

Letter to the Editor

Hospital epidemiologists and the art of salesmanship

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To the Editor—A recent editorial in *The Wall Street Journal* by Stewart Easterby, a management consultant, entitled “Climate Activists Are Lousy Salesmen”¹ led me to suspect that poor salesmanship is a common flaw among American hospital epidemiologists. Even successful hospital epidemiologists routinely encounter nurses, physicians, other healthcare workers and administrators who are dismissive of many evidence-based protocols for infection prevention. Could this failure to communicate be due in part to our lack of skills in salesmanship?

Stewart Easterby argues that politicians, scientists, and the media—collectively defined as “climate activists”—have failed to convince most Americans that the Earth is on a path to “catastrophe.”¹ Repeated calls for radical remedies have fallen on tens of millions of deaf ears for multiple reasons. First, a proportion of prominent “climate crusaders” lack clarity and a human touch when advocating for radical economic and social changes. Use of vague words like “climate change” baffle the public. Only a few members of the public understand or can assess the scientific validity of climate research. And many studies and models cited by qualified experts as scientific proof of climate variations have not been explained in clear layman’s terms.

The public has grown weary of sensational news stories of climate studies that have subsequently been debunked or discredited. And millions of average citizens believe that they cannot change the climate even if they fully embrace complicated, expensive, and inconvenient remedies to problems that will persist well beyond their natural lives.

Finally, and most importantly, millions of Americans become resentful when climate crusaders proclaim that “climate deniers” are a major reason that many policies, laws, and treaties have failed to either be enacted or be effective.

This synopsis has similarities and parallels in our world of hospital epidemiology. Although time pressures, inadequate staff education, and inadequacies in human factors engineering commonly lead to noncompliance with infection prevention measures, most of us hospital epidemiologists have at some time blamed our colleagues for the sorry state of poor compliance with prevention measures such as hand hygiene, isolation protocols, sterile techniques, and surgical infection prevention protocols. Our colleagues know this and often resent it. Virtually all healthcare workers want to do the right thing, but often they are too busy, improperly educated, or rightfully annoyed with cumbersome processes such as using gowns for isolation that they believe add no value to the care they provide.

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Hospital epidemiologists have made clarion calls about their deep concerns regarding emerging antimicrobial resistance. However, our remedies too often strike clinicians as impractical, inconvenient, unproven, invalid, and/or futile.

Antimicrobial resistance has been evolving for over 75 years and, like climate “deniers,” clinicians and nurses, even those who realize and admit that “bad bugs” are a big problem, are “. . . naturally disinclined to obsess daily about a phenomenon that started long before they were born and won’t reach fruition until long after they die.”¹ As a result, large numbers of clinicians, while acknowledging the problem of antibiotic resistance, continue to overprescribe antibiotics in their daily practice.

Perhaps the disconnection between our concerns about patient safety, infection prevention protocols, and antimicrobial resistance and their half-hearted acceptance by many of our colleagues can be explained by our lack of expertise in salesmanship.

How can we change the status quo? To begin, we should directly acknowledge that we are unable to definitively and temporally determine the cause or causes of transmission of numerous pathogens because of the complexity of modern healthcare, the enormous numbers of personal touch interactions between staff and patients and the movement of patients within the modern health system. Indeed, studies employing whole-genomic sequencing methods have illustrated the complexity of unresolved questions about the transmission of *Clostridium difficile*, carbapenem-resistant Enterobacteriaceae, and methicillin-resistant *Staphylococcus aureus*.^{2–4} Our lack of evidence on these fundamental points results in widespread skepticism when we propose that implementing a “bundle” will reduce infections or that handwashing is a panacea for reducing infections in complex and highly contaminated environments full of sick patients receiving extraordinarily complex care.

As Easterby suggests in the editorial cited above, we may attract more supporters and believers if we create a clear, consistent call to action using convincing spokespersons with local and/or national credibility. Overtly strident or overconfident hospital epidemiologists who advocate unproven protocols or policies are unlikely to stimulate cooperation from healthcare workers. Although simple measures and multipart bundles often improve outcomes, such bundles will not solve many refractory and vexing problems related to preventing transmission of healthcare pathogens nor will they work in all healthcare settings or systems.

