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SHEA Newsletter

SHEA Represented at CDC Consultants Meeting

On February 21-22, 1991, the Centers for Disease Control (CDC) sponsored a forum-style meeting to discuss "Risks of Transmission of Blood-borne Pathogens to Patients During Invasive Procedures" (see the March Newsletter). Several hundred people attended the meeting, including representatives from more than 100 organizations. SHEA was one of 12 national organizations that made invited presentations at the outset of the meeting. Representatives from more than 80 other groups also read brief statements during the next 1 1/2 days.

SHEA was represented by Dr. Michael Tapper, current chair of our AIDS Committee. The text of his comments are reproduced below. The opinions expressed by the other consultants assembled in Atlanta were overwhelmingly similar to those presented on behalf of SHEA.

SHEA's active role in policy making was highlighted again by the New *York Times; two* full paragraphs in Larry Altman's report on the CDC meeting were devoted to SHEA and our statement.

Comments read by Dr. Tapper on behalf of SHEA at the February 21-22 CDC meeting:

Last December, we published a joint position paper on the human immunodeficiency virus (HIV) -infected healthcare worker with the Association of Practitioners in Infection Control (APIC). We concluded that HIV infection per se does not constitute a basis for barring an HIV-infected person from any patient care activity, including the majority of invasive procedures. We believe that all individuals, including healthcare workers, who have had potential social or occupational exposure to HIV, hepatitis B, or other bloodborne pathogens, should determine their own serologic status with respect to these pathogens. Such determinations are clearly in the best interest of the individual to allow early initiation of appropriate treatment or prophylactic measures. Furthermore, such determinations facilitate the care of any additional individuals who may be inadvertently exposed to transmission of a bloodborne pathogen-either occupationally or socially.

We believe that those healthcare workers who are known to be HIV or hepatitis B-infected should be counseled to voluntarily avoid the small subset of invasive procedures that have been epidemiologically linked in the past to the transmission of the hepatitis B virus. We emphasize that testing of healthcare workers should be carried out in a voluntary and confidential fashion, and that the scientific data accumulated to date do not justify either mandatory testing of healthcare workers (including those who perform invasive procedures) or widespread proscriptions of professional practice based on serologic status for any bloodborne pathogen. We do not believe that spontaneous or forced disclosure of a healthcare worker's serologic status should be a requirement either for continued employment or for professional privileges to perform invasive procedures.

Before mandatory proscriptions of practice can be justified, quantification of risk is necessary; the level of risk that is deemed unacceptable must be asserted; the risk of the proscribed activity must be clearly above that unacceptable level. In addition, the expected benefits of proscription must be compared to the anticipated social and financial costs of implementation. The new CDC data on blood exchange during a variety of invasive procedures represent a first important step in this form of

risk assessment. We now urgently require additional observational and epidemiologic studies to confirm or refute these initial projections. Such studies should be designed to clarify the bi-directional risk of blood exchanges during invasive procedures and to stratify that risk by the type of procedure, the circumstances of the procedure, and the skill and experience of the individual who performs it. Epidemiologic studies-both prospective and retrospective—must be completed to resolve the question of how frequently these observed blood exchanges actually lead to infection with bloodborne pathogens.

We distinguished in our position paper between the fact of HIV seropositivity itself and the potential for neurologic or other forms of impairment that might occur with chronic infection with HIV. Institutions should have in place policies under which all healthcare workers who have physical, emotional, or neurologic impairments that may affect their fitness for certain aspects of work can be reviewed periodically and an appropriate determination made about necessary modifications of assigned tasks. State licensing boards also must make reasonable attempts to devise workable means for similar assessments of healthcare workers who function as independent contractors, in private offices, or in healthcare settings apart from institutional oversight. Since prejudice and fear continue to surround the HIV epidemic, institutions have a special responsibility to zealously guard the confidentiality of information regarding the serologic status of healthcare workers. Where seropositivity for any bloodborne pathogen has been determined, we find no requirement that individuals be required to disclose their status to any patient or colleague.

Since the publication of our position paper, the CDC has provided additional data regarding the possible transmission of HIV in a dentist's office practice. We have reviewed those data and concur with the likelihood that transmission of HIV did indeed occur in the course of dental practice. Whether such transmission occurred as a direct consequence of a major break in technique with blood contamination during an operative procedure, or whether such transmission occurred as a consequence of improper handling or inadequate sterilization of equipment remains unclear and probably will never be known with certainty. Such a rare transmission could have been and should have been anticipated, based on the hepatitis B model. Yet, all the existing serologic surveys reported to date from the professional practices of other HIV-infected healthcare workers performing invasive procedures have failed to demonstrate any evidence of transmission, emphasizing that the Florida case that has prompted so much concern remains at this moment a singular and unique event.

Major changes in healthcare policy should be based not on singular events, but rather on science, previous epidemiologic experience with other bloodborne pathogens, and a realistic assessment of the likelihood of a transmission occurring during a specific invasive procedure. Rather than hastening to mandatory programs of testing and practice restriction, we need additional studies, better engineering controls, better protective devices, and better training to enhance the safety of healthcare practice for patients and workers alike.

SHEA/CDC/AHA Hospital Epidemiology Training Program

The SHEA/Centers for Disease Control (CDC)/ American Hospital Association (AHA) Hospital Epidemiology Training Program will be held May 16-19, 1991, in Chicago, Illinois. The course is intended for infectious disease fellows and new hospital epidemiologists. It emphasizes hands-on exercises in which participants work in small groups to detect, investigate, and control epidemiological problems encountered in the hospital setting. These working sessions are sup plemented with lectures and seminars covering fundamental aspects of hospital epidemiology.

Donald Goldmann, MD, William Mar-tone, MD, and Robert Weinstein, MD, and Gina Pugliese, RN, MS, will co-chair the program. Meeting, hotel, and travel arrangements will be available through the AHA. The registration fee for this program is $495. The registration fee for infectious disease fellows is $250 if the application is accompanied by proof of training status. For general registration information call the AI-IA (Phil Gordon) : (312) 280-6764.

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