**Health Issues Column**

**Clostridium difficile Infections Can Hit Facilities in the Gut, Too**

Health care-associated infections can be costly to skilled nursing facilities. Hospital and skilled nursing facility fees for care of this illness have been targeted by regulators as areas of concern and restriction. Already, hospitals stays related to certain infections are no longer reimbursed by Medicare. Providers are also experiencing the string of lawsuits brought by patients who developed *Clostridium difficile* infections or by their families. No one wants to hear that a family member has acquired a dangerous or even merely unpleasant case of diarrhea. However, the rapid increase of *C. difficile* remains a common cause of significant morbidity and mortality among hospitalized patients and residents in long-term care facilities. So significant is the issue that the Centers for Disease Control and Prevention (CDC) has distributed specific informational materials on stopping *C. difficile* in those settings. While the health care community blames much of the *C. difficile* problem on bacterial resistance from antibiotic overuse, the public is resistant to having practitioners limit the prescribing of these drugs. The reduction in antibiotic use should be only one aspect of an aggressive plan to prevent *C. difficile* infection in settings. The CDC has estimated that 14,000 Americans die each year from *C. difficile*.

**Medical Expert Perspective**

This piece brings up some interesting issues of litigation involving multidrug-resistant organisms (methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococcus, *Clostridium difficile*), which we can probably expect to see more of. Remember that for plaintiffs to prevail in a civil lawsuit, they need to show – to a reasonable degree of medical probability or certainty (meaning “more likely than not”) – that the negligent act caused the bad outcome. In the case discussed here, in my opinion, it would be difficult to prove that the resident would not have contracted the infection had the facility implemented and followed a *C. difficile*-control regimen.

But clearly, the plaintiffs would have had a medical expert testify that the lack of such a program caused the infection. And whether or not that’s true, every facility should have solid infection-control policies.

A more valid theory for the cause of most *C. difficile* infections is that a negligent act (e.g., an avoidable pressure ulcer that got infected) required antibiotic therapy, which in turn caused or substantially contributed to the development of *C. difficile* infection. In this scenario, it’s pretty clear that if the patient had not been given the antibiotic, he or she would not have gotten *C. difficile*.

I’ve also seen lawsuits arguing that urinary tract infections are caused by bad catheter care. While that is certainly possible, I don’t think it’s a reasonable medical probability, considering that virtually every patient with a Foley catheter gets an infection eventually, regardless of the quality of the care. What’s more, asymptomatic bacteriuria is often called (and treated as) a urinary tract infection.

Along those same lines, if a patient gets a Foley catheter because of an avoidable pressure ulcer and then dies from a urinary tract infection, I believe that is a wrongful death. If the patient had not developed the pressure ulcer, he or she probably would not have died from the urinary tract infection.

In any event, the lesson here is well taken: Make sure your infection-control policies are up to date and that they are followed.

---

_—Karl Steinberg, MD, CMD, Editor in Chief_