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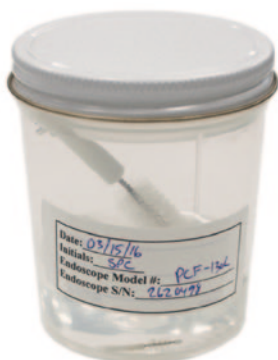
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## About the cover:



Since 2015, the cover format of each volume of *Infection Control and Hospital Epidemiology* has been changed to honor one of the many professionals throughout history who recognized not only how disease might be spread but also how those principles could be applied to reduce healthcare-associated infections.

Sir John Pringle (1707–1782) was born into a prominent Scottish family. He initially studied the classics and philosophy followed by 1 year of medical study at the University of Edinburgh. He planned to leave medicine for a mercantile career. While in the Netherlands, Pringle met Boerhaave, and his interest in medicine was re-energized. He received his medical degree in 1730 from the University of Leyden. In 1734, he assumed a chair in the Faculty of Arts in “Pneumatical and Ethical Philosophy” and practiced medicine at the University of Edinburgh.

At the age of 35, Pringle was appointed surgeon to the British Forces, which had formed an alliance with the Habsburg Dynasty against France. In 1745, as Physician General of the Army, Pringle played a role in assuring the humane treatment of prisoners of war and neutrality for military hospitals hundreds of years before the Geneva Convention and the formation of the Red Cross.

In 1748, Pringle returned to London and published his experiences in military hospitals. He recognized that hospital fever and jail fever were spread from person to person and that both syndromes were due to typhus. He mandated that prisoners be washed, that their clothing burnt, and that clean clothes be provided at public expense. He understood that hospitals were a major cause of patient sickness: crowding, filth, and lack of hygiene facilitated the spread of disease. Decades before Florence Nightingale, Pringle advocated for fresh air, cleanliness, and hygiene. He observed that fomites contaminated with body fluids, like bedding, spread sepsis. He adopted microscopy and understood that the mites he saw caused scabies. Many years before Lister and Semmelweis, Pringle used acids and distilled spirits to reduce the spread of sepsis, and the first use of the term “antiseptis” was attributed to him.

During his lifetime, Pringle was recognized for his work as President of the Royal College of Physicians (RCP), Member of the Academy of Sciences, and receipt of the prestigious Copley Gold Medal. He was made a Baronet in 1766 and physician to the King in 1774. By 1780, he retired from medicine and returned to Scotland, but the cold climate did not agree with him. Pringle returned to London, but not before he gifted 10 volumes of his *Medical and Physical Observations* to the RCP (Edinburgh) with the understanding that they would never be published or lent out. He died 4 months later.

The major advances in infection control that Pringle made to the field have too often been attributed to others, and few reminders of him survive to this day. His birthplace was demolished and his grave destroyed during World War II; 2 paintings remain. A memorial to Sir John Pringle can be found in Westminster Abbey albeit in Poets’ Corner; this location is ironic, as one friend noted that an inadequate appreciation of English poetry was one of Pringle’s few failings.

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Cover image: Sir John Pringle, 1707-1782. Oil Painting. Credit: Wellcome Collection. CCBY.

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# INFECTION in the time of RESISTANCE

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## Online CME/CPE HABP/VABP Activity

This activity was originally planned for SHEA Decennial 2020. Although we were unable to present live, we are pleased to provide you online access to this high-quality and timely content.

### Educational Overview

The past decade has seen a growing diversity of bacterial resistance mechanisms and the global rise and spread of multidrug-resistant (MDR) pathogens. These infections pose a significant health threat and burden to individuals and healthcare institutions. In the US, the CDC estimates that at least 2.8 million people acquire antimicrobial-resistant infections annually that result in at least 35,000 deaths. The diversity and spread of MDR and XDR (extensively drug-resistant) organisms challenge clinicians and substantially impact patient outcomes and healthcare costs. As a result, healthcare providers must be fully knowledgeable and remain up-to-date of the local epidemiology and resistance trends as well as recognize the latest tools available that aim to minimize the burden of these infections. These tools include rapid diagnostics and newer antimicrobials that can overcome resistance mechanisms and allow for pathogen-specific therapy. In this manner, clinicians have a greater ability to tailor management approaches based on patient factors and needs.

### Learning Objectives

At the conclusion of the educational activity, the learner should be able to:

- Summarize the changing epidemiology of antimicrobial resistance in relation to prevalence and resistance mechanisms
- Differentiate the pharmacology and antibacterial activity of newer antimicrobial agents to combat antimicrobial-resistant infections
- Identify strategies aimed to guide appropriate antimicrobial selection to optimize outcomes and reduce resistance development

### Target Audience

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