



Independent Democratic Conference

Deadly Ties and the Rise of Multi-Drug Resistant Infections: A Case For a New Health Care Practitioner Hygienic Dress Code

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Overview

New York is facing a crisis with regard to the availability and affordability of medical liability insurance coverage.¹ New York health care providers pay the highest premium rates in the country for their medical liability insurance and those rates continue to rise.² It has been demonstrated that these high premiums are exacerbated by the practice of defensive medicine which increases health care costs.³

Defensive medicine entails the practices of health care professionals tailored specifically at avoiding future lawsuits and is not necessarily targeted towards patient well being and treatment. It often incorporates excessive testing and avoiding taking on high-risk patients. This results in reduced access and affordability of medical care which can contribute to skyrocketing malpractice premiums.

To lower the use of defensive medicine and help curtail high malpractice premiums, some States have enacted various tort reforms to control the use of lawsuits against medical professionals. However, more needs to be done to control the growth of medical liability premiums and the practice of defensive medicine. New and effective approaches need to be developed to fundamentally change the practice of medicine and help to curb the rapidly increasing cost of medical malpractice insurance.⁴

Approaches to improve patient safety have been increasingly researched for their effects on curtailing medical malpractice liability costs. Malpractice claims that involve preventable injuries often result in large jury awards. Information indicates that, rather than increased frequency of claims, the soaring amount of individual malpractice awards accounts for increasing malpractice costs.⁵ Therefore, it is logical to reduce, and when possible, eliminate preventable injuries to curtail medical malpractice costs and accompanying premium rates.

Along these lines, the Independent Democratic Conference's (IDC) "dress code for health care practitioners" proposal should be considered to address an important facet of hospital and other health care facility liability and a pervasive public health issue:

¹ Greater New York Hospital Association, *Medical Malpractice Insurance Costs and Coverage*, Jan., 2005.

² New York State Department of Health, *New York State Department of Health. New York State to Conduct Medical Liability Reform Demonstration with \$3 Million Federal Grant*, June, 2010. Available at http://www.health.state.ny.us/press/releases/2010/2010-06-16_medical_liability_reform_demo_3_mill_fed_grant.htm; *see also*, National Governors Association Center for Best Practices, *Issue Brief: Containing Medical Malpractice Costs: Recent State Actions*, June, 2005. Available at <http://www.nga.org/Files/PDF/0507MALPRACTICECOSTS.pdf>.

³ Studdert, D. M., et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment* JAMA, 2005, 293(21): 2609-2617.

⁴ *See generally* Robert Wood Johnson Foundation, The Synthesis Project, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms*, No. 10. May, 2006; *see also* Rand Compare, *Analysis of Medical Malpractice*. Available at <http://www.randcompare.org/analysis-of-options/analysis-of-medical-malpractice>. *See also* Hellinger, F. J. & Encinosa, W. E., *Review of Reforms to Our Medical Liability System*, Agency for Healthcare Research and Quality, Dec. 31, 2009.

⁵ Greater New York Hospital Association; Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates in New York*, Jan., 2003; Solnik, C., [N.Y. medical malpractice insurer faces insolvency](#), Long Island Business News, Apr. 29, 2010.

nosocomial infections such as *methicillin resistant Staphylococcus aureus* (MRSA) infections which are spread through stays in the hospital and are resistant to sterilization techniques. This proposal would require New York Hospitals to develop and implement a new more hygienic dress code for health care professionals to help reduce the spread of such dangerous infections to patients while concurrently reducing malpractice claims for hospitals.

Lowered infection rates would reduce the need to practice defensive medicine, lower the costs of conducting many unnecessary tests, and increasing access to medical care. In turn, this could help to reduce future medical malpractice claims, and help to control insurance premium costs as the lowered risk will lead to lower medical liability premium rates.

The Severity and Extent of MRSA Infection Rates Needs to be Addressed

Methicillin-resistant staphylococcus aureus (MRSA) is one of the fastest growing hospital infections in the U.S. The number of reported infections in U.S. hospitals grew from 2,000 in 1993 to 368,000 in 2005, according to the Agency for Healthcare Research and Quality.⁶ In a survey published in JAMA, 2007, the researchers estimated that there were 94,360 invasive infections in 2005.⁷

“To put this number into context, the estimated rate of invasive MRSA is greater than the combined rate in 2005 for invasive pneumococcal disease (14.1 per 100,000), invasive group A streptococcus (3.6 per 100,000), invasive meningococcal disease (0.35 per 100,000), and invasive *H influenzae* (1.4 per 100,000),” noted by Elizabeth A. Bancroft, M.D., S.M., of the Los Angeles County Department of Public Health.⁸

Centers for Disease Control and Prevention (CDC) estimated that the MRSA-related death rate of 2005 was greater than that of HIV/AIDS in the same year. However, this number is “‘only the tip of drug-resistance iceberg’ with respect to disease burden”, stated Dr. Bancroft.⁹

More than 80% of MRSA infections are contracted in a health care setting-related area. Patients with MRSA stay longer in the hospital (more than doubled) and cost almost twice as much for their hospital stay as their non-infected counterparts, on average.

⁶ Elixhauser, A. & Steiner, C., *Infections with Methicillin-Resistant Staphylococcus Aureus (MRSA) in U.S. Hospitals, 1993-2005*. HCUP Statistical Brief #35. July 2007, Agency for Healthcare Research and Quality, Rockville, MD. Available at <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb35.pdf>.

⁷ Klevens, R. M., Morrison, M.A., Nadle, J., et al., *Invasive Methicillin-Resistant Staphylococcus Aureus Infection in the United States*, JAMA, 2007, 298 (15): 1763-1771 (stating that invasive MRSA infection is defined as infections in normally sterile sites, such as blood, cerebrospinal fluid, and internal organs.).

⁸ Crystal Phend, *Invasive MERSA More Pervasive Than Expected*, MedPage Today, Oct. 16, 2007. Available at <http://www.medpagetoday.com/InfectiousDisease/GeneralInfectiousDisease/6984>.

