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OUR UNSANITARY HOSPITALS

By: Betsy McCaughey
Last month, health inspectors in New York City shut down Serendipity, an upscale ice cream parlor. Though the closing made headlines, it is a common occurrence for less famous eateries charged with violations like unclean cutting boards and floors, workers who fail to clean their hands, and improper food handling that could lead to bacterial contamination.

In New York, restaurants are inspected, without prior notice, once a year. In Los Angeles, inspections are done three times a year and restaurants must display their grade near the front door. After Los Angeles instituted this inspection system, the number of people sickened by food-borne illnesses fell 13%, according to the Journal of Environmental Health. Columbus, Ohio, and other cities are now following L.A.'s lead.
But why aren't hospitals and doctors' offices held to the same standard and inspected regularly?

Going to a restaurant is voluntary. Going to the hospital is not. And inadequate hygiene in hospitals is far deadlier than in restaurants. The Centers for Disease Control and Prevention estimates that 2,500 people die each year after picking up a food-borne illness in a restaurant or prepared food store. Forty times that number—100,000 people—die each year, according to the CDC, from infections contracted in health-care facilities.

Data recently published by the Journal of the American Medical Association show that infections from just one type of bacteria—methicillin-resistant Staphylococcus aureus (MRSA)—kill about twice as many people in the U.S. as previously thought. The finding is based on lab tests, not on what hospitals report. If the same methodology were used to quantify deaths from all hospital infections (not just MRSA), the toll would likely be much larger than 100,000.

These infections are caused largely by unclean hands, inadequately cleaned equipment, and contaminated clothing that allow bacteria to spread from patient to patient. In a study released in April, Boston University researchers examining 49 operating rooms at four New England hospitals found that more than half the objects that should have been disinfected were overlooked by cleaners.

At one time, hospitals routinely tested surfaces for bacteria, but in 1970, the CDC and the American Hospital Association advised them to stop, saying testing was unnecessary. Astoundingly, the CDC still adheres to that position despite a 32-fold increase in MRSA

infections. CDC officials say that lab capacity should be reserved for tests on patients.

Testing surfaces is so simple and, inexpensive that it's used routinely in the food industry. Is it more important to test for bacteria in meat processing plants than in operating rooms?

The organization that accredits most hospitals, the Joint Commission, usually visits a hospital every three years. The Commission emphasizes hand hygiene, but that's not enough. As long as hospitals are inadequately cleaned, doctors' and nurses' hands will become recontaminated seconds after they are washed, whenever they touch a privacy curtain, or other bacteria-laden surface.

Joint Commission accreditation is no guarantee that a hospital is sanitary. An April 2007 study showed that 25% of California hospitals deemed unsanitary by state investigators responding to complaints had been accredited by the Joint Commission within the previous year.

Amazingly, physicians' offices are not inspected at all. Most physicians are required to take a yearly course on infection precautions, but there is no follow up to ensure they adhere to them or maintain clean offices. Patients' privacy concerns and cost issues may stand in the way of regularly inspecting doctors' offices, but when serious hygiene infractions are suspected, state health authorities should act decisively. In many states, health departments and state medical boards are under criticism for putting a physician's livelihood ahead of patient safety.

It was serendipitous that a Nassau County, N.Y., health official noticed repeated cases of Hepatitis C and called for an investigation of Dr. Harvey Finkelstein, a Long Island doctor. Finkelstein allegedly was reusing syringes, contrary to universal precautions, and injected patients with contaminated medications.
According to news reports, one of Finkelstein's patients became infected with Hepatitis C, an incurable virus, and over a thousand other patients have been notified by health officials that they could be at risk for Hepatitis C and HIV.

The New York State Dept of Health called Finkelstein's reuse of syringes a "correctable error," and is allowing him to continue to practice under observation.

"Correctable?" Not for the 53-year-old patient infected with Hepatitis C or the many other patients dreading the results of their blood tests. Restaurants are closed for far less.

Ms. McCaughey, a former lieutenant governor of New York, is founder and chairman of the Committee to Reduce Infection Deaths.