

Editorial

A Call to Arms

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"All I maintain is that on this earth there are pestilences and there are victims, and it is up to us, as far as possible, not to join forces with the pestilences." Albert Camus, *The Plague* (Vintage Books; New York, 1972)

The Netherlands and other northern European countries have been enduring leaders in methicillin-resistant *Staphylococcus aureus* (MRSA) control across hospital and community environments. When I spoke to a Dutch colleague about their secret, I heard that some twenty-five years ago, when MRSA was starting to be seen in Europe, the microbiologists from across the country got together and in a resolute Dutch manner decided that MRSA would not be allowed to march through their country. They went back to first principles of 'search and destroy' (inspired by John Spicer's seminal paper)¹ and evolved a unified Dutch policy to control MRSA in hospitals. All members of this group committed themselves and their facilities to full implementation of the approach. On several occasions, certain facilities and individuals appeared to be losing control and/or faith in the strategy and the professional group was effective at re-focusing efforts to ensure that these outbreaks were controlled. Effective control has continued in the face of the emergence of community and animal-associated MRSA strains and the constant influx of MRSA-colonised staff and patients from other countries. The approach to MRSA, supported by almost all Dutch infection control professionals has enabled development and implementation of uniform standards across many other fields of infection control².

The lessons for Australian infection control practice could not be plainer. Australia is faced with many infection prevention and control challenges both in healthcare and community and other looming developments overseas such as epidemic hypervirulent *Clostridium difficile*. Furthermore, the practice of infection control in some states in Australia is highly variable, as is the incidence of healthcare associated infection. The technical approach to the control of such problems as healthcare associated MRSA is now largely accepted worldwide, with European³, North American⁴ and New Zealand⁵ guidelines reflecting closely the established Dutch approach, perhaps more clearly termed 'Screen, isolate and, where feasible, decolonise/decontaminate'. Increasingly, a zero tolerance approach to healthcare MRSA transmission and morbidity is developing.

Most jurisdictions in Australia have moved or are moving towards similar control strategies for MRSA. The MRSA forum conducted by the Healthcare Infection Control Special Interest Group (HICSIG) at the recent Australian Society for Infectious Diseases meeting (see elsewhere in the journal for a synopsis of this event) highlights this concordance. However, both NSW and Victoria still experience high levels of preventable healthcare associated MRSA morbidity and are yet to implement effective statewide control measures. On the wider level of systems management and re-orientation of infection control programs to 'aim for zero', there is as yet little evidence of collective action in Australia – risking falling further behind evolving sophisticated international approaches most publicised by the Institute for Healthcare Improvement⁶.

The Australian Infection Control Association (AICA) has been a leader in establishing standards of practice. This is shown by its past support of a productive National Advisory Board, (National Surveillance Definitions⁷ and the extensive 2001 Review of National Surveillance of Healthcare Associated Infection in Australia⁸), and the recent launch of national AICA Infection Control Standards⁹. The majority of the NAB surveillance definitions were endorsed with minor modification by the then National Quality and Safety Council in 2004¹⁰. AICA has also contributed to and supported production of the National Infection Control Guidelines¹¹, but these guidelines were not endorsed by most jurisdictions and appear to lack a mechanism for ongoing revision and adoption by Australian states and territories.

Collective development and adoption of uniform technical approaches to infection control is problematic in Australia. Not only are there jurisdictional divisions, but also key professionals are splintered amongst many societies (Table 1). This has reduced our

Table 1. Professional groups associated with infection control in Australia.

AGAR: Australian Group on Antimicrobial Resistance

AICA: Australian Infection Control Association

ASA: Australian Society for Antimicrobials

ASID: Australasian Society for Infectious Diseases

ASM: Australian Society for Microbiology

CDNA: Communicable Diseases Network Australia

capacity for collective action and political influence. Furthermore, the Commonwealth's lack of jurisdiction over the hospital sector has previously reduced its interest in becoming involved in healthcare infection prevention and control.

The national situation may well change under the Australian Commission on Safety and Quality in Health Care's new agenda for healthcare reform. The Commission has been funded by the Australian, State and Territory governments to develop a national strategic framework and associated work program that will guide its efforts to improve safety and quality across the healthcare system in Australia¹². The commission definitely has prevention of healthcare infection in its sights. The corollary of this pleasing development is that we urgently need to form bridges between traditional nurse-based infection control endeavour and medical communicable diseases areas in order to influence and support the commission's work. Clearly this is a central role for AICA in strategic alliance with other groups such as ASID, Australian Society for Microbiology (ASM) and Communicable Diseases Network Australia (CDNA) in particular. In the past, AICA has not been overly successful in engaging communicable disease physicians and microbiologists. HICSIG, the new special interest group set up under ASID has the primary aim of facilitating the engagement of a wider range of professionals involved in infection prevention and control and thereby provide direct support to AICA initiatives.

