

REFERENCES

1. Miller PJ, Farr BM, Gwaltney JM Jr. Economic benefits of an effective infection control program: case study and proposal. *Rev Infect Dis* 1989;11:284-288.
2. Haley RW, Tenney JH, Lindsey JO II, Garner JS, Bennett JV. How frequent are outbreaks of nosocomial infection in community hospitals? *Infect Control* 1985;6:233-236.
3. Wenzel RP, Nettleman MD, Jones RN, Pfaller MA. Methicillin-resistant *Staphylococcus aureus*: implications for the 1990s and effective control measures. *Am J Med* 1991;91(suppl 3B):221s-227s.
4. Boyce JM, Opal SM, Potter-Bynoe G, Medeiros AA. Spread of methicillin-resistant *Staphylococcus aureus* in a hospital after exposure to a health care worker with chronic sinusitis. *Clin Infect Dis* 1993;17:496-504.
5. Boyce JM, Potter-Bynoe G, Opal SM, Dziobek L, Medeiros AA. A common-source outbreak of *Staphylococcus epidermidis* infections among patients undergoing cardiac surgery. *J Infect Dis* 1990;161:493-499.
6. Boyce JM, Opal SM, Chow JW, et al. Outbreak of multidrug-resistant *Enterococcus faecium* with transferable *vanB* class vancomycin resistance. *J Clin Microbiol* 1994;32:1148-1153.
7. Graham KK, Boyce JM, Medeiros AA, Mahoney GM, Kaufman RL. Improved dosing through use of an antimicrobial order sheet with a table of dosage adjustments for renal function. Presented at the 13th Annual Meeting of the American College of Clinical Pharmacy, Toronto, Ontario, Canada, 1992.
8. Boyce JM, Opal SM, Potter-Bynoe G, et al. Emergence and nosocomial transmission of ampicillin-resistant enterococci. *Antimicrob Agents Chemother* 1992;36:1032-1039.
9. Boyce JM, Potter-Bynoe G, Dziobek L. Hospital reimbursement patterns among patients with surgical wound infections following open heart surgery. *Infect Control Hosp Epidemiol* 1990;11:89-93.
10. Boyce JM, Potter-Bynoe G, Dziobek L, Solomon SL. Nosocomial pneumonia in Medicare patients: hospital costs and reimbursement patterns under the prospective payment system. *Arch Intern Med* 1991;151:1109-1114.

Court Rejects HIV-Positive Surgical Technician

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An operating-room surgical technician employed by a medical center in Michigan was asked to submit to HIV testing. The technician refused testing; when he also refused to accept an alternative accommodating position at the hospital, he was laid off.

The federal district court dismissed the plaintiff's Americans With Disability Act claim and Rehabilitation Act claim, finding that the technician's HIV-positive condition disqualified

him from working as a surgical technician and that he was not "otherwise qualified" to perform his job. The technician acknowledged that his position required him upon occasion to place his hands upon and into surgical incisions and that this put him at risk for needlestick or laceration injuries. However, the technician presented expert testimony asserting that the risk of transmission of HIV was so slight as not to justify his exclusion from surgery.

The court agreed with the medical center that there was a real possibility of transmission of HIV, and,

because the consequence of transmission is death, the nature, duration, and severity of the risk outweighed the fact that the chance of transmission was small. The court also ruled that the risk could not be eliminated without removing the technician from the operating room. Moreover, because the ability to assist the surgeon was an essential job function, the medical center was not required to alter the position to accommodate the technician.

FROM: *Mauro v Borgess Medical Center*, No. 4:94-CV-05 (WD MI, S Div 1995).