⁴ The court found that the patient contracted the virus during her stay in a hospital.⁴⁵ The expert witness doctor hired by the plaintiff testified that, much like in the situation dealt with by Dr. Semmelweis, the maternity patient here most likely contracted the disease from the unclean hands of a nurse also caring for a patient with an active herpes outbreak.⁴⁶ For reasons unexplained in the legal opinion, another patient—already infected with Herpes—requested to be taken off of herpes-infection precautions.⁴⁷ The treating nurse passed on this request to the attending doctor, but the nurse provided incomplete information.⁴⁸ Thereafter, the doctor removed the infection precautions without examining the patient.⁴⁹ The expert witness testified that the likely cause of the infection was the nurse's transfer of the herpes infection from the already infected patient to the plaintiff.⁵⁰ The expert also testified that the patient *could have* also become infected from contaminated fomites, although the likelihood was less than the transmission through the nurse.⁵¹ This testimony was sufficient for the court to allow the case to go to the jury and for jury to find the hospital liable, even without complete certainty as to the cause. The jury awarded the plaintiff \$125,000.⁵² Her husband recovered an additional \$25,000 for the exposure that he would suffer from marital relations.⁵³

This case provides some significant practical insights for those pursuing actions against medical-care providers for HAIs. The key to increasing the likelihood of success in such cases is obtaining concrete evidence on the possible sources of infection coupled with an expert witness with sufficient skill to examine that evidence.

Of course, while the former is beyond a litigant's control, the latter is not. Having an expert witness who can connect the dots for both the judge and the jury is a necessary ingredient for a successful unclean-hands lawsuit. The *Kimberly* case facts further supported a successful verdict because the infection involved was not one that normally lives on the skin of patients

43 *Kimberly F. v. Mary Hitchcock Mem. Hosp.*, No. 93-1438, 1993 WL 498026, at *10. (1st Cir. Dec. 3, 1993).

44 *Id.*

45 *Id.* at *10.

46 *Id.* at *5.

47 *Id.* at *3.

48 *Id.*

49 *Id.*

50 *Id.* at *5.

51 *Id.*

52 *Id.* at *10.

53 *Id.*

but, rather, must be transmitted from another infected patient.⁵⁴ Equally, in that case, the judge was sophisticated enough not to dismiss the case simply because the expert could not completely guarantee the source of the infection—understanding that “[a]ll evidence is probabilistic.”⁵⁵

The *Kimberly* case, while the most vivid, does not stand alone. Indeed, other cases have resulted in significantly greater recoveries. For example, in one West Virginia case, a fourteen-year-old girl who underwent anterior cruciate ligament (ACL) surgery contracted a HAI that destroyed her bone and the ACL graft itself.⁵⁶ The infection abated only after seven surgeries over four years.⁵⁷ The jury awarded \$10,084,989.39, consisting of \$10 million in general damages and \$84,989.39 in medical expenses.⁵⁸ And in a New York case, a 25-year old patient died of a nosocomial infection incident to gastric stapling.⁵⁹ The case primarily involved the hospital’s failure to address the decedent’s symptoms after release, but of course these failures could not have occurred absent the initial HAI.⁶⁰ Interestingly, while the plaintiff demanded \$400,000 and the hospital offered \$250,000 to settle, the jury awarded over double the amount sought—\$900,000.⁶¹

Under current law, liability in HAI cases results from the legal determination that these infections are not just random agnogenic illnesses but, rather, the result of hospitals’ and staffs’ failure to abide by the basic procedures initially discovered by Dr. Semmelweis. The broader conclusion is that the passive-voiced defense that a patient simply “contracted” an infection while in the hospital no longer will provide a justification for unhygienic practices in those forward-looking jurisdictions that have allowed science to inform the law. Much like we no longer accept that patients “die of old age” because we know that death has specific causes, the law will increasingly decline to accept for the purposes of legal liability nosocomial infections as idiopathic. As already seen, courts have

54 Many bacteria routinely live on the skin of healthy individuals. This bacteria typically does not cause illness because of individuals’ immunity. In contrast, patients with compromised immunities may become infected by the bacteria ordinarily living on their own skin merely as a result of their diminished health condition. Under such circumstances, nobody “transmitted” the infection—and nobody should be held liable for transferring that infection to the patient. This, of course, does not speak to whether any health-care providers have met the standard of care for treatment of any infection.

55 *United States v. Veysey*, 334 F.3d 600, 605–06 (7th Cir. 2003). Unfortunately, it appears that a few judges have on occasion demonstrated a willingness to dispose of cases through summary proceeding not as a function of the merits of the pleadings but, rather, as a consequence of the desire to clear their overbearing caseloads.

