Hospitals get dinged for reporting too many infections. In some cases, the solution is not to test

Bannow spoke with 25 clinicians and experts and reviewed medical guidelines, scientific papers, and government data to report this story.

By Tara Bannow

Sept. 22, 2025

When a hospitalized patient shows signs of a dangerous, potentially deadly infection, you'd expect clinicians to move quickly: testing to figure out what's wrong, then treating with the right medicines.

But that's not always what happens. And the reason is often financial: Federal regulators can fine hospitals hundreds of thousands or even millions of dollars if too many of their patients get hospital-acquired infections.

Some hospital leaders, realizing that if they don't look for infections, they won't find them, are discouraging testing, clinicians told STAT. Without testing, patients may not get the best treatment. Executives have also pressured staffers in some cases not to report infections to the government, they said.

What's more, regulators have known about the problem for a decade, but neither Medicare nor Congress has taken action to fix it.

"This is like health care's dirty little secret," said Carol McLay, president of the Association for Professionals in Infection Control and Epidemiology. "Everybody knows it's done. Nobody talks about it."

Clamping down on testing looks different at every hospital, but the more than 20 clinicians who described the practices to STAT said they have at least one thing in common: They're almost never written down. A policy in a handbook or posted on a bulletin board could easily make it back to a regulator or reporter. Instead, it happens more informally, through verbal directives and conversations between colleagues.

Infection control experts said if denied or deferred tests for infections delay the administration of antibiotics, patients' conditions could deteriorate and even develop into sepsis, a serious condition that is estimated to strike 1.7 million hospitalized adults in the U.S. every year and kill hundreds of thousands of them.

It's impossible to know how widespread the problem is, as so much of it happens through word of mouth. Clinicians described it at both nonprofit and for-profit hospitals, although seven of the doctors, nurses, and infection control specialists who spoke to STAT said they felt more pressure not to test for or report infections at hospitals owned by HCA Healthcare, a large, for-profit chain of about 190 hospitals, than at nonprofit hospitals where they had worked.

At an HCA hospital in New Hampshire, for example, David Itkin, an infectious disease physician, said doctors had to negotiate a series of hurdles when they tried to test patients' stool for Clostridioides difficile, or C. diff, a bacterium that infects the colon, causes diarrhea, and can lead to deadly conditions like an inflamed colon or sepsis. Tellingly, he said, they only ran into these barriers when they wanted to test patients who'd been in the hospital longer than three days, after which a C. diff infection is considered hospital-acquired.

Before that point, Itkin said he did not encounter restrictions.

Asked about the clinicians' assertions, HCA sent STAT a statement that said its hospitals have processes to treat patients at the earliest sign of infection, and its clinicians monitor patients' infection risk and conduct appropriate testing to improve outcomes. If a patient has an infection, HCA said it is important to determine whether it was acquired before or after they entered the hospital to effectively manage their care. The company said it performs internal audits of its infection documentation and uses a third-party auditor. HCA did not respond to clinicians' assertion that testing was restricted after a certain number of days.

There's another reason hospitals limit testing: Medicine's push to cut down on unnecessary antibiotic use so as not to contribute to the rise of antibiotic-resistant bacteria. The World Health Organization has warned of a "potentially disastrous drug-resistance crisis" if action isn't

taken to rein in antibiotic overuse, with deaths from drug-resistant diseases projected to reach 10 million globally by 2050.

Leaders of this antibiotic stewardship campaign say doctors tend to order too many blood, urine, and stool cultures to test for infections, resulting in antibiotic overuse when those tests yield false positives. In the case of blood cultures, for example, research suggests that 20% to 60% of positive cultures are false positives. For that reason, it's important to have policies that ensure tests are appropriate and necessary before they're performed.

The clinicians interviewed for this article maintained that the policies they encountered were not designed to ensure antibiotics were used appropriately. Instead, administrators at HCA hospitals are using the banner of antibiotic stewardship to avoid testing for and reporting infections, said Diana Maria Stark, director of infection prevention at George Washington University Hospital in Washington, D.C., who previously worked at three HCA hospitals.

"It is to feed into this mirage of, 'We are safe,'" Stark said. She has not observed that behavior where she currently works.

When infections are detected, administrators in some cases pressure the clinicians responsible for reporting them to the government not to do so, exploiting the power imbalance between them by questioning their judgment. Infections don't automatically qualify as hospital-acquired; they have to undergo an analysis and meet certain criteria.

Federal regulators first raised concerns about whether hospitals were accurately reporting patient infections in a 2015 letter. In the letter, they said they'd become aware of two inappropriate practices: doctors skipping tests on symptomatic patients to avoid reporting infections, and blanket testing of asymptomatic patients shortly after admission to avoid getting dinged for infections later on.

