

demically-oriented specialists with qualifications and positions quite different from that of the average member of APIC; it is not made clear why a branch or divisional structure within one organization focused on infection control would not have sufficed. While I readily agree that SHEA is "... not just a club of academically-oriented chums..." the Editorial strongly implies that it is the realm of *physicians* regardless of their qualification or experience in hospital epidemiology.

Given the young nature of this field, the relative strengths and weaknesses within each of the various disciplines for entry into the field, and the need for collaboration and evolution to a socially-justifiable end result, the question of "Why SHEA" remains. The question of where those of us with graduate degrees and applied research orientation belong remains. If all of the infection control organizations strive for a future role of primacy in the field, we may be in for a painful collision.

Most of us agree on the needs for better research, better tools and resources, education, etc.; however, divisional representation based on professional origin may not be the most desirable strategy. As an MPH-qualified epidemiologist employed as the "Hospital Epidemiologist" in charge of an Infection Surveillance and Control Program, I find it disappointing that I cannot join the same society of epidemiologists that a physician without training in epidemiology may enter. I have a strong interest in furthering the professional standing of hospital epidemiologists, but the Society for Hospital Epidemiologists of America would seem to limit this future to physicians only. Is this truly in the best interest of furthering our documentation of improved health and medical care? Should the goals of hospital epidemiology really be limited to the control of nosocomial infections? In exploring the future of infection control in *Conversations in Infection Control*,² we noted that epidemiology may be applied to many aspects of hospital practice. Since the proper role of epidemiology has been defined by many as involved in planning and evaluation of health services, the most cost-effective utilization of Hospital Epidemiologists may require

broader goals. It may also be more cost-effective to consider "cross-bred" epidemiologists as well as physicians with postgraduate training. "Why SHEA" raises many points for consideration; I hope that SHEA will consider them in the widest terms possible. While not a physician, and therefore not eligible to become a member of SHEA, I would respectfully offer to accept Dr. Goldmann's invitation/challenge to provide advice and help as one who is responsible for infection control.

REFERENCES

1. Goldmann DA: Editorial: Why SHEA? *Infect Control* 1984; 4:437-439.
2. Goldmann DA (moderator): The infection control profession. Its growth and its future. *Conversations in Infection Control* 1983; 4(1).

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Donald A. Goldmann, MD, author of the Editorial, "Why SHEA?" was invited to respond.

Mr. Birnbaum's letter raises a variety of questions, but his principal theme concerns the criteria for membership in SHEA. He believes that qualified non-physicians who are serving as hospital epidemiologists have been unfairly excluded from the Society, while physicians who may have little formal training in epidemiology have been accepted without reservation. I will not attempt to speak for the Society on this complex issue, but will gladly offer my own point of view.

Mr. Birnbaum implies that only physicians will be considered for membership in SHEA. According to the Society's by-laws, a MD degree is not required, but a doctoral degree is. Actually, it was the intent of the Society's founders to be *inclusive*, not *exclusive*. It was clear that the vast majority of hospital epidemiologists were—and still are—physicians, so physicians naturally would constitute the core of any organization of hospital epidemiologists. The MD degree was felt to be a major advantage since so many of the infection control problems that the hospital epidemiologist must confront involve issues of medical practice. Non-physician hospital epidemiologists might acquire exper-

tise in areas of medical practice, but they would still have to gain the respect of the medical staff. On the other hand, it was recognized that well-trained non-physicians might know considerably more about epidemiology than many of their physician counterparts and would achieve credibility by virtue of their skill and expertise. The doctoral degree was intended to serve as a marker of advanced training.

In my opinion, an individual who has not received a PhD conceivably could acquire the relevant skills to be a hospital epidemiologist, while a PhD degree is no guarantee of proper preparation. In retrospect, the doctoral requirement seems arbitrary to me. The President of SHEA, Dr. Richard Dixon, has appointed an ad hoc committee to study membership, so there will be ample opportunity to debate these important issues again.

While I agree with Mr. Birnbaum that SHEA membership requirements deserve a second look, I strongly disagree with some of his other comments. It is incorrect to assume that APIC, SHEA, ASM, and other infection control organizations "intend to fulfill the same destiny" and are "in for a painful collision." I believe that there is room in the infection control field for people with different backgrounds, skills, responsibilities, and goals. As I stressed in the Editorial, the field will be richer if we all work together, recognizing each other's strengths, limitations, and complementary roles. For this reason, SHEA maintains active liaisons with other infection control organizations, and many SHEA members are also active in other societies. Mr. Birnbaum himself is a fine example of the value of a multidisciplinary approach for infection control.

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Effectiveness of Centralized Skin Testing

To the Editor:

Although reported cases of active tuberculosis have been declining since

1975, the CDC has released annual statistics of 25,520 cases for 1982, still indicating a significant incidence of this disease.¹ Since tuberculin skin testing is the least expensive and most sensitive method for detecting infected individuals, the accuracy of case-finding often rests on the proper application and interpretation of the PPD (Mantoux) skin test.² We concluded a study examining the accuracy of in-patient skin testing at a 330-bed community hospital and then offered solutions to resolve deficiencies in the program.

Prior to 1979 all diagnostic skin tests were applied by nursing personnel on all units at Hampton General Hospital. It was impossible to monitor this program since centralized records were not maintained. A prospective study was then designed by the Infection Control Department in which all nurses placing skin tests on hospitalized patients (PPD, Mumps, Candida, SKSD) were first trained in the application and interpretation of these tests through practical demonstrations and individual supervision. A rubber stamp was used in the physi-

cians' progress notes and medication karex to aid in recording test results. All skin tests were monitored from April through June 1979.

Of the 52 skin tests (36 PPDs, 12 Mumps, 3 Candida, 1 SKSD) applied during this three-month period, incomplete documentation was found in 65% of the cases. Moreover, spot checks revealed that in many instances tests were being administered too deeply and measurement results were imprecise. Efforts at correcting these deficiencies proved futile since too many nurses were involved in placing and reading tests.

A centralized skin testing program proved to be the solution to inaccuracy inherent in the previous system. The Infection Control Department, utilizing the services of two Infection Control nurses, is now responsible for administering, interpreting, and recording all in-patient skin tests. These duties require a time commitment of approximately 10 hours per week for both nurses combined.

Since September 1979 when this new program went into effect, several benefits have accrued, such as insured

accuracy of testing, centralized filing of information thus preventing inadvertent retesting of known PPD converters, physician confidence in the program which has resulted in a significant increase in the number of tests ordered, earlier case isolation, and the discovery of many more individuals who might benefit from INH prophylaxis.

Tuberculosis is a major health issue in our community. In 1980 we discovered 24 culture proven cases among 12,453 admissions. The centralized skin testing program is helping to meet the challenge of this continuing problem.

REFERENCES

1. Tuberculosis—United States 1982. *MMWR* 1983; 32:36.
2. Reichman LB: Tuberculin skin testing, the state of the art. *Chest* 1979; 76:764-770.

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