56 *Riggs v. W. Va. Univ. Hosp., Inc.*, 656 S.E.2d 91, 93 (W. Va. 2007).

57 *Id.* at 103 (Starcher, J. dissenting).

58 *Id.* at 97 (majority opinion).

59 *Cooper v. Genesee Hospital*, No. 3332/92 (Monroe Cty. Sup. Ct. N.Y. Sept. 24, 1999).

60 *Id.*

61 *Id.*

held health-care providers responsible for the transmission of infections that could have been avoided through the observance of proper sanitary precautions, albeit in limited circumstances.⁶²

This is not to say that health-care providers are or should be legally responsible for every HAI. Basic notions of tort law require a health-care worker's acts or omissions actually to have caused the infection for her to be liable.⁶³ In other words, a patient could contract an infection while in the hospital where the doctors and nurses failed to follow infectious-control procedures, but the doctors and nurses may not have been the cause of *that* infection.⁶⁴ The transmission source of the infection could have come from elsewhere. For instance, the patient could have contracted the infection from a relative who did not observe proper hygienic procedures and passed on the illness during a visit with the patient, or a patient's condition could have been so weak that even reasonable precautions would not prevent infection.⁶⁵ With this said, of course, the law does not mandate definitive proof of causation against the hospital. Since malpractice cases are not criminal, they do not require proof beyond a reasonable doubt.⁶⁶ They, like virtually all civil actions, merely require proof by a preponderance of the evidence, i.e., "that the scales tip, however slightly, in favor of the party with the burden of proof as to that fact."⁶⁷

Moreover, patients seeking to recover under a negligence standard will not recover just because they demonstrate causation. Health-care providers face liability only if they fail to meet the standard of care,⁶⁸ and the law requires only *reasonable* precautions. Therefore, a doctor will not be found to have committed medical malpractice merely because a patient suffers an injury as a result of treatment, even if the doctor "caused" that harm. For example, in *Zaccone v. American Red Cross*, a man sued the American Red Cross for the death of his wife alleging that the Red Cross was negligent

62 See, e.g., *Riggs*, 656 S.E.2d 91; cf. *Lamont v. Brookwood Health Servs., Inc.*, 446 So.2d 1018 (Ala. 1983).

63 *Elswick v. Nichols*, 144 F.Supp.2d 758, 764 (E.D. Ky. 2001); *Gahm v. Thomas Jefferson Univ. Hosp.*, No. CIV.A. 94-2050, 2000 WL 233247 (E.D. Pa. Feb. 29, 2000).

64 See *Jain*, *supra* note 31.

65 See *id.*; *Nolan*, *supra* note 38, at 142 (stating, "One scholar argues that 'not all nosocomial infections are necessarily preventable by even the most advanced techniques or utmost care. For example, many hospital-acquired infections occur in patients with impaired immune systems, or in patients who require indwelling urinary catheters, which provide a path for organisms to enter the body.'" (citing 43 AM. JUR. 2D *Proof of Facts* § 1 (1985))).

66 See *United States v. Fatico*, 458 F.Supp. 388, 406, 411 (E.D.N.Y. 1978), *aff'd*, 603 F.2d 1053 (2d Cir. 1979).

67 See *Blossom v. CSX Transp.*, 13 F.3d 1477, 1480 (11th Cir. 1994) (internal quotations omitted).

68 *Bars v. Palo Verde Hosp.*, No. E036019, 2005 WL 2561660, at *1 (Cal. App. Oct. 12, 2005).

because it gave his wife HIV-infected blood.⁶⁹ The Red Cross did not dispute that it gave the man's wife HIV-infected blood,⁷⁰ but denied liability on the grounds that the blood was taken in April, 1984, before the test for HIV existed. At the time of the donation, the Red Cross relied on questions and observations of blood donors as a screening method.⁷¹ The court ruled that at the time of the donation, the Red Cross met the standard of care normally possessed by the blood-bank profession.⁷² Thus, under the contemporary standard of care, even though the Red Cross "caused" the transmission by transfusing infected blood, it was not legally culpable because it acted reasonably.

Of course, patients suffer complications not infrequently as a result of medical care, notwithstanding treatment under the prevailing standard of care. Health-care workers understand that even when they do everything pursuant to the latest guidelines, patients sometimes suffer harm. Patients' failure to grasp often this basic point invariably is a source of much frustration in the medical community.⁷³ Undoubtedly nearly every medical practitioner can relate a story of an ungrateful patient, aided by an unscrupulous lawyer, suing a capable doctor for a bad outcome despite good medical treatment. If health-care workers were liable for any injury suffered by a patient regardless of fault, this would constitute strict liability.