Part of the problem is the penalties themselves. Medicare reduces its reimbursement by 1% to the one-quarter of hospitals with the highest rates of five types of health care-associated infections: C. diff, central line-associated bloodstream infections, catheter-associated urinary tract

infections, surgical site infections, and methicillin-resistant Staphylococcus aureus bacteremia, or MRSA. Critics say that relying on hospitals to tell on themselves is a big concern. Research has also shown the program disproportionately penalizes hospitals that treat more low-income patients.

“Basically, the measures are just really, really bad,” said Andrew Ryan, a professor of health services, policy, and practice at Brown University. “There have been a lot of pay for performance programs, but this is honestly the worst one.”

In a statement, the Centers for Medicare and Medicaid Services said it takes seriously any suggestion that hospitals may avoid appropriate clinical testing to reduce publicly reporting infections. “We strongly discourage such practices, which may compromise patient care and violate” Medicare’s rules, the agency said. “We continue to work closely with partners across HHS to monitor reporting patterns and investigate anomalies as part of our broader oversight efforts.”

Doctors’ experiences

At HCA’s Portsmouth Regional Hospital in New Hampshire, Itkin and another doctor described the barriers to testing their patients for infections once they’d been hospitalized for longer than three days. The electronic health records portal would take them through several prompts to ensure the patients met strict testing criteria. If the doctors made it through and placed the order, then they got calls from the hospital’s infection prevention team asking whether they really wanted to do so.

“At the very least, they make it very difficult,” said Itkin, who worked at the hospital for over three decades before he left in 2022. “If this is a battle of attrition, then it is eminently possible that they get into a situation where they just kind of wear people down so they don’t order the test.”

Hospitalist Lane Beatty had over 20 years of experience under his belt when he started working at Portsmouth Regional in 2023. He said the

barriers he encountered to infection testing there left him feeling unable to use his clinical judgment with patients.

He said one of the hospital's finance leaders would regularly attend clinical rounds and tell doctors not to order certain tests. "It's intimidating for some providers," Beatty said. "You're making them second-guess their clinical rationale and you end up canceling a lot of orders that way."

Beatty, who worked as a medical director, said it was obvious to him that the scrutiny around testing was to avoid Medicare's penalties, even though leadership claimed it was about antibiotic stewardship. He felt leadership meetings were focused on increasing profit by bringing in more patients and performing more procedures. Beatty said he told his colleagues those goals were compromising patient safety by overwhelming clinicians and unnecessarily exposing patients to infections, but nothing changed. He left after 10 months because of his frustration over this and other safety concerns.

Medicare's Hospital Compare website, where data for all hospitals is posted publicly, shows Portsmouth Regional reported fewer infections than national benchmarks for all infections for which data were available. The website was updated this year with infection data from 2023.

While the metrics make the hospital look like a safe place, "there was just a total disconnect there regarding how you approach patient safety in general," Beatty said. "So when you start to pick and choose one issue you're framing in terms of that," he added, referring to antibiotic stewardship, "especially as a medical director and experienced clinician, I don't buy it. There's nothing about the way you act that makes me think this is really part of your mission."

Checks on ordering lab tests can be appropriate — helpful, even — but it matters what they are, said Shira Doron, Tufts Medicine's chief infection control officer. In the case of C. diff, for example, it's appropriate to ask whether patients with diarrhea were given laxatives, as that may be causing their diarrhea.

Doron said she often hears about an inappropriate restriction, and it's the same one the Portsmouth Regional doctors described. Hospitals will

put barriers around testing once patients have been hospitalized long enough that their infections would be blamed on the hospital, and little to no barriers before that.

A C. diff infection is considered hospital-acquired on or after the fourth day of admission, while most other infections are considered hospital-acquired on or after the third day. Infections detected earlier in patients' stays are considered to be acquired elsewhere and hospitals don't have to report them to the government.

At New Hampshire's Frisbie Medical Center, an HCA hospital 30 minutes north of Portsmouth Regional, Dawn Vinciguerra, a former intensive care unit administrator, made the distinction clear in a 2022 email to staff that was obtained by STAT: "Consider testing for C. Diff if [patient] comes in with diarrhea or starts having it within the 4 day window will keep it from falling out as hospital acquired."

Vinciguerra's email didn't address testing for infections after that time period, and she did not respond to a request for comment.

One of the nurses who received that email said it was virtually impossible to test patients for C. diff once they'd been at the hospital longer than that cutoff. Before that, there were no barriers to testing, said the nurse, who asked to remain anonymous because they still work in the industry.

A doctor who works at an HCA hospital in South Florida recalled a time he treated a patient who had diarrhea. When he asked that the patient's stool be tested for C. diff, a nurse replied, "Doctor, can't you just treat without testing?" The doctor, who asked to remain anonymous because he still works at the hospital, went ahead with the test. It came back negative.