⁹ *Id.*

Moreover, the mortality rates for patients with MRSA were more than twice the rates for a non-MRSA stay.¹⁰

The elderly and African Americans are disproportionately more threatened by MRSA infections.¹¹ As New York State has a large number of people sixty-five and over (ranked third in the number of Medicare enrollment in 2008)¹² and a large African American population (15.6% New York State versus 25.1% in New York City versus 12.3% nationally¹³), the efforts to control MRSA infection within the State's medical settings is surely needed.

Why a Health Care Practitioner Dress Code?

A new hygienic dress code to help curb inborn health care facility infection rates faces opponents who argue that there is no solid evidence supporting the need for adopting such a dress code. Others, including medical malpractice insurers maintain that a health care professional dress code has the potential to reduce MRSA infection rates and other inborn health care facility infection rates. Ample direct and indirect evidence supports the need for the adoption of such a dress code. For instance, in one study, researchers found that the same strain of organisms found on staff clothing was also found in three of five patients, of whom there were surveillance cultures taken.¹⁴ An earlier study also demonstrated the case in which a mock patient was infected by *Bacillus* spores due to contact with contaminated uniforms.¹⁵ Additionally, a study investigating nurses' dress habits not only affirmed that uniforms are contaminated during clinical duties, but also demonstrated that transfer of bacteria to patients is possible as "some uniforms that were positive at the start of a shift were negative at the end".¹⁶

Promising results which indicate effectiveness of a dress code have been noted in several health care centers in the United States. For instance, "St Mary's Health Center in St. Louis reduced infections after Cesarean births by more than 50 percent by providing all caregivers with hospital-laundered scrubs, as well as requiring caregivers to double-glove. Stamford Hospital in Connecticut recently banned wearing of scrubs outside the hospital, given the surge in *C. diff.* [*Clostridium difficile*] cases, a new superbug threat. Monroe Hospital [in Bloomington, Indiana] opened its doors two years

¹⁰ Elixhauser, A. & Steiner, C., *supra* note 32.

¹¹ Klevens, R. M., Morrison, M.A., Nadle, J., et al., *supra* note 33.

¹² Kaiser State Health, *Kaiser Family Foundation State Health Facts. Medicare*. Available at <http://www.statehealthfacts.org/comparetable.jsp?ind=290&cat=6&sub=74&yr=63&typ=1&sort=a>.

¹³ U.S. Census Bureau, *2006-2008 American Community Survey: New York State*. Available at http://factfinder.census.gov/servlet/ACSSAFFacts?_event=Search&geo_id=&_geoContext=&_street=&_county=&_cityTown=&_state=04000US36&_zip=&_lang=en&_sse=on&pctxt=fph&pgsl=010.

¹⁴ Hedin, G., *Staphylococcus Epidermidis – Hospital Epidemiology and the Detection of Methicillin Resistance*, *Scand J Inf Dis*, 1993, Suppl. 90: 32-37.

¹⁵ M'Tero, S.S., Sayed, M., & Tyrrell, DAJ., *Quantitative studies on preventing the spread of micro-organisms in a hospital isolation unit*, *J. Hosp. Infection*, 1981, 2: 317-328.

¹⁶ Perry, C., Marshall, R., & Jones, E. *Bacterial Contamination of Uniforms*, *J. Hosp. Infection*, 2001, 48: 238-241.

ago and has had no hospital-acquired infections. The extraordinary success of this Indiana hospital is due in part to hospital laundering of scrubs and prohibiting personnel from wearing scrubs beyond the building.”¹⁷

A dress code for health care professionals was initiated by the National Health Service (NHS) in the United Kingdom. Published in 2007 and updated in 2010 due to its popularity, *Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers*, stated that “[a]lthough there is no conclusive evidence that uniforms and workwear play a direct role in spreading infection, the clothes that staff wear should facilitate good practice and minimize any risk to patients.”¹⁸ The report advises that those coming into contact with patients should wear short-sleeved shirts/blouses and avoid wearing white coats of any length due to the sleeves and wear no fake nails or jewelry but for a plain wedding ring. The guidelines also state that neckties are unacceptable during patient contact. Based on this report, “many NHS trusts adopted a ‘bare-below-the-elbows’ and necktie-free dress policy.”¹⁹

Two beliefs support the adoption:²⁰

- “Anything with long sleeves limits one’s ability to effectively wash hands and wrists between patient contacts.”
- “Long-sleeve cuffs can become colonized with bacteria.”

Several researchers investigated an in-vitro model in the laboratory and reported that they isolated MRSA and two other harmful bacteria from sanitized pig skin samples after the skin were rubbed across the bacteria-inoculated white coat.²¹ This study “establishes biological plausibility for the transmission of important nosocomial pathogens by contaminated clothing”, and was presented in part at the Society for Healthcare Epidemiology of America Annual Meeting, San Diego, CA on March 20, 2009. In practice, MRSA colonization rates were found to decrease in some regional UK health centers after the implementation of the new dress code.²²

Further, some researchers documented how dirty the neckties, and even bowties, could be. For instance, Biljan et al. published their findings in *British Medical Journal*, which revealed, by a multicenter randomized double blind crossover trial, both neckties

¹⁷ *Hospital Scrubs Are a Dangerous Fashion Statement*, Infection Control Today, Dec. 3, 2008. Available at <http://www.infectioncontrolday.com/news/2008/12/hospital-scrubs-are-a-dangerous-fashion-statement.aspx>.

¹⁸ Department of Health (UK), *Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers*, 2010. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114754.pdf.

¹⁹ S. Palazzo, D. Hocken, *Patients’ perspectives on how doctors dress*, 74 J. Hosp. Infection 30-34, May 2010.

²⁰ Barbieri, R. L., *The Hospital Has a New Dress Code for its Vectors -ER Doctors*, OBG Management, 2008, 20 (11); 6, 8.

²¹ Butler, D. L., Major, Y., Bearman, G., et al., *Transmission of Nosocomial Pathogens by White Coats: an in-vitro Model*, J. Hosp. Infection, 2010, 75: 137-138.

