Decade of progress: Decade of change
The future is now!

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Over the short history of infection control practice, a mere quarter century, those of us in the profession have witnessed, developed, and adapted to continuous change. In spite of responding to this rapid change, we are constantly urged to reevaluate what we are doing, as well as how we are doing it.

We continue, challenged with new ideas, new processes, and new information. Indeed, even some of the microorganisms and diseases we deal with are new discoveries (and actually, the microorganisms are better adapters to their environment than some of us).

Fifteen years ago, those of us in the profession were not always sure how we became infection control practitioners. Some of us were conscripted into service and some assumed our positions because of our expertise, but all of us were risk takers. We actively supported this new position and the challenges inherent in it. We did not always know what the position entailed, but we were eager to assume new challenges and opportunities and to assume a leadership role in an emerging profession.

The science of infection control as a unique entity was in its developmental stage. Most of the tools that were proffered to guide our actions were based on limited information, scientific public health principles, tradition, or our own imagination. There were no textbooks or journals devoted to infection control, only the beginnings of a newsletter, and few, if any, appropriate educational and audiovisual aids.

Most of our education and training was on-the-job training. Many of us attended the only available formalized course provided by the Centers for Disease Control.

Isolation, not disease-specific or categorical but personal, was a major problem. As the only infection control practitioners within a hospital, and in many cases within an entire city or state, shared ideas and problem-solving were still luxuries not easily found. However, networking when available with other neophyte infection control practitioners was our most useful and used resource.

Much of our time was spent in doing surveillance. Full hospital surveillance was the expected norm, and almost more time-consuming than the surveillance was the monthly compilation of the surveillance data. The data were organized in a variety of creative ways, showing infection by site, pathogen, patient placement, sex, age, risk factors, and surgeon-specific wound infections. Line listings, infection rates, patient-days, and number of discharges: all of these terms became a part of our everyday language. Often many of the data were not fully appreciated, although the monthly report came to be expected by the members of the infection control committee required by the Joint Commission on the Accreditation of Hospitals. But how the data were to be used was often left unanswered, except to file.

The Association for Practitioners in Infection
Control (APIC) was also in its infancy. Started by a handful of infection control practitioners, the Association was developed as a means of providing mutual support, communication, and education. APIC became a forum for practitioners to formalize interactions, encourage one another, teach and counsel each other, and strategize toward consistent approaches to solve the many infection control problems found in acute care settings.

Even 10 years ago, when APIC first met in Miami, the situation was changing. Although the environment for practitioners was different, it was still far from perfected. During this period, many infection control practitioners were realizing that surveillance, although important, could not be the major thrust of their infection control program, but should complement other infection control activities. The education of hospital staff, development of infection control policy and procedure, and infection control methodology became higher priorities. Infection control departments were instituted in more than 50% of the hospitals in the nation, and our departments were beginning to expand. Infection control personnel were becoming more assertive and self-directed. With the growing awareness of the importance of facts, we began research projects, and some of us published our studies.

APIC also changed. Our membership increased, not incrementally, but exponentially. From our meager beginnings, we now numbered more than 2000 in the late 1970s. Organizationally, we recognized our leadership role and worked diligently to provide our members with what they needed most: educational tools. Not only did APIC produce annual conferences, but we also provided a variety of services and educational information, including publications.

During this recent decade, even more changes have taken place in our profession. Today, infection control, although young when compared with nursing or medicine at large, is a firmly established scientific field. Most acute care hospitals are staffed with infection control personnel well versed with a more elaborate armamentarium of standards, guidelines, scientific information, and expertise in key areas including communication, education, and management skills.

Your professional association, not one to be left behind, has also changed. Our membership has increased to more than 7000, and our influence has expanded into industry and government, and beyond national boundaries. Our capacity and productivity have increased, and we have an arsenal of products and services for our members. We have raised our sophistication and confidence along with our consciousness. Of all of this I am extremely proud, and I congratulate all of you on jobs well done.

However, in spite of these advances, health care professionals are faced with even more intense changes and challenges. During the next 10 years changes affecting us will become greater and more rapid. We are well aware of diagnosis-related groups, prospective payment system, health maintenance organizations, preferred provider organizations, independent practice associations, and “docs in a box.” We all know of hospitals that have made large profits under the current changes and of those hospitals that have closed. The days of the privately and individually owned hospital are numbered, and we will soon be facing the megahospital; some are already here.