"If you think about that, if I were just to listen to those nurses and say, 'okay, just treat,' then I would be treating someone who didn't have that bacteria, and that's a problem," the doctor said.

As that episode highlights, some hospitals may be worsening the problem of antibiotic resistance by giving patients broad-spectrum

antibiotics instead of performing tests to learn what specific infections they have. Four clinicians — three doctors and a nurse — reported this happening at the HCA and nonprofit hospitals they work or worked at. They asked to remain anonymous for fear of retribution.

A 2017 study said one hospital's policy was to prescribe broad-spectrum antibiotics to patients with catheters instead of performing urine cultures to check for infections.

Infectious disease experts said broad-spectrum antibiotics can come with a number of adverse consequences. They disrupt the gut's healthy bacteria, making patients more vulnerable to C. diff and to antibiotic-resistant bacteria, making the next infection harder to treat. They can also injure patients' kidneys and liver.

Sometimes when patients first arrive at the hospital, using a broad-spectrum antibiotic is necessary until doctors receive the results of their urine or blood cultures, said Emily Landon, executive medical director for infection prevention and control at University of Chicago Medicine. But after that, the goal should be to use a targeted antibiotic, she said. And that requires testing.

'No cultures at all'

It's not just HCA. Two doctors, who asked not to be named out of fear of repercussions, described similar practices at nonprofit hospitals that they felt were meant to discourage testing for bloodstream infections and urinary tract infections, both of which are reportable to Medicare.

One, a resident physician formerly at the Robert Wood Johnson University Hospital in New Brunswick, N.J., said most of the times he ordered blood tests from patients' central lines — long tubes inserted into patients' veins to deliver fluids or blood — they were either canceled by the lab or an administrator called him and told him to cancel the tests. He said he was also in situations where he couldn't test from peripheral veins, either, unless it had been at least 24 hours since the patient's central line had been removed. He found the same to be true for patients with urinary catheters. Infections detected 24 hours after central lines

and catheters were removed are no longer considered device-related and, as a result, are not reportable to the government.

“It’s quite egregious, actually, because there are cases where patients are really sick and we’d like to know what the bug is,” said the resident physician. “And for fear of it being called a catheter-associated infection, they just say, ‘No cultures at all. Just keep treating with broad-spectrum antibiotics.’ That’s not good for antibiotic stewardship.”

An infectious disease physician described encountering similar protocols during his residency at Henry Ford Hospital in Detroit. He said blood cultures were almost never permitted on patients who had central lines, and the same was true for urine cultures on patients with urinary catheters.

That doctor also said the hospital had a policy of not providing antibiotics until blood or urine cultures were drawn from the patients, but since cultures required approval from a team of nurses, treatment was sometimes delayed.

Both central lines and urinary catheters can easily become contaminated with bacteria, resulting in false positive infection tests. For that reason, many hospitals have policies that try to cut down on false positives, like discouraging doctors from taking blood samples from the central lines.

Experts say it can be a tough balance to strike. Keith Kaye, allergy, immunology, and infectious diseases chief at Robert Wood Johnson University Hospital, said in a statement that most current evidence indicates that drawing blood cultures from peripheral sites as opposed to a central line provides more meaningful data with regards to identifying pathogens in the blood. The hospital recommends central line cultures if peripheral cultures can’t be obtained.

His statement did not specifically address the resident’s assertion that he had to wait 24 hours after removing devices to test. A spokesperson said that the hospital does not restrict ordering of cultures in patients with urinary or blood catheters.

In a statement, Henry Ford Health said that the system does have a policy to avoid taking cultures from central lines, as they are associated with high false positive rates compared with cultures taken from peripheral veins. The system also said that while some cultures require additional approval, doctors are empowered to start antibiotic treatment when clinically indicated, even as culture results are pending.

Pressure not to report

When testing does uncover reportable infections, some hospital administrators try to prevent disclosure by pressuring the people responsible for doing so, five sources told STAT.

Hospitals have teams of so-called infection preventionists. They're specially trained clinicians — often nurses or epidemiologists — who implement policies to prevent infections from spreading. They're also the ones who report infections to the Centers for Disease Control and Prevention's National Healthcare Safety Network, the tracking system that Medicare uses to learn hospitals' infection rates.

A blood or urine test that's positive for an infection doesn't automatically qualify as a hospital-acquired infection that must be reported to the government. The CDC has specific criteria that incorporate how long the patient had been hospitalized and other factors. Infection preventionists review patients' clinical notes and test results to determine whether an infection must be reported.