²² Barbieri, R. L., *supra* note 45.

and bowties worn by participating OB/GYN physicians were contaminated.²³ This finding is in line with the results of more recent studies published in *Intensive Care Medicine* and *Journal of Hospital Infection*.²⁴ Because ties are not laundered as often as other clothes such as scrubs,²⁵ with some of them even have never been laundered,²⁶ one study found a substantial amount of colonized bacteria on 20% of forty neckties, and one of them had *methicillin-resistant Staphylococcus aureus* (MRSA). A 2004 study at Queens Hospital, New York, reported more astonishing discoveries that “47% of the 42 ties worn by medical staff at the hospital harbored illness causing bacteria” and “clinicians ties were eight times more infectious than security guards ties”.²⁷ A study conducted in an Irish hospital reported results akin to the other studies in that 42% of neckties had more than fifty colony-forming units, 18% of ties harbored potential pathogens, and 8.4% were contaminated with MRSA.²⁸ This study had a larger sample size (N=95), which helps diminish the impacts of bias to ensure the validity and generalizability of the results. It was indicated that, within only two weeks of wearing a neck tie, 25% of new silk neckties “were colonized with non-commensal flora”.²⁹ Doctors also voiced their concerns.³⁰ For instance, as reported by CBS in May 2004:

Dr. Allison McGeer, head of infectious diseases at Toronto's Mount Sinai Hospital, suggested [that the findings in the Nurkin study] are a result of doctors not washing their hands enough or at the right times. Also, the findings probably also pertain outside hospitals, noting male pediatricians often wear ties with cartoon themes to entertain their young patients. "And they should probably think twice about that."

McGeer said it's easy to see how easy it might be to spread antibiotic-resistant bacteria and other pathogens.

"I go see a patient who has MRSA," she explained, using the acronym for methicillin-resistant *Staph aureus*.

"I get MRSA on my hands, I transfer it to my tie. Then I wash my hands.... While I talk

²³ Biljan MM, Hart CA, Sunderland D, Manasse PR, Kingsland CR., *Multicentre Randomised Double Blind Crossover Trial on Contamination of Conventional Ties and Bow Ties in Routine Obstetric and Gynaecological Practice*, *BMJ*, 1993, 307:1582–1584.

²⁴ Dixon M., *Neck Ties as Vectors for Nosocomial Infection*, *Intensive Care Med*, 2000, 26:250;
Ditchburn I., *Should doctors wear ties?*, *J. Hosp. Infection*, 2006, 63:227–228 (this and other articles from this journal on this topic available at http://www.journalofhospitalinfection.com/issues/contents?issue_key=S0195-6701%2809%29X0012-5).

²⁵ Lopez PJ., *Bacterial counts from hospital doctors' ties are higher than those from shirts*, *Am J Infect Control*, 2009, 37: 79–80.

²⁶ McGovern, B., Doyle, E., Fenelon, L.E., & GitzGerald, S.F. The Necktie as a Potential Vector of Infection: Are Doctors Happy to Do Without? *J Hosp Infect*, 2010, 75(2): 138-139.

²⁷ Nurkin, Steven, MD, Urban, C., Mangini, E., Maurer, J., Mariano, N., Grenner, L., Sabo, E., and Rahal, J., *Is the Clinician's Necktie a Potential Fomite for Hospital Acquired Infections?*, on file with author.

²⁸ McGovern, *supra* note 51.

²⁹ Lintott, P. & Parry, D., *Let's Lose the Tie*, *J. Hosp. Infection*, 2001, 48(1): 81-82.

³⁰ Nurkin S, Urban C, Mangini E, et al., *Is the Clinicians' Necktie a Potential Fomite for Hospital Acquired Infections?*, In: Abstract of the 104th General Meeting of the American Society for Microbiology 2004, New Orleans, Louisiana. p. 204.

to the (next) patient, I fiddle with my tie. And then I transfer the MRSA back from my tie to my hands. And that's what would create the problem."³¹

Neckties are not the only potential carriers of harmful bacteria that are worn by physicians and other medical staff. A total of twenty-seven lanyards and eighteen identification badges were identified with pathogenic bacteria when seventy-one health care workers were examined.³² As reported in 2010, wristwatches caused excess hand contamination because bacteria were transmitted to hands when the watch was removed.³³

There are also concerns from researchers and news reporters toward white coats worn by health care professionals. As early as 1991, researchers concluded that “white coats [particularly cuffs and pockets] are a potential source of cross infection, especially in surgical areas” and “the level of bacterial contamination . . . increased with the degree of usage by the individual doctor” after they examined 100 white coats worn by physicians of different grades and specialties.³⁴ The Committee to Reduce Infection Deaths (RID), through chair Betsy McCaughey, PhD, also publicized their concerns stating that “[c]lothing is frequently a conveyor belt for infections. When doctors and nurses lean over a patient with M.R.S.A., their coats and uniforms pick up bacteria 65 percent of the time, and carry it to other patients.”³⁵

Possible Reactions of Patients and Physicians regarding the New Dress Code

The change in doctors’ dress will *not* jeopardize the doctor-patient relationship. Several studies have investigated patients’ attitudes toward the appearance of doctors. In 1991, the majority of patients, especially older patients, preferred doctors to dress formally with a preference for male doctors to wear a suit and tie. Wearing white coats by doctors was especially highly desired.³⁶ However, preferences have changed substantially in the past two decades. A 2008 study shows that, though professional appearance was still greatly valued by patients, most patients did not favor white coats, ties, and long-sleeve shirts any longer.³⁷ Palazzao & Hocken’s study supported this change in patients’ attitudes.³⁸

³¹ Lloyd de Vries, *How Clean is Your Doctor’s Tie?*, CBS News, May 25, 2004. Available at <http://www.cbsnews.com/stories/2004/05/25/health/main619496.shtml>.

³² Kotsanas D, Scott C, Gillespie EE, Korman TM, Stuart RL. *What’s Hanging around Your Neck? Pathogenic Bacteria on Identity Badges and Lanyards*. *Med J Aust*, 2008,188: 5–8.