Some of you may be aware of the proposed capitation payments for hospital-based physicians, the radiologists, anesthesiologists, and pathologists, known as RAPs. This method of reimbursement is only the beginning to place every health care provider under a single payment per case. And surely all of us are aware of the crises in medical and nursing malpractice insurance. I just this week learned that effective within the next 3 months nurse practitioners will lose their malpractice insurance. Nurse midwives already have.

However, we can take comfort in knowing that it is not regulation or things that drive change, but people, and each of us can be a part of change and influence the dynamics of the health care system. Not only can we influence, but we must influence our future or we will surely be left behind. In Lewis Carroll’s famous and delightful Alice in Wonderland, there is a conversation between Alice and the Cheshire Cat. In it Alice asks the Cheshire Cat for direc-
tions, also telling him that she is not sure where she is going, to which the Cheshire Cat replies, "If you don't care where you are going, it doesn't really matter which way you go!" To all infection control practitioners, I say we must know and care where we are going and we must have a plan for how to get there or surely we will find ourselves wandering in a health care delivery system maze with no way out except to be left by the wayside.

In her August 1984 editorial for Nursing Management, Leah Curtin talks of theory and practice in nursing. She says, "In theory nursing suffers from inflation of philosophy, purpose, means and goals. In practice, nursing suffers from devaluation of roles, scope, competence and contribution." In other words, nursing has lofty goals, but in reality the actions necessary to achieve these goals are undervalued. I submit to you that we as infection control practitioners do not want to find ourselves in this same situation.

In 1985, the health care industry had total expenditures of approximately $425 billion. That is more than $1.2 billion per day or $4 million per hour expended on health care. Today, health care costs this nation in excess of 10% of its gross national product and is projected to jump to over 14% by the year 2000. In 1985, the federal government spent over $124 billion. Medicare and Medicaid alone accounted for $86 billion.

Unfair as it may seem, in a society that pays its entertainers and athletes seven-figure salaries (that is seven figures before the decimal point), infection control practitioners and all health care professionals must realize that we must continuously prove our worth. We must constantly strategize in order to be in a position of power to survive in the future. The cost of health care today is rapidly escalating, and positions and services that have no perceived value will be eliminated. Each of us here today knows our worth, but do others know and understand our importance to the health care system? We must make others aware to achieve and maintain our place in the health care system for only then can we truly serve our clients. We must strategize, plan, communicate, and prove our value to the system for power is not automatically bestowed; it must be earned. Each of us can and must increase our power base to survive and prosper in a system that increasingly demands value for the dollars spent.

I submit to you that there are many ways to increase the perception and recognition of our value. I would share with you today several ideas concerning our future.

The first is team work: the health care team is an overworked, underutilized concept in health care. I would like to suggest that there never really has been a team, but rather a collection of individuals all directly or indirectly having an impact on the patient through their own specialty or practice.

However, we must truly work as a team or we will find that our adversarial relationships will interfere with the job to be done and will allow others, primarily business people with no knowledge of health care, to assume and direct patient care. Economics could then dictate who lives and who dies, who qualifies for treatment, who has convenient access to health care, and possibly even who is qualified to provide health care.

Health care professionals must rethink their interrelationships and work together, not only in the hospitals, but in the legislative arena and in health care policy development. A team leader, to be successful, must possess qualities not only by education but, even more important, through developing skills to encourage cooperation, build positive relationships and interaction, communicate openly and positively, and develop a win-win philosophy in negotiations. The art of compromise may become our most important tool, as long as we do not compromise patient care. We must all learn to share in the gains as well as the losses. Territorial protection and the divine right of our position is passe. Teamwork, with equality for all contributing members of the team, is essential in today's health care system. To paraphrase John F. Kennedy, "Let all [health care professionals'] problems unite us, instead of belaboring those problems which divide us."