Strict liability in health care would hold medical professionals responsible for any harm that befalls a patient no matter how well the health-care workers meet, or even exceed, the prevailing standard of care.⁷⁴ While the law generally does not impose this level of legal responsibility on medical professionals, it has done so under some unique circumstances.⁷⁵ For example, Fred P. Gardner, a Korean war veteran, was entitled to free medical care in any of the nation's overworked and often under-equipped Veteran's Administration (VA) hospitals.⁷⁶ Well after, and unrelated to, his military service, Gardner underwent back surgery in a VA hospital.⁷⁷ Afterwards, Mr. Gardner had pain and weakness in his left leg.⁷⁸ There was no suggestion that the VA failed to meet the prevailing standard of care.⁷⁹

69 *Zaccone v. Am. Red Cross*, 872 F. Supp. 457, 458 (N.D. Ohio 1994).

70 *Id.*

71 *Id.*

72 *Id.* at 462.

73 Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 J. AM. MED. ASS'N 1001, 1001-07 (2003).

74 *Brown v. Gardner*, 513 U.S. 115 (1994).

75 *Id.*

76 *Id.*

77 *Id.* at 116.

78 *Id.*

79 *Id.* at 118.

Mr. Gardner simply suffered an unfortunate complication incident to his back surgery. Nonetheless, he sued the VA and, surprisingly, won.⁸⁰

In unsuccessfully arguing before the U.S. Supreme Court, the VA asserted that Mr. Gardner was not entitled to any recovery for his injury, because he should only be compensated if the injury resulted from negligence, i.e., medical malpractice.⁸¹ But in Mr. Gardner's case, the traditional tort rules were replaced by legislative action. Congress enacted a law that changed the "rules" and required the VA to compensate a veteran for, among other things, any injury "caused by hospital care, medical or surgical treatment," as long as the injury was "not the result of such veteran's willful misconduct."⁸² Thus, in contrast to *Zaccone*, the VA need not be negligent, said the High Court, for it to be liable for the injuries it caused. In this relatively unique instance, medical professionals were essentially subjected to strict liability.

Strict liability is not the prevailing standard for medical malpractice cases for good reason. If it were, we would have fewer doctors and nurses willing to engage in their professions, more expensive health care for patients, and—most importantly from a legal-economic perspective—a level of investment in precautions that outweighs the potential benefit for patients.⁸³ As discussed, negligence law, in contrast, provides a much more deferential standard for medical professionals.

Despite this deference, medical professionals often lament the abuses of litigation and its unfair results. Studies have demonstrated, however, that for the most part the legal system gets it right.⁸⁴ That is, most of the time doctors who act within the standard of care do not get sued when a patient suffers an injury.⁸⁵ And in those limited circumstances when good doctors get sued for bad outcomes in the absence of negligence, courts generally find in their favor.⁸⁶ To be clear, good doctors wrongfully sued undergo enormous personal and professional burdens, regardless of whether they eventually win their cases.⁸⁷ They not only face the hardship of a lawsuit and the time that they must invest in their defense, but also the significant cost of rising malpractice insurance premiums needed to defend even the cases they win.⁸⁸ Notwithstanding popular lore to the contrary, however,

80 *Id.* at 122.

81 *Id.* at 116.

82 38 U.S.C. § 1151 (2000 & Supp. 2005).

83 RICHARD POSNER, *ECONOMIC ANALYSIS OF LAW* 177–182 (2003).

84 David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 *NEW ENGL. J. MED.* 2031 (2006).

85 *See id.*

86 *See id.*

87 *See id.*

88 *See id.*

doctors do not generally face legal liability and adverse judgments for non-negligent behavior.⁸⁹

Some criticize more broadly even the negligence standard in the health-care environment. They aptly point out that in the zero-sum world of limited resources in which we live, the money expended on legal actions necessarily diminishes what remains available for other expenditures, such as the treatment of patients. This dichotomy, however, is often false. The law is designed not only to compensate the injured, but it also equally pursues the goal of regulating society's future behavior.⁹⁰ Financial responsibility is a strong motivator. It affects much of what we do—including by example what professions we pursue and where we live.

Thus, while negligence verdicts invariably reduce resources available for other patients in the short term, it has a positive effect for the health-care system overall in the long term. By incentivizing medical professionals not to deviate from the standard of care, malpractice judgments change the way medical workers behave and benefit future patients in addition to those who recover judgments.⁹¹

Critics complain that the legal system, with its negligence standard, constitute a heavy-handed method of improving care. And it may very well be. But, unfortunately, we cannot wholly rely on eleemosynary motives in our health-care system to ensure compliance with hygiene requirements. While no one method for reducing nosocomial infections should control, we must acknowledge the prophylactic nature of litigation.⁹² As a chairman of an Emergency Department once told me, lawsuits have contributed to improved patient care by changing the previously-presumed proper paradigm of treatment.