³³ Jeans, A.R., Moore, J., Nicol, C., et al., *Wristwatch use and hospital-acquired infection*, *J. Hosp. Infection*, 2010, 74: 16-21.

³⁴ Wong D, Nye K, Hollis P., *Microbial Flora on Doctors’ White Coats*, *BMJ*. 1991, 303:1602–1604.

³⁵ Betsy McCaughey, *Coming Clean*, *NYTimes*, June 6, 2005. Available at <http://query.nytimes.com/gst/fullpage.html?res=9D04E0D71538F935A35755C0A9639C8B63&sec=&spon=&pagewanted=all>.

³⁶ McKinstry B., *Putting on the Style: What Patients Think of the Way Their Doctor Dresses*, *Br J Gen Pract*, 1991,41:275–278.

³⁷ Hathorn IF., *Ties and White Coats, to Wear or not to Wear? Patients’ Attitude to Doctors’ Appearance in the Otolaryngology Outpatient Clinic*, *Clin Otolaryngol*, 2008;33:505–506.

Although some researchers voiced their concern that patients' opinions may vary due to the differences of regional and temporal variations, strategies that increase patients' awareness for the reasons underlying the new dress code helped to eliminate existing negative attitudes, if there were any.³⁹ In one study that was designed to investigate patients' attitudes toward "bare-below-the-elbow," increasing awareness of the purpose of the new dress code—reducing cross-infection—successfully altered patients' original preference toward white coats and ties.⁴⁰ Shelton's study supported the proposition that patients preferred their doctors' new appearance after receiving education on the reasons of implementing the change.⁴¹

Objections were also not perceived from physicians and Medical Societies such as the American Medical Association (AMA) and British Medical Association (BMA). In one study, ninety-five physicians that represented all grades were enrolled to investigate individual physician's attitudes.⁴² The majority of them (81%) reported they "would be happy not to wear a tie to work."⁴³ Medical Societies also noticed the potential benefits of the new doctors' attire. BMA issued their new guidelines in 2006, "discarding of functionless items of clothing such as ties, which the report notes are rarely cleaned and are often worn every day" is one of them.⁴⁴

In the U.S., the House of Delegates of AMA proposed a resolution to adopt a new doctor dress code at their 2009 annual meeting. Unfortunately, a dress code was not passed and in lieu the importance of hand washing was addressed.⁴⁵ However, as was recently stated by the Committee to Reduce Infection Deaths, "[c]leaning hands is essential, but it's only the first step. Caregivers also need to learn how to prevent their hands or gloves from becoming re-contaminated before touching the [next] patient. Stand in the emergency room, and watch caregivers clean their hands, put on gloves, and then reach up and pull open the privacy curtain to see the next patient. That curtain is seldom changed, and it is frequently full of bacteria. The result? Caregivers' gloves are soiled again."⁴⁶

³⁸ Palazzo S, Hocken DB., *Patients' Perspectives on How Doctors Dress*, J. Hosp. Infection, 2009, 74:30–34.

³⁹ Wilis-Owen, C. A., Subramanian, P., & Houlihan-Bume, D.G., *Do Patient Understand the Changes in the Way Doctors Dress?*, J Hosp Infect, 2010, 75: 139.

⁴⁰ Ardolina, A., Williams, L. A.P., Crook, T. B., & Taylor, H. P., *Bare below the Elbows: What do Patients Think?*, J. Hosp. Infection, 2009, 71(3): 291-293.

⁴¹ Shelton, C.L., Raistrick, C., Warburton, K., & Siddiqui, K.H., *Can Changes in Clinical Attire Reduce Likelihood of Cross-Infection without Jeopardising the Doctor-Patient Relationship?*, J. Hosp. Infection, 2010, 74, 22-29.

⁴² McGovern, *supra* note 52.

⁴³ *Id.*

⁴⁴ Day, M., *Doctors are Told to Ditch "Disease Spreading" Neckties*, BMJ, 2006, 332 (7539): 442.

⁴⁵ Dolan, P.L., *AMA Meeting: Hand-Washing Trumps Dress Codes in Preventing Infections*, American Medical News, June 28, 210. Available at <http://www.ama-assn.org/amednews/2010/06/28/prsn0628.htm>.

⁴⁶ Committee to Reduce Infection Deaths, *MRSA Screening*. Available at <http://www.hospitalinfection.org/mrsascreening.shtml>.

Healthcare Association of New York State (HANYS) also provided comments on the issues of hygiene. During a conference call with staff members of HANYS' Governmental Affairs, it was mentioned that, at this point, some of HANYS' members have adopted policies and guidelines regulating hand-washing procedures and the cleaning process of medical equipment to address the issue of inborn hospital infection. Because vast variations exist among New York Hospitals (*e.g.*, size, geography, etc.), and because the complicated characteristics of the hospital-acquired infection, HANYS voiced their concern that the mandate of one single solution such as altering a practitioners' dress code might hinder actions to implement other strategies that are tailored, and therefore, are mostly effective for the individual hospital. "One size does not fit all" is the core concept.

However, the implementation of a new dress code may not substantially increase a hospital's burden to the extent that it impedes all other courses of action, as some dress codes are already present in hospitals. One of the sample dress codes provided by HANYS, for instance, requires "employees providing direct patient care may not wear earrings that dangle from the ear." There is no requirement to include wrist jewelry in the policy. It is also not uncommon that hospitals ban employees, including professional staff, from wearing jeans and other unprofessional clothes in the hospital setting. There is also no burden to simply add white coats, long-sleeved shirts, and ties to the list of clothes that cannot be worn. It is true that the new dress code might be more effective in some hospitals than in others due to the variations that exist between individual hospitals, but merely supplementing existing hospital dress policies should not present substantial barriers to adopting other safety initiatives.

