

*Testimony of Raymond T. Wagner, Jr.*  
*Before the*  
*United States House of Representatives*  
*Committee on Energy and Commerce*  
*Subcommittee on Oversight and Investigations*  
*On the subject of*  
*Public Reporting of Hospital-Acquired Infections:*  
*Empowering Patients, Saving Lives*  
*March 29, 2006*

Chairman Barton, Chairman Whitfield, Members of the Committee,

Thank you for the opportunity to appear before you today to speak about this very serious issue of hospital-acquired infections.

My name is Ray Wagner. I am from St. Louis, Missouri. I am employed by Enterprise Rent-A-Car where I serve as the Government Relations and Legislative Vice-President. However, I do not appear before you today as a representative from my company. I appear before you today as a father.

I thank this Committee for involving itself in this issue. As you will undoubtedly learn, this growing phenomenon of hospital-acquired infections is reaching epidemic proportions. It is time that state and Federal policy makers undertake a comprehensive, and even coordinated, look at these infections. The Center for Disease Control has estimated that 90,000 deaths per year are caused from hospital infections. Nearly 3/4 of the deadly infections or about 75,000 were preventable according to the CDC, the result of unsanitary facilities, germ-laden instruments, unwashed hands, and other lapses in hospital practices. Astoundingly, deaths linked to hospital germs represent the fourth leading cause of mortality

among Americans, behind major heart disease, cancer and lung ailments according to recent studies. These infections kill more people each year than motor vehicle accidents, fires and drownings combined. In addition, according to Consumers Union, one in 20 hospital patients will get an infection while being treated for an unrelated health care problem, thus translating to almost two million patients each year. And yet, it seems there has been a quiet paralysis in the medical and hospital community about what to do about this problem.

I appear before you because my family is one of these statistics. My son is one of those nameless, faceless statistics which we read about all too often with increasing frequency on an almost daily basis.

I will begin by telling you a bit about the nosocomial infection or staphylococcus aureus infection which infected my son, Raymond Wagner III. Today, Raymond is a healthy junior in high school. He is an honor student, currently studying in Europe at the International School of Luxembourg while my wife is working in Luxembourg for the time being. Raymond wishes he could be here, but that is not possible under the circumstances. On his behalf, I have submitted his brief statement for the record. And, with the Chairman's permission I have a brief video which I would like to show at the end of my remarks.

On Christmas Eve, December 24, 2002, the day before Raymond's 14<sup>th</sup> birthday, we had a beautiful snow fall in St. Louis. That afternoon, Raymond, then 13, went out to ride his sled behind our house with some friends. While he was playing, he suffered a serious break to his left humerus bone from falling off his sled as he was coming down the hill. When his brother raced in to tell us about the accident and I saw Raymond moments later, I knew instantly that we had a problem. We put him in the car. I drove him on the snow-covered roads to a local hospital. Once in the hospital, pain medication was administered and X-rays were taken. As was immediately clear from the X-rays, the orthopedic surgeon on call

explained that he would need surgery on his left arm due to the seriousness of the break.

After consulting with his pediatrician, we calmly and coolly determined to move him in an ambulance to a different hospital where he would be attended to by a more experienced surgeon specializing in pediatric, orthopedic surgeries. His surgery appeared to go well, although he received a screw and two pins in the area of his elbow. Raymond was discharged the next morning, on Christmas day, also his 14<sup>th</sup> birthday.

In the following days, a fever developed and persisted. There were several immediate trips to the hospital where we were told that such a fever was normal following such a traumatic break. To make a nearly year long story very short, Raymond had acquired staph infection which also developed into osteomyelitis, meaning the infection had burrowed into his bones. In total, he endured six additional surgeries and surgical procedures following the initial surgery. All of this, we firmly believe resulted from his broken arm. It was a serious break, but one without a cut or tear to the skin when he arrived in the hospitals.

Cumulatively, Raymond spent several weeks in the hospital. It seemed all too often we were meeting with his medical team of orthopedic surgeons, infectious disease doctors, pediatricians and nurses only to learn that we had not yet rid his body of this invader, and that we needed one more surgery. We were devastated each time we were informed that the infection had returned. He endured bone scans, CAT scans, ultra-sound scans, X-Rays, aspirations, hearing tests and kidney tests due to the strong medicine, all to name just a few procedures. He can even tell you about one surgery he well remembers where he was awake with his eyes closed during the surgery because he was not given enough anesthesia for a boy his size; he remembers every detail of that surgery.

