

## Medical News

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### Hospitals Must Notify Emergency Response Workers of Exposure to Infected Patients

Hospitals and medical facilities must have programs in place by April 20, 1994, for notifying emergency response employees (EREs) of their possible exposure to life-threatening infectious disease. This requirement is part of the Ryan White Comprehensive AIDS Resource Emergency Act (Public Law 101-381) enacted in 1990. In the March 21, 1994 issue of the *Federal Register*, the CDC outlined the final list of diseases to which these provisions apply, the circumstances under which exposure may occur, and guidelines for determining whether an exposure has occurred.

EREs include firefighters, law enforcement officers, paramedics, emergency medical technicians, and other persons, including legally recognized volunteers who respond to emergencies. The CDC has divided the list of diseases that require notification into three categories: 1) airborne disease including only tuberculosis; 2) bloodborne diseases including hepatitis B and HIV; and 3) uncommon or rare diseases including diphtheria, meningococcal meningitis, plague, hemorrhagic fevers, and rabies. The rule requires immediate (within 48 hours) notification of a "designated officer" only in cases involving airborne diseases—that is, pulmonary tuberculosis. The designated officer is the liaison between the ERE and the medical facility. The rule requires the state public health officer to select a designated officer for every employer of EREs.

Hospitals do not face damages or civil action for failing to comply with the CDC's notice. However, the

secretary of Health and Human Services can seek "appropriate injunctive relief" against alleged violators. Although many states already have some notification systems in place, union representatives have applauded these guidelines because they will provide consistency across the country and greater protection for emergency response employees.

FROM: *Federal Register* March 21, 1994;59(54):13418-13428.

### Transmission of Hepatitis B from Surgeon to Patients Continues

Researchers from the United Kingdom, Canada, and the United States presented the results of investigations of transmission of hepatitis B from surgeon to patients at a recent conference on preventing bloodborne pathogen transmission in surgery cosponsored by the American College of Surgeons and the CDC (see the Abstracts in this issue).

In the most compelling report, epidemiologists from the CDC presented the results of an investigation of the patients of a cardiothoracic surgery resident in Los Angeles with acute HBV infection. Of the surgeon's 142 susceptible patients, 18 (13%) had been infected recently with HBV, compared with 0 of 155 patients of other surgeons. The HBsAg subtype and DNA sequence of a region of the HBV genome were identical in isolates from the surgeon and infected patients. In a follow-up study of the surgeon that simulated the procedure of typing sutures, lesions were observed on the surgeons hand after 1 hour, and HBsAg was found in his glove