Other concerns of HANYS were rooted in costs. HANYS mentioned that many hospitals would contract the laundry services to outside agencies if they were mandated to provide and launder scrubs for medical staff. This will inevitably increase the operating costs of hospitals, but, due to the lack of empirical data, the magnitude of the costs is unknown. However, as stated in the following "Fiscal Concern" section of this report, the supplier of uniform and work apparel indicated the service would only result in an affordable cost increase. When compared to treating hospital-acquired infections that are less and less reimbursed by third-party payers as Medicare and Medicaid,⁴⁷ the expenses of providing and laundering scrubs are considerably less than a fraction for the individual hospital.

The difficulty in regulating health care professionals' behavior is another barrier to implement the new dress code, according to HANYS. Hospitals are not comfortable, and more importantly, not confident in mandating changes in such behaviors. It is uncertain if physicians would change their street dress to scrubs at hospitals even if scrubs are readily available. This concern emphasizes a pertinent point: Strategies and

⁴⁷ Centers for Medicare and Medicaid Services, *Fact Sheets, Details for: CMS Improves Patient Safety for Medicare and Medicaid by Addressing Never Events*, August 4, 2008. Available at <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3224&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=safety&keywordType=All&chkNewsType=6&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date>.

incentives to facilitate behavioral change should also be introduced as one component of the new dress code so that the effectiveness of the new dress code is not impaired. Education and information is a prime methodology. Incentives may include reductions in medical malpractice premium rates. Appropriate and timely education that increases health care practitioners' awareness on this benefit is surely needed.

In sum, HANYS is hesitant to advocate for this initiative because the research is insufficient. Lack of national guidelines from such infection control agencies as Centers for Disease Control and Prevention (CDC) is another reason that holds back HANYS' advocacy. However, as the medical malpractice "crisis" is not as acute nationwide, and not all states are facing the severe threats, national agencies might not feel the same urgency to explore this issue as is the case in New York. Moreover, such infection control organizations usually do not adopt interventions to address medical malpractice issues. In spite of the hesitation of HANYS to favor a new dress code, the issue of high medical malpractice liability premiums was cited as among the highest priorities of New York hospitals, HANYS, Greater New York Hospital Association, the New York State Medical Society, and numerous local county medical societies. The adoption of a hygienic dress code should be reviewed and ultimately adopted in a thoughtful way to address this issue.

There is a Link Between Patient Safety and the Increasing Cost of Medical Malpractice Liability Insurance

Patient safety is always of paramount concern. However, this issue is also being studied for its economic impacts on the cost of providing health care. That is, decreasing infection rates to curtail the rising costs of health care and medical malpractice insurance rates. While defensive medicine is believed to contribute largely to the overall high cost of providing health care, a reduction in defensive medicine does not necessarily help to control the growth of medical liability premiums. Over the years, New York State has turned to the Legislature to help in this process.

This includes:⁴⁸

- **ATTORNEYS' FEES**

To limit the appeal of inflated awards for attorneys who work under a contingent fee agreement, in 1985 N.Y. Jud. Law sec. 474-a adopted sliding scale fees. Under this scale, contingency fees in medical, dental, or podiatric malpractice actions may not, without extraordinary circumstances as described in subsection four, exceed: 30% of first \$250,000, 25% of next \$250,000, 20% of next \$500,000, 15% of next \$250,000 and 10% of damages exceeding \$1.25 million. This section was most recently targeted in 2009 by Senator DeFranciso through S. 2040 which sought to repeal the sliding scale fee schedule as being unfair to injured citizens who may be counseled to settle as opposed to going to trial

⁴⁸ American Tort Reform Association (ATRA), *Medical Liability Reform*, ATRA Issues. Available at <http://www.atra.org/show/7338>.

because of curbed attorney recovery. S. 2040 was referred to the Judiciary Committee in February of 2009 and has not been passed into law.

- **PRETRIAL SCREENING PANELS, REPEALED**

Although N.Y. Jud. Law 148-a created mandatory submission of medical injury claims to a "medical malpractice panel", this provision has since been repealed. Currently N.Y. Civ. Prac. Law (CPLR) §§ 3012-a and 3406 respectively require both a certificate from the plaintiff's lawyer attesting consultation with an appropriate medical expert establishing a "reasonable basis" for the claim and a pre-calendar conference for each malpractice claim. Section 3012-a operates in tandem with CPLR § 3406, under which "plaintiffs are required to file with the Clerk of the Court, no more than sixty days after issue is joined, a notice advising that a medical malpractice action has been commenced and accompany such notice with the following: 1) proof of service of such notice upon all parties; 2) proof that authorizations to obtain medical records have been served upon the defendants; and 3) such other papers as may be required to be filed by rule of the Chief Administrator of the Courts. This discovery section of the CPLR was intended by the Legislature to expedite discovery so that medical malpractice files will not languish in the file cabinets of an attorney's office and will trigger a pre-calendar conference."⁴⁹

- **STATUTE OF LIMITATIONS**

In 1975, CPLR § 214-a was passed to limit the window in which an injured patient may recover from a medical professional. It set the window to two years and six months from injury or from last treatment where there is continuous treatment for condition giving rise to a claim. However, in the case of a foreign object, such as medical equipment wrongfully left in a patient, the time limit was set at one year from discovery or time of reasonable discovery of that object.

- **PERIODIC PAYMENT OF DAMAGE AWARDS**

CPLR Art. 50-A §§ 5031-5039 lays out the calculus for determining medical award amounts. It provides guidelines for payment of medical injury or wrongful death awards and additionally states methodology for periodic payment of future damages, those expected to be incurred, in excess of \$250,000, although parties may agree to lump sum payment.

- **JOINT AND SEVERAL LIABILITY⁵⁰**

Along with several states, New York has adopted limited joint and several liability. New York codified these principles in CPLR Art 15 and 16. Generally, a defendant who is 50% or less at fault is only severally—that is, partially as

⁴⁹ Michael T. Loffredo, *In Medical Malpractice Action, Plaintiff's Failure To Serve A Certificate Of Merit Pursuant To The Pleading Requirements Of CPLR 3012-a Can No Longer Be Ignored*. Available at http://www.clausen.com/index.cfm/fa/firm_pub.article/article/208c291f-afa1-4112-beb5-a03de9eab942/In_Medical_Malpractice_Action_Plaintiffs_Failure_To_Serve_A_Certificate_Of_Merit_Pursuant_To_The_Pleading_Requirements_Of_CPLR_3012a_Can_No_Longer_Be_Ignored.cfm.

