Editorial

Responding to a pandemic

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> If you can keep your head when all about you are losing theirs and blaming it on you...
>
> Rudyard Kipling

There has been a great deal of anxiety worldwide about the emergence of swine origin H1N1 influenza A[1] or Influenza A (H1N1–2009) which the World Health Organization has chosen to call this virus at the time of writing. The first reports that came out of Mexico were very alarming with thousands of cases and hundreds of deaths reported in the lay media and online, mainly in young people raising the spectre of a 1918-like pandemic. The World Health Organization responded dramatically and swiftly, raising the pandemic alert level from 3 to 5 in 3 days![2] Countries all over the world rushed to institute travel restrictions, quarantines and other drastic measures. Soon, however, it became apparent that the new virus might not be deadly as had been feared and many countries scaled down their preparations. Concerns were raised in the infection control community that such intense attention focussed on a novel pathogen that might not (emphasis here on might!) be more lethal than the regular seasonal influenza would distract attention away from the 'mundane' day to day work of preventing infections that Infection Control Practitioners face every day in hospitals and healthcare facilities worldwide. However, some of us were cheered that there was going to be a renewed focus on seasonal influenza which carries a considerable mortality and morbidity every year[3] but often remains under the radar for most administrators and the lay media.

This issue of *Healthcare Infection* has a nice balance between articles which focus on the 'bread and butter' of dealing with healthcare-associated infections and articles that concentrates on respiratory viral infections and the realities of providing enough isolation facilities to protect healthcare workers, patients and visitors in crowded urban hospital systems.

Irvine *et al*.[4] provide a nice report of an intervention at one Western Australia hospital that enhanced respiratory viral surveillance leading to rapid identification of patients infected with respiratory viruses who were then promptly isolated in either single cohort rooms. In addition, hand hygiene campaigns were ramped up, cough etiquette was promoted and early discharge was encouraged. These measures were estimated by the authors to have reduced hospital-acquired respiratory viral transmission and actually saved the hospital A$98 000 over one respiratory viral season. While it is possible that this might be an overestimate due to a simple cost assessment without a detailed cost-effectiveness analysis, it is encouraging to see that a simple program with good support from laboratory, administration, nursing and medical staff could have a significant beneficial effect in reducing the burden of respiratory viral infections.

In another paper in this issue of the journal, Morton and colleagues[5] from Brisbane showed that when isolation and cohort facilities were reduced, the incidence density of multi-resistant organisms increased and only began to decline when increased isolation and cohort facilities were made available. Both papers point to the urgent need to ensure that there are adequate resources in terms of infrastructure, laboratory support and clinical manpower whether we are dealing with multi-resistant organisms or pandemic threatening respiratory viruses.

On the other front, there are important papers in this issue of *Healthcare Infection* that address the question of surveillance.[5,6] In the modern information era where almost all information is available through Google or You Tube, hospitals are increasingly asked to compare themselves with 'benchmarks'. Morton *et al*.[5] have shown the importance of using standard definitions in comparing rates of *Staphylococcus aureus* bloodstream infection. The rates of methicillin-resistant *Staphylococcus aureus* bloodstream infections have fallen in the UK[7] and USA[8] and it would be good to have robust national surveillance systems in Asia and Oceania to show similar positive effects from the efforts of infection preventionists in the region. There is also a manuscript which illustrates the relationship between surgical volume and surgical site infection rates.[6] While it is tempting to make the connection between higher volumes and better outcomes as has been shown in settings such as liver transplantation,[9] the authors correctly identify the need for accurate and reproducible data ascertainment before drawing conclusions that affect public policy.

Finally, in addition to the usual Journal Watch and review articles, there is an important paper from Saudi Arabia[10] that highlights gaps in infection control knowledge and practice in the Kingdom. In an increasingly globalised world, we are all vulnerable to emerging infectious diseases that appear in other parts of the globe. This should be viewed as an opportunity rather than a threat as there are many in Australasia who have the expertise

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and knowledge to impart to young infection preventionists in developing countries. Years of experience cannot be reproduced by an online teaching module and very often the important teaching points are not those that come from a textbook but those that arise from observing and supervising what actually goes on in the wards. Funding agencies should consider tapping on the expertise of infection preventionists in this society and others who can help raise the standard of infection control in many developing countries thus protecting patients and healthcare workers both locally and globally. That is going to be a crucial part of our response to the threat of this and other future pandemics.

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