There is a large opportunity cost from having imperfect networking of our small group of stakeholders. Many of us in our infection control programs are regularly reinventing the wheel – designing approaches to particular challenges based on published evidence and standards. HICSIG represents an opportunity for sharing of this work amongst colleagues in perhaps a more productive and comprehensive manner than achieved through the AICA or OZBUG listserv mechanisms. A primary HICSIG intent this year is to formalise an organisational structure and work plan for the group. A likely initial objective will be to form a representative expert group (perhaps with external support) to examine the AICA-NAB derived MRO screening and indicator documents. This ties in with the intent of the Australian Commission on Safety and Quality in Health Care to support national HCA infection indicators. It also is in accord with the consensus of the ASID MRSA Forum that there needs to be a robust national system for tracking MRSA and MSSA morbidity across Australia, initially focused on healthcare associated bacteraemic infection¹³.

Some may question the establishment of yet another group when we already have so many. The existing groups will always have strong reasons to continue. The intent is for HICSIG to be a forum and a vehicle for networking across professional groups involved in healthcare communicable disease control, rather than another competing player. An eventual aim will be to support development of professionally supported, comprehensive technical recommendations that can then underpin developing national

standards for healthcare. I would encourage all with an interest in furthering these aims to 'join' HICSIG via its website, share your own views and documents, policies, procedures and systems and participate in future developments to the full.

Acknowledgements

Thank you to Ms Sandy Berenger, Dr Rod Givney and Dr David Looke for their useful suggestions and advice.

References

1. Spicer WJ. Three strategies in the control of staphylococci including methicillin-resistant *Staphylococcus aureus*. *J Hosp Infect* 1984 Dec; 5(Suppl A):45-9.
2. Netherlands Infection Control policies. Viewed 30 April 2007 www.wip.nl.
3. Coia JE, Duckworth GJ, Edwards DI et al. Guidelines for the control and prevention of methicillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities. *J Hosp Infect* 2006; 63(Suppl 1):S1-44.
4. HICPAC. Management of Multi-drug resistant organisms in Healthcare Settings 2006. Viewed 1 May 2007 <http://www.cdc.gov/ncidod/dhqp/pdf/ar/mdroGuideline2006.pdf>.
5. National NZ MRSA Guideline 2002. Viewed 1 May 2007 http://www.esr.cri.nz/NR/rdonlyres/5AE8FDA1-48F2-411F-A084-9A8B81242DAB/0/MRSA_guidelines.pdf.
6. Zell BL, Goldmann DA. Healthcare-Associated Infection and Antimicrobial Resistance: Moving Beyond Description to Prevention. *Infect Control Hosp Epidemiol* 2007; 28(3):261-4.
7. AICA National Advisory Board: national surveillance definitions. Viewed 30 April 2007 <http://www.aica.org.au/default.asp?PageID=80>.
8. AICA National Advisory Board. National Surveillance of Healthcare Associated Infection in Australia; A Report to the Commonwealth Department of Health and Aged Care 2001. Viewed 30 April 2007 [http://www.aodgp.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-jetacar-archive-index.htm/\\$FILE/scope.pdf](http://www.aodgp.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-jetacar-archive-index.htm/$FILE/scope.pdf).
9. Australian Infection Control Association (AICA). AICA Infection Control Standards 2006. Order form, viewed 30 April 2007 <http://www.aica.org.au/default.asp?PageID=12>.
10. Australian Council for Safety and Quality in Health Care. Health Care Associated Infection (HCAI) Surveillance Definitions 2003. Viewed 30 April 2007 <http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/former-pubs-archive-hcai-definitions>.
11. Australian Government, Department of Health and Ageing. Infection Control Guidelines for the prevention of transmission of infectious diseases in the healthcare setting. January 2004.
12. Australian Commission on Safety and Quality in Health Care: 5 year workplan 2007. Viewed 30 April 2007 [www.safetyandquality.org/internet/safety/publishing.nsf/Content/EAAE455F59E41B59CA257226001140C4/\\$File/Commission%20Work%20Plan.pdf](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/EAAE455F59E41B59CA257226001140C4/$File/Commission%20Work%20Plan.pdf).
13. Collignon PJ, Wilkinson IJ, Gilbert GL, Grayson ML, Whitby RM. Health care-associated *Staphylococcus aureus* bloodstream infections: a clinical quality indicator for all hospitals *MJA* 2006; 184 (8):404-406.