We need to better “label” our programs, policies, and protocols. These labels and our terminology should be credible, accurate, consistent, logical, and understandable. For example, slogans such as “getting to zero” are not plausible, and our colleagues know this. On the other hand, honest and humble messages that emphasize

that individuals and institutions should persistently and incrementally strive to do the best they can do to reduce HAIs and improve patient safety are more likely to achieve acceptance by staff who have varying roles and priorities and numerous other job-related concerns.

We also need to recognize that our efforts to reduce antimicrobial resistance should be tempered with the reality that many of its causes are not amenable to direct intervention by individual doctors, healthcare systems, or government agencies. Burdening clinicians with this responsibility or blaming them when resistance gets worse makes our job harder when we recommend partially effective but still useful changes in policies, protocols, and care practices. Instead, we may have more credibility and impact by focusing on explaining and attempting to address basic principles, the relationships between colonization and subsequent infection, the role of local antibiotic pressure and local emergence of resistance, and the adverse risks of devices.

We should endorse Easterby's recommendation that activists need to listen to their doubters and resist, as best they can, temptations to lambaste them when their opinions clash with ours. Hospital epidemiologists who occasionally disparage colleagues who doubt, ignore, or are indifferent to our efforts are more likely to be frustrated than successful.

Also, we need to fix "computer models" overly reliant on flawed surveillance definitions. It is often counterproductive to rely on metrics and outcomes such as *C. difficile* "lab ID events" that currently cannot reliably distinguish between true infection and colonization or endorsing and using flawed definitions of a catheter-associated bloodstream or urinary tract infection. Many of our colleagues are skeptical because they correctly realize that use of these metrics to assess and monitor the impact and efficacy of specific prevention protocols and policies is often misleading. We need to develop surveillance definitions that are clinically accurate; comprehensible to clinicians; and have clear impact on clinical practice, quality, and safety. Otherwise, we will continue to experience the same skepticism and indifference that climate activists encounter when they then rely on unintelligible and sometimes inaccurate National Oceanic and Atmospheric Administration climate data.

Finally and most importantly: how can hospital epidemiologists become better salesmen? For starters, we can collectively and individually alter prior behaviors and approaches that have led to failure. We should stop assuming that apathy or ignorance of our physician and nursing colleagues are behind the frequent failure of our protocols, policies, and recommendations. All of us need to

become better versed and trained in the arts of salesmanship, negotiations, active listening, communication and even marketing. Multiple on-line and on-site training programs are available for developing these and standard business and sales skills. Some of us could benefit from hiring a personal coach to provide individual help and feedback. We can also learn by observing and mimicking effective people who understand and are skilled in sales and marketing. Our society should be urged to collectively and publicly petition The Centers for Disease Control to revamp or even abandon flawed surveillance definitions. Our society should stop overt or tacit support of the use of inaccurate and flawed metrics to punish hospitals. We need to realize that many of our prior efforts have failed because we, too, lack "clarity, credibility, and empathy" in dealing with our fellow healthcare brethren.

Although effective hospital epidemiologists utilize numerous other "tools and assets," such as negotiation and complex strategies requiring flexibility, compromises, relationship building, and priority setting, salesmanship is too often underutilized. But salesmanship alone will never be a panacea. Even if we achieve reasonable competency in the preceding skills and techniques, we will still periodically encounter failure, frustration and disappointment. And when these failures and frustrations occur, I advise making our best effort to sustain our focus and retain our optimism and goals while pondering Shakespeare's famous line: "The fault, dear Brutus, is not in our stars but in ourselves, that we are underlings."

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Strict sequestration versus lenient isolation precautions during hematopoietic stem cell transplant: results of a quality initiative

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To the Editor—Inpatient bone marrow transplant (BMT) requires long hospitalization on the order of weeks to months. During this time, hematopoietic stem cell transplant (HSCT) recipients are at