Two infection preventionists told STAT they personally experienced pressure from administrators at HCA hospitals not to qualify infections and report them to the government. They said it did not change their decision making, but it might convince others not to report infections. Sometimes, it came in the form of C-suite leaders directly questioning their judgment. If they reported the infections, they said it felt like they were punished for not preventing them.

Infections should be treated as a systems problem, not the failure of one person, and especially not the infection preventionist, said APIC's McLay. There are strong power dynamics at play in a hospital, and

infection preventionists are low in the ranks, making them vulnerable to such influence, McLay said.

“Even though they know it is a reportable infection, they know that they risk losing their job if they report it, so they don’t say anything,” she said. “It’s a culture that’s pervasive throughout the organization.”

Stark, of George Washington University Hospital, said in the face of such intimidation, it’s important that infection preventionists have ethics and integrity. Stark said she experienced pressure not to report infections when she worked at HCA hospitals in Florida. She said she has not felt that pressure since leaving HCA.

Whenever she did classify an infection as hospital-acquired, Stark said HCA administrators would interrogate her about why she didn’t prevent it. While it’s appropriate for hospital officials to investigate the reasons for an infection, she said that didn’t seem to be the goal.

“I’m going to get sat down and they’re going to grill me,” Stark said. “I have people who are not infection preventionists talking down to me. It’s a toxic feedback loop that was not aimed at improving my practice, it was aimed at holding me down.”

Stark said she understands why some people simply decline to qualify infections: It can feel like self-sabotage.

An infection preventionist who used to work at HCA’s Portsmouth Regional said she felt the same pressure. Whenever she did qualify and report infections, there would be tense morning meetings to review the infections, condescending treatment, and micromanagement.

Ultimately, the infection preventionist said the pressure not to identify infections caused “unbearable stress” and led her to quit.

“I literally couldn’t sleep at night,” she said. She said she does not experience that at the nonprofit hospital where she now works.

History of the metrics

In the 10 years since the government started slapping financial penalties on hospitals that report the most infections, a number of studies have sought to understand their impact. Their findings have been mixed.

Rates of some of the infections targeted indeed dropped between 2015 and 2023: C. diff by 58% and catheter-associated UTIs by 38%, for example.

Two studies from 2019 cast doubt on whether the penalties assessed under the Hospital-Acquired Condition Reduction Program encouraged hospitals to improve their performance on certain conditions, with one finding that they disproportionately penalize large academic medical centers and hospitals that care for a higher proportion of disadvantaged patients. A study from last year, by contrast, found that the worst-performing hospitals — the ones that were penalized — were more likely to improve their scores in subsequent years than those that performed well.

The program's penalties amounted to $3.2 billion across all hospitals between 2015 and 2024. The annual totals have decreased over the years, from $381 million in 2015 to $231 million in 2024, which could reflect an actual decline in hospital acquired infections — or increasing efforts to avoid reporting them.

Daniel Diekema, a professor of medicine at Tufts University who studies hospital infections, said tying financial penalties to hospitals' infection rates has overall been a good thing for patient safety and lowering infection rates, even if some hospitals game the metrics.

Same policy, different interpretations

Judging which hospitals are gaming the system isn't always clear-cut. The University of Chicago Medical Center has a policy that, on its face, might raise eyebrows: All hospitalized patients get screened for C. diff upon admission. If patients are labeled as having C. diff when they arrive, the hospital can't get dinged for the infection later on.

But Landon, who leads the system's infection control program, said it's not about avoiding Medicare's penalties. Her research has found roughly

4% of patients admitted to the ICU are colonized with C. diff, meaning it's in their body but not harming them. Those people can spread C. diff through their stool, so the health system keeps them apart from other patients.

"If we already know that you are colonized with C. diff, we do not need you getting the same test again two days later to see if you still have it, because we know you had it before," Landon said.

Outside experts who commented on UChicago Medicine's policy said it seems well intentioned, since patients who test positive are isolated. Steven Simpson, a professor of medicine at the University of Kansas and board member at the Sepsis Alliance, said the policy covers two bases: antimicrobial stewardship and avoiding reporting infections, and he doesn't see a problem with that.

"To me, that's a win for the patient," he said. "It's a win for the hospital. And I suppose it's a win for Medicare. It's a winning solution all around."

Even so, the policy shows how gray the line can be between too little testing and too much. Hospitals want to be judicious to avoid false positives, but they also don't want to jeopardize patient safety by missing infections.

"There are initiatives … which are driven by laudable aims and can be helpful to patients, but they can also go overboard and be harmful if they fail to detect infections when they ought to," Diekema said.

What makes that tricky, though, is the policies that Diekema and others described as falling under the stewardship mantra were the same ones other doctors cited as examples of hospitals trying to dodge reporting infections. It's the intention behind the policy that matters.