Thus, the real issue is not whether the law has any role in health care, but rather the relative position that litigation should hold in improving health

89 *See id.*

90 Todres, *supra* note 31, at 683. "Medical malpractice law is intended to provide protection against [medical] errors. The prevailing view is that it has two primary purposes—to provide patients with compensation for injuries resulting from substandard care and to deter healthcare providers from negligent behavior." *Id.* at 679.

91 Michelle Beaver, *Hand Hygiene Programs Prove Successful but Widespread Work Still Needed*, INFECTIOUS CONTROL TODAY MAG., May 31, 2007, <http://www.infectioncontrolday.com/articles/401/77h1614375179387.html>.

92 Kenneth Jost, *Medical Malpractice: Are Lawsuits Out of Control?*, 13 CQ RESEARCHER 129, 134 (2003) ("The drop in claims illustrates what some say is the major public benefit of allowing malpractice victims to recover damages from doctors or hospitals responsible for their injuries: deterrence. 'The threat of liability is what works as a deterrent to improve patient safety,' says consumer advocate Doroshow."). *But see* Randall R. Bovbjerg & Robert A. Berenson, *Surmounting Myths and Mindsets in Medical Malpractice* (The Urban Institute, Washington, D.C.), HEALTH POLICY BRIEFS, Oct. 2005, at 1, 3, http://www.urban.org/UploadedPDF/411227_medical_malpractice.pdf (arguing that litigation does not have a strong prophylactic effect because "replacing the individuals who are involved in a particular patient injury will seldom decrease the incidence of future injury.").

care. It must be only one aspect of a multifaceted approach. Reward also should be provided to those who are on the cutting edge of reducing the transmission of nosocomial infections. Just as the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for monitoring compliance with the Medicare conditions of participation,⁹³ rewards hospitals that follow specific treatment protocols—i.e., giving aspirin to heart-attack patients upon arrival⁹⁴—and adjusts overall payments based on the Blended Reimbursement Rate of the hospital, medical institutions should receive a multiplier based on the effectiveness of their infection-prevention programs. Further, more effective training and education must play a critical role, as well.

This comprehensive approach to systems improvement is not novel. We provide rewards and penalties throughout society to incentivize good behavior and discourage bad behavior. For example, local and national government agencies provide—albeit highly limited—prenatal care and parental training for some expectant and new mothers. That does not mean that the same governments would not—and should not—criminally pursue neglectful parents. While this latter check on parental care sometimes results in the removal of children from their parents' charge, with the significant attendant costs directly impacting the highly limited resources of the child-welfare system that remain available for other children in need in the short term, we certainly would not want to eliminate this ultimate tool from our arsenal for protecting children. The threat of criminal prosecution undoubtedly acts as a deterrent in many circumstances and offers long-term benefits to the child-welfare system.

The same is the case for litigation as a *final* method to assist in regulating and improving health care. While it is unfortunate that good doctors and other health-care providers operate in an environment occasioned by the specter of potential lawsuits, we must also keep in mind that requiring pecuniary responsibility for failing to meet the standard of care often saves lives. Litigation is both forward looking and retrospective. The results of a lawsuit are not only the rectification of legal, and perhaps moral, wrongs—as imprecise a tool as it may be. But lawsuits also affect the future behavior of individuals in similar circumstances—in this case health-care providers.

CONCLUSION

A patient's death from an HAI is tragic. While some argue that the cost of compensating the victim's family only diverts funds from an already

93 See Centers for Medicare & Medicaid Services, Medicare, <http://www.cms.hhs.gov/home/medicare.asp> (last visited Sept. 21, 2008).

94 See Joint Commission, Guidelines for Publicizing Hospital National Quality Improvement Goals, http://www.jointcommission.org/AccreditationPrograms/PublicityKit/nqig_pub.htm (last visited Sept. 21, 2008).

strapped medical system,⁹⁵ that diversion will not only provide some very rough justice to the family members, it may change the behavior of the medical system. If that death ultimately saves lives through litigation, hopefully it will not be as meaningless as it first appears.

We should not be too quick to employ litigation in the health-care environment, nor should we be quick to abandon it altogether. It is just one treatment modality for the illnesses that compromise the American health-care system and will, along with other tools, help address HAIs.

95 Jost, *supra* note 92, at 134 (claiming, “However, most doctors and medical observers believe malpractice lawsuits do more harm than good to the practice of medicine. ‘We see no credible evidence that litigation has improved safety,’ says AMA President Palmisano.”).