⁵⁰ American Tort Reform Association, *supra* note 7.

opposed to fully—liable for non-economic damages, with exceptions of certain courses of action such as automobile accidents.

New York has also enacted laws to control the growth of medical malpractice rates by mandating malpractice carriers to obtain approval from the State Insurance Department (SID) before they raise the premiums (§ 40, Chapter 266 of the Laws of 1986). Moreover, to ensure that all doctors and hospitals have access to malpractice coverage, the state created the Medical Malpractice Insurance Association (MMIA, which was replaced by the Medical Malpractice Insurance Plan, MMIP in 2001) by an Act of the Legislature in 1975. As of October 2010, New York State had not yet reach consensus for further medical malpractice tort reform.⁵¹

Aside from tort reform, in 2011 S.2809-D/A.4009-D (Budget Bill) § 52 created an indemnity fund to help reduce premium costs for medical malpractice insurance, primarily from obstetricians, by adding Title 4 to Article 29-D of the Public Health Law. This fund is targeted towards funding “future health care costs associated with birth related neurological injuries”.⁵² The fund’s custodian is the commissioner of Taxation and Finance and it is administered by the Superintendent of Financial Services who makes payments to claimants who have either a court order or settlement derived from a birth-related neurological injury.⁵³ However, either party may apply for the indemnification, even retroactively before the fund’s enactment, thus the health care practitioner who is the subject of the claim may also ask to be indemnified so long as he or she meets the criteria. By indemnifying these types of claims, New York helps to counteract a source of the rising insurance premiums experience by obstetricians, historically the bearers of some of the highest insurance rates in the medical profession, which should help to lower the overall medical malpractice costs in New York.

However, regardless of all of these efforts that New York State has adopted to address the problem of rising medical liability insurance premium and payouts, New York health care providers still pay the highest premium rates for their medical malpractice coverage in the country.⁵⁴ Between 1999 and 2004, the cumulative premium increase was 147%, which is an average yearly increase of 27%.⁵⁵ In 2007, Healthcare Association of New York State (HANYS) President Daniel Sisto cited a 14% medical malpractice insurance premium rise that occurred that year as “another warning that our

⁵¹ New York State Department of Health Press Release, *New York State to Conduct Medical Liability Reform Demonstration with \$3 Million Federal Grant*, 2010. Available at http://www.health.state.ny.us/press/releases/2010/2010-06-16_medical_liability_reform_demo_3_mill_fed_grant.htm

⁵² S.2908-D/A.4009-D (Budget Bill) of 2011.

⁵³ Under § 2999-h (1), a “‘Birth-related neurological injury’ means an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery, or resuscitations or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both.”

⁵⁴ New York State Department of Health, *supra* note 2.

⁵⁵ Greater New York Hospital Association, *supra* note 1, at 4.

malpractice system is in complete disarray”.⁵⁶ These “double-digit growth in malpractice premiums will only make it harder for hospitals to fill those positions [doctor shortages]”.⁵⁷

These skyrocketing malpractice premiums, paralleled by large compensation awards, exacerbated the issue of accessibility and affordability of health care in certain specialty services. For example, in a 2003 report of the United States Government Accountability Office (GAO), “Medical Malpractice: Implications of Rising Premiums on Access to Health Care”, the researchers reviewed the access issue in five states and found that hospital-based emergency surgery and newborn deliveries were negatively affected by the rising malpractice premiums.⁵⁸ In New York, the availability of obstetrics was adversely impacted by the malpractice crisis. According to a literature review conducted by Greater New York Hospital Association,⁵⁹ hospitals shutting down their obstetric departments or reducing the number of obstetric beds occurred in both upstate and downstate New York. A shortage of OB/GYN practitioners has occurred and will persist due to high medical liability premiums. This has also resulted in fewer new practices opening in-state and the early retirement or relocation of existing physician practices to lower-cost states.

New York State is not unique in facing these difficulties and in the possible ineffectiveness of tort reform to address them, according to various studies. There lacks conclusive evidence that the majority of tort reforms are able to restrain the growth of medical malpractice premiums.⁶⁰ New York may be unable to enact meaningful reforms to curtail future increases in the cost of obtaining medical malpractice insurance and providing medical care. Even if some reforms were possible, it is likely they would only have a moderate effect on controlling malpractice premiums and many raise equity issues for severely injured.⁶¹ Preventable adverse events have resulted in large individual claim payouts, as reported by an article in LawyersUSA and other news reports. Examples of various medical malpractice cases that were recently resolved for several million dollars are:⁶²

⁵⁶ HANYS News Release, *Statement by HANYS President Daniel Sisto on the 14% Medical Malpractice Insurance Premium Increase*, July, 2007. Available at http://www.hanys.org/communications/pr/2007/upload/07_03_07_medmal_statement.pdf.

⁵⁷ *Id.*

⁵⁸ GAO-03-836 *Medical Malpractice and Access to Health Care*.

⁵⁹ Greater New York Hospital Association, *GNYHA Study Shows Deepening Medical Malpractice Crisis in New York*, Vol. 8, 2005. Available at <http://www.gnyha.org/372/Default.aspx>.

⁶⁰ Robert Wood Johnson Foundation, *supra* note 4; Greater New York Hospital Association, *supra* note 16; Fan, J., et al., *U.S. Medical Malpractice Enjoys Profitability, but Tort Reform Still Uncertain and Volatility Anticipated*, May, 2006. Available at <http://www2.standardandpoors.com/portal/site/sp/en/eu/page.article/2,1,5,0,1145727886634.html#TOP>

⁶¹ Robert Wood Johnson Foundation, *supra* note 4.

