sive. Specifically, Dr. McGowan implies that groups like the American Thoracic Society are insular and perhaps uninterested in reaching out and working with other groups of health professionals to contain tuberculosis. In fact, nothing can be further from the truth.

The American Thoracic Society, and particularly its Assembly on Microbiology, Tuberculosis, and Pulmonary Infection, is a heterogenous organization with expertise in an array of specialties including microbiology, nursing, preventive medicine, infectious diseases, and pulmonary medicine. The American Thoracic Society has a long history of working effectively with other organizations interested in various aspects of tuberculosis and is, like SHEA, a member of the National Coalition for the Elimination of Tuberculosis. That the American Thoracic Society has been working hard to deal with tuberculosis is reflected in the fact that most of Dr. McGowan's references are either published by the American Thoracic Society or authored by members of the organization.

These points notwithstanding, Dr. McGowan's call for collaborative effort is appropriate and welcome. Speaking for our assembly and the American Thoracic Society, we would welcome an opportunity to work together with groups like SHEA to address problems in tuberculosis control in general and nosocomial tuberculosis in particular.

Jeffrey Glassroth, MD
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Chicago, Illinois

The author replies.

It is a delight to see this rapid and positive response to my editorial[1] by such a prominent and respected expert in the field of tuberculosis as Dr. Glassroth. I hasten to assure him that he has suspected potential insult where none was intended. In fact, close cooperation between pulmonary clinicians and hospital epidemiologists is crucial to tuberculosis control efforts in our hospital; I am sure that this is the case in most other medical centers.

My suggestion in the editorial was for hospital epidemiologists to work to change the perception of the public and of groups like the national, state, and local Lung Associations for whom pulmonary physicians and the American Thoracic Society (ATS) are their only resource. In Georgia, through a state TB Task Force, we have found that the hospital epidemiology community and the Lung Association have mutual interests and common concerns. Establishing a working relationship has benefited both.

I welcome the offer of Dr. Glassroth and the ATS Assembly on Microbiology, Tuberculosis, and Pulmonary Infection to work closely with SHEA I agree that both groups being active in the National Coalition for the Elimination of Tuberculosis is probably not sufficient contact. Perhaps appointment of liaison representatives by each organization to the other would be a useful way to build a continuing and productive relationship.

The invitation by Dr. Glassroth to work together should pave the way for further networking among SHEA and other pertinent groups, as dealing with revitalization of this old adversary will require strong, persistent efforts by all those affected.

John E. McGowan, Jr., MD
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of Medicine
Atlanta, Georgia

REFERENCE

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TB Test Results May Be Skewed

To the Editor:

In the Brief Report entitled "Increased Rate of Tuberculin Skin Test Conversion Among Workers at a University Hospital," published this past October,[1] the authors described that intermediate strength tuberculin (0.5 ml) was inoculated subcutaneously. Standards recommended by the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC)[2] emphasize the intradermal injection of 0.1 ml of 5 TU PPD. Any modification to this procedure may cause an important mistake in calculating the rate of tuberculosis infection. There are two problems with the method described by Ramirez et al. One is the dose of 0.5 ml, and the other is the subcutaneous injections. They are giving a larger dose by an unusual method that makes it very difficult to interpret their results. If this is the case, their conclusions may be wrong.

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Julio Molina, MD
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The author replies.

The policy for tuberculin skin testing at the Humana Hospital University of Louisville included

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the intradermal inoculation of intermediate strength (5 TU/PPD), in accordance with the current CDC recommendations.

The subcutaneous inoculation of PPD, which results in no retention of the antigen in the skin site, is one of the causes of negative skin test reactions in persons who are infected with *Mycobacterium tuberculosis.*

Drs. Ponce de Leon and Molina correctly noted that the methodology for skin testing described in our article was incorrect, and we apologize for not having recognized this error in the manuscript.

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Responsibilities of Infection Control Practitioners

To the Editor:

I take issue with this statement from the editorial in the May 1992 issue of *Infection Control and Hospital Epidemiology:* "In retrospect, most infection control practitioners overestimated the efficacy of behavioral infections and were slow to apply established principles of industrial hazard control to healthcare environments."

First, the infection control practitioner's primary responsibility is to improve patient care, not to control industrial hazards. We are educated in epidemiology, infectious diseases, and patient care practices, not industrial hygiene. Second, many of us have had the responsibility of carrying out the Occupational Safety and Health Administration's (OSHA) bloodborne pathogen standard thrust upon us because no one else in our hospitals is capable or willing to take it on. Most infection control practitioners have provided education and have had written policies on Universal Precautions (UP) in place for several years. Not only are infection control practitioners the initiators and proponents of UP, many infection control practitioners receive an appalling and indefensible lack of support from hospital administrators. OSHA's bloodborne pathogen standard would have been unnecessary if hospital administrators had enforced their own policies. "Slow to apply established principles?" No. Most noncompliance with infection control policies is a management problem, not an infection control problem. Infection control practitioners need less complaining and scapegoating from their fellow employees and more leadership from their leaders.

Ginger **Panico,** MPH
Columbus, Ohio

The author replies.

Ms. Panico is correct in her defense of the efforts made by infection control practitioners to develop, implement, and train healthcare workers in UP, often with a paucity of administrative, personnel, and financial support. I have the utmost respect for these efforts and in no way meant to undermine the tremendous contributions that infection control practitioners have made toward improving patient care and preventing nosocomial infections. Moreover, the infection control community has had to assume the responsibility for preventing occupational infections in healthcare settings and, in many cases, has provided the only leadership for implementing rational policies.

Like it or not, we have been thrust into a situation where we are expected to deal effectively with industrial hazards, especially in the form of needlestick injuries and exposure to tuberculosis. lb do so effectively, we must learn the language and understand the principles of hazard management, as evidence by the recent OSHA bloodborne pathogen standard and National Institute for Occupational Safety and Health (NIOSH) recommendations for preventing tuberculosis. Approaching these problems from the industrial hygiene paradigm (engineering controls, work practice controls, and personal protective equipment) represents a new theoretical framework for problem-solving that does not necessarily negate the tradition of infection control practice. Rather, we can evaluate this and other novel approaches and implement those that prove useful and discard those that are inappropriate for the unique needs of the healthcare environment. It is imperative that we as infection control professionals use our expertise in epidemiology and patient care to moderate the recommendations made by those who lack the knowledge and practical experience necessary to create sensible guidelines. Our input and involvement is absolutely vital to ensure a balanced approach to occupational infection prevention that does not protect our workers at the expense of our patients. lb accomplish this, we do indeed need more leadership from our leaders and more support from our colleagues and administrators.

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