Second, develop a high level of competence. Attack your job with a vengeance. Be sure you do your job better than anyone else by increas-
ing your knowledge and proving your abilities. True professionalism is based on competence. Our abilities and competence must be maintained life long. New challenges never end, and efforts to meet these challenges must be ongoing. Competence relates to the understanding and control of pertinent information, and having that information is power. In her speech entitled "Power," Martha Lamkin, manager of the Indianapolis office for the U.S. Department of Housing and Urban Development, expresses the belief that "power is control of data, technical knowledge, political intelligence or expertise... Why do you want information? To keep it to yourself? To hoard it? [No.] We seek information to make plans, create strategies, and become a sought after distribution point of credible information." Information gathering for professionals is not limited to reading scientific journals. It must include knowledge of the goals of the institution in which you work, the purpose and objectives of your professional association, a thorough understanding of your community, an awareness of the needs of your clients, and methods of devising research and study problems as a way of uniquely increasing your information base and improving your professional skills.

If you each significantly increase your knowledge and assimilation of information, your level of competence and value will dramatically increase.

Number three: each of us must recognize the value of building and being a part of a support system. Historically, infection control practitioners have built networks and coalitions. We must learn to prize these relationships. By definition, a network is a support system, usually consisting of members within the same professional group, allowing for communication vertically and horizontally. Once developed, networks should be lasting. Coalitions, on the other hand, are alliances of groups that have a common shared cause. Although the coalition members may be diverse, their ultimate goals are similar. Once the goals are met, the coalition may disband, but the important contacts made will always be available.

There are limitless advantages to being a part of coalitions and networks. Strength in numbers is important and in instances where an individual might fail, many can be victorious when working toward a common goal. Sharing of ideas and project development occur in coalitions or networks and provide broadened, rapid dissemination of information. But most important, being a part of a group increases the productivity of individuals and decreases stress. Individual problems become part of the group process with shared solutions that minimize individual risk. I now becomes we with the group working toward successful implementation of solutions.

Finally, I encourage each of you to communicate. Communication is an overused word and underimplemented concept. Most of us wonder about its value. But, we must renew our understanding of communication and seek ways to effectively share our information and knowledge with more people than ever before. In the past, most infection control practitioners have been communicating with infection control committees, employees, their colleagues, and peers. Now, we must expand our targets of communication to patients, administrators, accreditors, community leaders, educators, and governmental leaders who decide our future through health policy.

Infection control is one of the few services provided in the hospital that can actually save money through reduced cost. Have you shared your facts of cost savings with your hospital administration?

Infection control can prevent sickness in an otherwise healthy young population. Have you educated your community members, day-care administrators, and school health officials on the benefits of infection control?

Infection control can shorten a patient's hospital stay and minimize morbidity. Have you met with patients and taught them their role in controlling and preventing infections?

Infection control can prevent inappropriate and wasteful use of our health care resources, minimize fears about transmissible disease, and provide documentation and scientific facts to support proper health care policies for our society. Have you written or called and offered
your availability to legislators and regulatory personnel to assist in their health policy deliberations?

Infection control is based on scientific information. Have you provided assistance to accreditors to concentrate on major issues rather than minor ones?

Your professional association, APIC, is communicating with all of these groups. Have you presented your point of view to the APIC Board of Directors so that we can adequately reflect your thoughts in APIC statements and policy decisions?

Today, the United States is no longer based on a “smokestack” or manufacturing economy, but rather on a service-oriented economy. Health care is the primary example of a service industry. Health care is a big business, accounting for expenditures in the billions of dollars. Even though caring, humanism, and charity are very important parts of the health care industry, equally important are strategic planning, financial management, and business plans. The practice of infection control should continue as long as we expand our professional activities, effectively demonstrate and communicate our usefulness, provide competent and effective service, increase our cost-effectiveness, and remain dynamic through change.

Through the ages there have been many very eloquent statesmen and philosophers who have left us with the encouragement to move forward: impressive and now famous lines such as “I have a dream” or “A journey of a thousand miles begins with one small step” and “You can, because you think you can.”

But none has left the same gentle, yet important impression on me as Shel Silverstein, the famous and clever children’s author, in his poem, “Listen to the Mustn’ts”:

LISTEN TO THE MUSTN'TS
Listen to the MUSTN'TS, child,
Listen to the DON'TS
Listen to the SHOULDN'TS
The IMPOSSIBLES, the WON'TS
Listed to the NEVER HAVES
Then listen close to me—
Anything can happen, child,
ANYTHING can be.

References