During the ordeal, Raymond spent many months with a “PIC line” inserted into his arm. In this procedure, a plastic catheter tube was inserted through his veins in the area of his wrist where it was threaded up his arm and into his chest muscle to inject antibiotics into his upper body. The line originated from a pump strapped around Raymond’s waist for several months, 24 hours per day. When the veins in Raymond’s arm failed and he could no longer sustain the PIC line, he received something known as a “Broviac catheter pump.” This was surgically imbedded into his chest cavity right above his heart, again connected to a strapped pump for several months. And, there were regular visits from the home health professionals for wound cleanings, broken equipment, pulled catheter lines, and concerns of further infections. Fourteen year old Raymond became extremely adept at changing his dressings and antibiotic packets.

Once the Broviac pump was removed from his chest, Raymond underwent a very structured antibiotic pill regiment for many months. He consumed two large pills at exactly 6:00am, noon, 6:00pm and midnight. He spent countless hours in physical therapy to stretch his arm, which had frozen into a right angle during the course of his surgeries and subsequent casts and braces. He dutifully engaged in many months of early morning and evening stretching exercises to regain the full use of his arm.

Needless to say, Raymond missed many days of school. He was, however, able to perform the role of the Cowardly Lion in his 8<sup>th</sup> grade school play, the Wizard of Oz; he was escorted from the hospital by a nurse and he was returned to the hospital right after the play that evening where he was reconnected to his lines and monitoring devices. Raymond missed baseball that spring, swimming that summer, and most unfortunately - in his mind - football that fall, his freshman year in high school. He was also scheduled to be a junior lifeguard during that following summer. He had competed for one of these few positions and he was

excited for the opportunity. He was able to remain working for the pool, although he was forbidden from getting wet. Raymond spent that summer monitoring the pool deck for running children.

My family and our relatives, friends and colleagues endured many days of anxious agony. One very poignant moment captures the essence of the agony of this whole experience. As Raymond's mother and I were talking to the team of infectious disease doctors and other doctors over his bed one evening, one doctor looked at our boy in his bed and asked if he had any questions. He replied, "Yes. Am I going to die from this?" We assured him that he would not die; we would not let that happen to him. His mom and I looked at each other. We were not so sure. Raymond next asked, "Am I going to lose my arm?" Again, we assured him that would not happen. We told him we would go anywhere and do anything we needed to ensure that he would not lose his arm. (Then he pushed the envelope too far and asked if he would be able to play football at St. Louis University High School in the upcoming fall of his freshman year in school. He served as the team manager that freshman season and waited until his sophomore year to play.)

Today we believe Raymond's infection is cleared up. Although, one cannot be certain for sure; the staph infection may spring back to life someday with a slight trauma of some sort. In addition, Raymond is unable to fully extend or flex his arm, even though it is fully functional. We want to believe we are through the most difficult stages. We thank God and we consider ourselves to be among the lucky ones in light of what these infections are doing to thousands of families across the country each year.

Aside from the very real human emotional costs, another dimension to this problem is the financial costs to victims of hospital-acquired staph infections. We spent several thousand dollars in miscellaneous expenses associated with Raymond's treatments, including co-pays, deductibles, out of network

expenditures, unreimbursed expenses etc. And, of course, as is probably all too common, we had ongoing battles with certain providers about expenses and coverages which took over two years to resolve. From my conversations with many others who have endured hospital-acquired infections, they have suffered similar financial experiences and strains. And, of course, there were the lost days of work for Raymond's mother and me.

We were not content to simply thank our lucky stars. Raymond had suffered too much and the family had made too great a sacrifice to not see something positive come out of this ordeal. We kept telling Raymond throughout his treatments that something good would come from this. Yet, the question which haunted me, as a parent, throughout all of this was: How could this have happened to us? We live in a community with more than a dozen excellent, highly-regarded hospitals. I had even transferred my son on the evening of his accident from one hospital to another where I thought he might receive better care from the specialist on call that evening. How could we have known that the hospital we chose might be more likely to cause our son a hospital staph infection which threatened his life? The answer at that moment was that we simply could not have known whether one hospital was more prone to cause infections over another hospital in our community. There was no form of public or non-public reporting or comparisons of hospital-acquired infection rates.<sup>1</sup>

Standing in line at the pharmacy to refill a prescription for Raymond, I saw the February 2003 publication of Readers Digest. The cover read "FATAL HOSPITAL MISTAKES How to Avoid Them." I found myself reading the entire

