Would a rose by any other name really smell as sweet? Framing our work in infection prevention

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To the Editor—From consumerism to politics to health care, the way we label or frame an issue plays a huge role in how we understand and respond to it. This is why we now shop for "pre-owned" cars and "dried plums" rather than used cars and prunes and buy "tall" (not small) coffees at Starbucks. Realtors are also excellent at framing. A cottage home seems more marketable when described as "cozy" or "charming" than as "tiny" or "cramped." Cognitive linguist and professor George Lakoff has pointed out how critical framing is in politics as well, from how initiatives are named (eg, "The Clear Skies Initiative" or "No Child Left Behind") to how concepts are described (eg, "drilling for oil" vs "exploring for energy" or "undocumented workers" vs "illegal aliens").[1]

This is also true in the fields of health care and public health. Many tobacco "control" programs began to use the term tobacco "prevention" instead, focusing on the superior aspects and more positive connotation of prevention. The term for "other people's smoke" has also evolved from "environmental tobacco smoke" (coined by the tobacco industry) to the more commonly used "secondhand smoke," which proponents argue puts the focus on the exposed nonsmoker.[2] Public health advocates began using the term "car crashes" rather than "accidents" to focus on the fact that most car crashes stem from the preventable results of human error.[3,4]

In health care, we aim to be more inclusive of the changing landscape of our personnel by using terms such as "licensed independent providers" to include nurse practitioners, certified nurse midwives, and physician's assistants when discussing programs that affect "providers" rather than defaulting to "physicians." We also attempt to be more accurate in describing our work: for example, "holding units" have become "clinical observation units" because we are providing active care, not simply "holding" patients.

Similarly, the infection prevention community is redefining some of its terms and phrases for several reasons: to place them in a more positive light; to improve compliance; or simply to be more precise, accurate, and inclusive with our language. First, the term "healthcare workers (HCW)" has been expanded by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices to "healthcare personnel (HCP)." The latter term is broader and more inclusive because HCP also includes volunteers and trainees, who are not employees or "workers." Clearly, pre-exposure prevention (eg, appropriate vaccines) and personal protective equipment (eg, gloves, masks, and gowns) should be made available to all HCP. Antibiotic stewardship is now recommended by both the CDC and the Centers for Medicare and Medicaid Services (CMS). At the University of North Carolina (UNC), we have embraced stewardship activities for many years, but our pharmacy and therapeutics subcommittee is named the "Anti-Infectives Subcommittee" because this group also provides expertise and interventions to improve appropriate use of antifungals, antivirals, drugs used for parasitic diseases, vaccines, and relevant antibody preparations (eg, hepatitis B immune globulin).

Similar to the movement with tobacco control, in recent years there has been a movement to further define our activities to focus on *prevention* rather than control. Thus, our infection control nurses became infection preventionists, and our work moved from "infection control" to "infection prevention." We are also shifting from the term "chlorhexidine bathing" to "chlorhexidine treatment." The use of the term "treatment" is part of efforts to increase staff compliance and to reduce patient refusals of the chlorhexidine "bath" by emphasizing its essential role as part of a patient's medical treatment plan for infection prevention rather than as an optional part of daily care for hygiene.

Finally, we have increasingly moved to using terms that are less negative or pejorative. For example, at UNC, when we perform observations with feedback on our units, we are moving from the term "compliance audits" to "just-in-time coaching." We have a full-time staff member devoted to bedside coaching with nurses and other HCP. While audits are a fundamental component of quality improvement at our institution, we have come to see that the term itself can create anxiety and other negative reactions. On the same note, some practitioners have begun to use the term "fidelity" rather than "compliance," which conveys more power and choice to stakeholders. Given that the purpose of our work is to coach staff to follow evidence-based guidelines for infection prevention, we wish to frame this work so that staff view following these guidelines as a decision they make to provide the best patient care possible and see interactions with our bedside coach as a conversation, not as a judgment.

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This brings us back to our titular question derived from Shakespeare: Would a rose by any other name really smell as sweet? We believe the answer is no—our language and framing matter. Being thoughtful in our communication ensures that we are including all our stakeholders, accurately framing our work in a positive light, and correctly describing the work we do—all are critical components of our work in infection prevention.

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References

1. Abadi M. Democrats and Republicans speak different languages—and it helps explain why we're so divided. *Business Insider* website. http://www.businessinsider.com/political-language-rhetoric-framing-messaging-lakoff-luntz-2017-8. Published August 2017. Accessed February 19, 2018.
2. Chapman S. Other people's smoke: What's in a name? *Tobacco Control* 2003;12:113–114.
3. Stewart AE, Lord JH. Motor vehicle *crash* versus *accident*: a change in terminology is necessary. *J Trauma Stress* 2002;15:333–335.
4. Richtel M. It's no accident: advocates want to speak of car 'crashes' instead. *The New York Times* website. https://www.nytimes.com/2016/05/23/science/its-no-accident-advocates-want-to-speak-of-car-crashes-instead.html. Published May 22, 2016. Accessed April 2, 2018.