⁶² Hospital Malpractice, *Hospital Infection Medical Malpractice Lawsuits Increase*, Oct., 2010. Available at http://webcache.googleusercontent.com/search?q=cache:5GUc1BBqGYoJ:law.freeadvice.com/malpractice_law/hospital_malpractice/hospital_infection_lawsuit.htm+medical+malpractice+claims+nosocomial+infection&cd=8&hl=en&ct=clnk&gl=us.

- **November 2008:** The family of a Massachusetts woman who died of a flesh eating bacteria virus while in a hospital for cancer treatment for Ewing's sarcoma was awarded \$13.5 million in a jury verdict.
- **November 2008:** A Utah woman contracted a flesh eating bacteria and lost three of her limbs and several of her organs while in a hospital delivering her child and settled her case for \$16 million.
- **July 2008:** A Missouri man contracted a staph infection and lost his kidney, a leg and a foot while in the hospital having a pacemaker inserted and was awarded \$2.58 million.

Due to the adverse consequences of high rates of medical liability premiums and compensation awards, coupled with ineffective adoption of reform and a persistent use of defensive medicine, approaches targeting patient safety have become a popular topic among researchers in the area. For example, William M. Sage, MD, JD, a professor of Law in Columbia University, stated “patient safety may therefore serve as a bridge between medical liability and health policy” in his article published in *Health Affairs* in 2003.⁶³ In 2005, researchers in Congressional Research Service (CRS) reported to Congress that “it may be appropriate and timely to re-consider these issues [patient safety concerns and medical malpractice issues] collectively, and re-visit the role patient safety initiatives could play in the prevention of both medical errors and medical malpractice” based on their observation of legislation from various states and a variety of research findings that “have explored the links between the two issues”.⁶⁴

Current New York Law

There is currently no legislation to require hospitals or other health care facilities, public or private, to adopt hygienic dress codes for physicians and other medical staff who work at these facilities. According to the Healthcare Association of New York State (HANYNS), some hospitals have adopted policies which require clean clothing and guidelines regarding wearing jewelry, such as forbidding dangling earrings. However, there are no specific regulations which target the length of white laboratory coats, dress shirt sleeves, disinfecting health care facility identification badges, or which target the presence of neckties. This may be because it was not realized until relatively recently that long coats, sleeves, identification badges, neckties, and even jewelry can harbor harmful bacteria, and therefore, can potentially increase the risk of nosocomial infections which has historically lead to large jury awards due to the severity of the resulting injuries and treatment necessary.

Why Patient Safety?

In the CRS report, patient safety was defined as “the panoply of rules, practices, and systems related to the prevention of patient injury, also known as ‘adverse events’ ”.

⁶³ Sage, W., *Medical Liability and Patient Safety*, Health Affairs, 2003, 22 (4): 26-36.

⁶⁴ Fernandez, B. & Larkins, F., *Medical Malpractice: The Role of Patient Safety Initiative*, Congressional Research Service (CRS) Report for Congress, order code RL32092. Available at <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3209201242005.pdf>.

The patient safety issue had not reached a national prominence until the publication of Institute of Medicine (IOM) report, *To Err is Human: Building a Safer Health System*.⁶⁵ However, well before its publication, States and researchers had become aware of the beneficial effects of enhancing patient safety to prevent medical errors.⁶⁶ For instance, the State of California included patient safety and physician disciplinary activities, along with such other reforms as limiting damage awards, in the Medical Injury Compensation Reform Act (MICRA), which was passed during the first malpractice insurance “crisis” in the mid-late 1970’s. The significant adverse health and financial consequences incurred by individual patients, their families, and the nation resulted from medical errors were observed by researchers during the 1990’s, though it was not connected to medical malpractice in state and federal legislature.

Links between medical errors/patient safety and medical malpractice “crisis” were highlighted by more recent researchers. Two studies published in 2006 indicated that 73% of settled claims included medical errors.⁶⁷ Although there are detractors of this connection,⁶⁸ the Federal government started to emphasize the adoption of more related demonstration programs. For instance, the Patient Protection and Affordable Care Act (PPACA) (P. L. 111-148) was signed into law March 23, 2010 and establishes grants for initiatives that promote patient safety by collecting and analyzing related data.⁶⁹

In the scientific arena, researchers are beginning to realize that “emphasis on liability and damage awards [alone] negatively impacts the patient-provider relationship, which, in turn, affects malpractice claims.”⁷⁰ Experiences from the aviation industry suggested that a system safety approach is better than solely relying on professional liability.⁷¹ That is, it is better to examine the big picture of an issue—in this case, the infections which are the cause of malpractice claims rather than simply addressing the resulting legal action and inflated awards. Studies show that, rather than rising frequency of claims being filed, the increase of severity of cases, illustrated above, is one of the

⁶⁵ American Committee on Quality of Health Care in American, Institute of Medicine, *To err is Human: Building a Safer Health System*, National Academies Press 1 ed. 2000.

⁶⁶ Fernandez, B. & Larkins, *supra* note 23, at F. P4.

⁶⁷ Studdert, D., et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, New England Journal of Medicine, 2006, 354 (19): 2024-2033; *see also* Bloom, J., *Disproving Frivolous Myth*, The National Law Journal, July, 2006.

⁶⁸ For example, filed claims that involve negligence only account for 17%-22% of all, and as few as 2-2.5% of negligent adverse events were filed by patients suffered from negligence. *See, e.g.*, Studdert, D. *Medical Malpractice*, New England Journal of Medicine, 2004, 350 (3): 283-292; White, M., *The value of Liability in Medical Malpractice*, Health Affairs, 1994, 13 (4): 75-87; Thomas, E., et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, Medical Care, 2000, 38 (3): 261-271.

⁶⁹ Fernandez, B., et al., *Medical Malpractice Insurance and Health Reform*, CRS report for Congress, April, 2010. Available at <http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=25648>.

⁷⁰ Fernandez, B., et al., *Medical Malpractice Insurance: The Role of Patient Safety Initiatives*. CRS report for Congress, June, 2006. Available at http://www.abanet.org/poladv/priorities/mpl/CRS_SI.pdf.