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<sup>1</sup> Missouri statutes and regulations are replete with reporting requirements for other issues. For example, genetic and metabolic diseases in newborns are reportable to the department of health. Animal bites are to be reported to the department of health. Hospitals are to report AIDS, arsenic poisoning, carbon monoxide poisoning, different venereal diseases, mercury poisonings, hepatitis, lime disease, mumps, pesticide poisoning, respiratory diseases triggered by environmental contaminants, rocky mountain spotted fever, salmonellas, tetanus, toxic shock syndrome, West Nile fever and even leprosy, only to name a few. Yet staph infections were not reportable and the information was not collected by the department of health in any fashion. Any yet staph infections are the fourth leading cause of death in this country behind heart disease, cancer and lung ailments.

related article entitled “Death Beds. Dirty hospitals kill 75,000 patients a year. Unnecessarily.” before I left the pharmacy. The basic premise of the article was that hospitals do have the capacity to take steps to minimize staph infections; the article underscored that there is little government regulation to force hospitals to step up infection control. About the same time, I learned that Pennsylvania and Illinois had passed laws to require public reporting.

Inspired by this article and the actions in Pennsylvania and Illinois, Raymond and I discussed the idea of starting an effort to require public reporting in Missouri. It was too late at that point for the 2003 session, so we focused on the next 2004 legislative session. I wrote a draft, starting with the Illinois and Pennsylvania reporting laws, as well as concepts from other Missouri reporting laws. I contacted the Consumers Union which had just undertaken a major initiative to address the subject of hospital-acquired infections. I am very grateful to the Consumers Union for its tenacious efforts which can be reviewed at [www.stophospitalinfections.org](http://www.stophospitalinfections.org), and in particular Lisa McGiffert who is here today. Together, we prepared a model bill which we would introduce in Missouri and hopefully other states around the country. (Legislation has been introduced in 30 states this year and six states have passed reporting bills: Illinois, Pennsylvania, Missouri, Florida, Virginia and New York.)

With this first draft of a public reporting type bill in Missouri, we joined forces with a then-freshman State Representative who is also a practicing medical physician. Dr. Robert Schaaf had a very keen interest in hospital-acquired infections. We approached the Missouri Hospital Association and ultimately enlisted their help and support in refining a bill that would be workable and acceptable to the hospitals. From this effort, Senate Bill 1279 was introduced.

In short, SB1279 requires the department of health to make available on their website risk-adjusted infection rates for certain types of infections such as

class I surgical site infections, ventilator-associated pneumonia, central line-related bloodstream infections, and other infections defined by rule by the department. The bill also requires hospitals to monitor for compliance with infection control regulations. The bill required the department of health and an advisory committee of mostly medical experts to work out the technical, finer details of the reporting system. This bill provided effective dates well off into the future in order to allow the department, the advisory committee and the medical community sufficient opportunity to develop specific guidelines to deal with these important matters. In addition, this bill directed the advisory committee to draw upon the considerable body of expertise and methodology established by the Federal Centers for Disease Control and Prevention National Nosocomial Infection Surveillance System.

The simple philosophy behind this bill is that a certain level of public reporting on hospital-acquired infections will serve the public in two ways. One, patients will be given an opportunity to evaluate their health care facility choice and therefore make more informed decisions. More importantly, hospitals will work diligently to improve their outcomes on publicly reported indicators which will help facilitate the adoption of best practices of patient care (hand washing, surgery prep, cleanliness, etc) thus minimizing such infection rates in hospitals.

Prompt passage of SB 1279 proved very successful. The effort had enthusiastic sponsors in both Chambers of the legislature. The process was transparent and inclusive of all concerned. SB 1279 passed the legislature in a single session. It passed unanimously in the Missouri Senate and with all but one vote in the House of Representatives. The Governor signed the bill in a large signing ceremony.

My son Raymond and I testified before the Missouri legislature. We together visited and called legislators about the bill. His story received considerable attention. The bill became widely known as “Raymond’s Bill”.

During that process, it became apparent about how many people are affected by hospital-acquired staph infections. Lobbyists, legislators and their staffs all freely and willingly joined in the effort because of their own experiences. The various business groups and consumer groups all saw the benefits to be derived from SB1279. While the cause was predominantly consumer and patient driven, the hospital association and other medical groups ultimately embraced this issue in an effort to do something constructive to address these staph infections.

Notwithstanding the benefits of disclosure and public reporting, I have come to recognize that it is not as easy as simply reporting raw incidences of hospital-acquired infections to a department of health for a public report. A system must address issues relating to the patient-base or type of the hospital, the types of infection, the disparate statistic gathering practices within those hospitals, and so on. Each of these must be taken seriously. But, to let these doubts and issues overcome any solution or serious effort to address the problem would be a grave injustice to the victims of hospital-acquired infections.

Some critics of public reporting have said a reporting law can not be consistently applied from hospital to hospital. They contend it would cause hospitals with scrupulous reporting practices to look unfavorable as compared to hospitals with less- meticulous practices. While I recognize the complexity of the task, I don't accept this premise. As a society, we are able to apply health codes to rate all kinds of restaurant establishments. We are able to apply a complex set of state and Federal tax codes to every type of business, as well as individuals. We have building codes, traffic codes, uniform labor codes, all to name just a few. I believe these challenges can be overcome with proper guidance and instruction at the state and Federal level, experience in gathering statistics, potential adverse licensure consequences for intentional under-reporting, etc.

Some say that public reporting will be flawed due to differences in the types of hospitals and the practices and services they offer. A rural hospital and an urban hospital will have different reportable experiences; a teaching hospital and non-teaching hospital will have different reportable experiences; a critical-care hospital will have different experiences; and so on. I believe states are developing valuable experiences to address these issues. Missouri, for example, has developed categories for hospitals and surgical procedures. The Missouri statute also calls for risk-adjusted assessments. I think much can be learned from the growing volume of state experiences.

Some raise the difficulty in distinguishing between hospital-acquired infections and community-based staph infections which also are reportedly on the rise. There is concern that any hospital reporting system may falsely include staph and other serious infections acquired outside of the hospital. Reporting systems will have to be sensitive to this. In Missouri, the law focuses primarily on Class I surgeries i.e., surgeries where the patient does not have an open wound upon arrival in the hospital. In my son's case, he arrived at the hospital with no broken skin. Surgery was performed on his left elbow. The infection and osteomyelitis was located at the surgery site. It was clear to me that this was likely a hospital-acquired infection, not a community-based staph infection. On the other hand, patients arriving in the hospital burn unit should not be placed in the same category as Class I surgery patients.

I spoke earlier of the financial cost to my family. I would venture to say that the overall cost on the national health system for hospital acquired infections is staggering. And so much of it can be avoided. I mentioned the costs to my family and the several thousand dollars this cost us. The balance of most of those costs was covered by my health insurance carrier. Ultimately, in theory, employers absorb these costs the following year through increased co-pays, higher

deductibles, etc. And for those victims of staph infection who have no insurance, the system as a whole absorbs those expenses. At that point, all consumers and taxpayers pay. I can not begin to quantify what must be a very large amount, but it becomes easy to see that all of us are absorbing a tremendous cost, much of which might be avoidable if hospitals reduced the incidences of these infections.

During the course of our work on Missouri SB1279, it was important for me personally to underscore that our involvement in this cause, like our involvement here today, was never about assigning any blame or embarrassment to any hospitals for my son's staph infection. Nor is it about in any way disparaging hospitals or the important work they do. We certainly never considered any sort of legal recourse. I personally, have nothing but gratitude and respect for the doctors, the scientists, their teams and hospitals involved in my son's case. I have never publicly named the hospitals or doctors involved in my son's case. Our simple goal was to help put a spotlight on a growing very serious problem. We wanted to stimulate discussion about how imperative it is for hospitals to reduce their infection rates by all available means. In my opinion, hospitals were not leading this discussion, as they should. This is the positive outcome we wanted to see come from Raymond's ordeal. In Missouri, the policymakers concluded that public reporting was the most important way for consumers to pick the best and safest hospitals. Other states are adopting similar measures, and still other states are taking other approaches. I can't tell you for sure that Missouri has adopted the best approach. I hope that in ten years we will look back on the Missouri approach and recognize that it was a good first step, but that it evolved and improved.

I respectfully ask this Committee and Congress to study all of the approaches under consideration by the states today, as well as the Centers for Disease Control. I encourage you to collaborate with CDC and other government experts to study what works. I encourage you to include the medical community

and hospital community. I urge them to embrace this issue of hospital-acquired infections and to earnestly look for solutions to this major health threat with a level of commitment they have not universally shown to date. This effort needs their expertise. And, I believe it is critically important to include individual consumers in this process, people such as myself who have been touched by hospital-acquired infections. This effort needs their motivation.

Together, I believe we can make huge advances toward minimizing the devastating consequences of these all too frequent infections so that other hospital patients do not have to become a statistic like my son, Raymond.

Thank you, Mr. Chairman and Members of the committee.