⁷¹ Bovbjerg, R. R., Miller, R. H., & Shapiro, D. W., *Paths to Reducing Medical Injury: Professional Liability and Discipline vs. Patient Safety – and the Need for a Third Way*, Journal of Law, Medicine, & Ethics, 2001, 29: 369-380.

major factors that contributed to soaring premiums.⁷² Therefore, through a system's safety analysis, huge jury awards that result from a preventable adverse event (including nosocomial infection) are obviously an important contributor to the skyrocketing medical malpractice premiums. This provides a sound rationale for targeting patient safety for a solution of rising medical malpractice costs/premiums.

The Independent Democratic Conference's Recommendations

As discussed above, adopting a new hygienic dress code has the potential to reduce MRSA and other viral or bacterial infection rates in New York hospitals and other health care settings. This reduction in nosocomial infections can result in improved patient safety, which is critical to reducing health care costs and curtailing medical liability insurance premium increases.

The IDC has introduced legislation that will help establish a hygienic dress code for medical professionals. Under the legislation, a 25-member advisory council made up of experts appointed by the Commissioner of Health will be charged with developing the codes. Areas of examination would include:

- Barring the wearing of neck ties for doctors and hospital workers in a clinical setting;
- Adopting a "bare below the elbow" policy: wearing short-sleeve shirts, cleaning identification badges, avoiding wearing wrist watches and jewelry, and abandoning long white coats;
- Providing education to patients and practitioners about how the new hygienic policy helps reduce cross-infection;
- Requiring hospitals to provide an adequate supply of scrubs to medical staff to ensure frequent change;
- A ban the wearing of uniforms outside of the hospital, or other health care setting.

Financial Incentives to Implement a New Hygienic Dress Code

In cooperation with the New York State Insurance Department and Health Department, implementing this new dress code could help reduce both health care provider and facility liability as well as exposure to future medical malpractice actions and payouts that arise from such actions. The savings for such providers could be two-fold.

First, it could reduce the number of medical malpractice actions that are filed. This could lead to substantial savings in legal costs to defend such actions. Unlike other

⁷² The other two factors are insurer mismanagement and deteriorated return on investment. These two factors are not detailed discussed in this report as they are not closely related to dress code.

forms of malpractice actions, defending medical malpractice actions is very expensive in the time that needs to be devoted by attorneys and expert witnesses. Reducing the number of actions could generate substantial savings in overhead costs to manage the overall medical malpractice payment system.

Second, the severity of judgments awarded by the judiciary may be reduced because there would be fewer court cases in which a sympathetic jury awarded substantial verdicts to persons who, through no fault of their own, contracted an inborn infection such as MRSA or similar severe infection or condition.

Through the rate setting powers of the New York State Insurance Department, reductions in medical malpractice insurance premiums could be awarded to health care providers that initiated effective new hygienic dress code policies that demonstrated an actuarially appropriate reduction in liability exposure. This financial incentive could offset the costs of establishing and enforcing any new hygienic dress code policy.

Fiscal Concerns

There may be additional operating costs for physicians, other health care providers, and hospitals under the provisions of this proposal. Before moving forward with this proposal, the fiscal implications and medical practice insurance cost savings would need to be analyzed. Obviously, requiring physicians to be bare below the elbow and to not wear a tie will have little cost. Not wearing long white coats and other uniforms outside the hospital building does not financially hurt physicians. The only cost that could be experienced is the expense to provide and launder scrubs for medical staffs if that service is to be provided. However, as stated by Adam Soreff of UniFirst, a leading supplier of uniforms and work apparel programs to businesses throughout the U.S. and Canada, specialized uniform rental service⁷³ “costs less than a daily cup of coffee per wearer”.⁷⁴ If true, this may be an extremely small cost when compared to the costs to cure one infection or to pay for one jury award. Not to mention that it begins to lower the injury rate to both young and old patients. According to RID, the average costs to cure one infection is \$15,275, which can be “translated into more than 7,000 changes of rental lab coats or scrubs”. If the costs are examined from a societal perspective,⁷⁵ the costs of new dress codes may be small when compared to the average jury awards in medical malpractice cases, which “has tripled to \$3.5 million since 1994”.⁷⁶

⁷³ Such services are designed particularly for healthcare workers to produce a long-lasting, sanitizing cleanliness of their uniform. The services include pick-ups, deliveries, automatic repairs and replacements, and use self-sanitizing, EPA-approved wash formulas and handling procedures.

⁷⁴ PRNewswire, *Clean Uniforms Can Help Hospitals ‘Cure’ \$30 Billion in Infection-Related Overhead*, June 25, 2010. Available at <http://www.prnewswire.com/news-releases/clean-uniforms-can-help-hospitals-cure-30-billion-in-infection-related-overhead-97167679.html>.

⁷⁵ Contrary to organizational point of view that only investigates the costs incurred by one organization, say a hospital, the societal perspective requires the examination of costs incurred by various parties, which usually includes, but not limited to, patients and their families, insurance carriers, and government agencies.

⁷⁶ Mpmlc.com, *About Medical Liability Insurance*. Available at <http://www.mpmlc.com/>.

Conclusion

The patient safety approach should be more actively considered as a reasonable alternative to help lower patient injury and to curtail future medical malpractice insurance premium increases. Based on a system safety approach, the possible stalemate in adopting meaningful tort reform in New York, and the size of jury awards stemming from nosocomial infections which drive up the premiums, this is the logical direction which will address both patient safety and economic concerns.

The dual benefits of lowered patient infections in all medical arenas ranging from public and private hospitals to doctors' offices to even retirement homes, should reduce liability expenses, diminish medical malpractice premiums, and help to reduce overall costs of providing health care. With the reduction in premiums and in infection rates, it may also effect a change in the use of defensive medicine which is also increasing health costs while lowering accessibility. Particularly for New York State which is losing practitioners, especially OB/GYN professionals, enacting a hygienic dress code as specified in this proposal is an avenue to responsibly reduce the fast growing incidences of MRSA and other bacterial and viral infection while contemporaneously providing economic benefit and better health care for the citizens of New York.

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