Letters to the Editor

Nonclinical Epidemiologists Concerned About Quality in Healthcare

To the Editor:

Massanari and Simmons suggest that only clinicians have the "right stuff' to provide leadership in hospital epidemiology and health service quality assurance.[1] That sort of elitist position is consistent with the Society for Hospital Epidemiology of America's (SHEA's) history of discriminating against hospital epidemiologists with MPH rather than MD or PhD degrees,[2] slights the integrity of PhD (and other non-MD) researchers who are sensitive to patient-oriented values of numerous stakeholders in health service decisions, and is not conducive to interdisciplinary collaboration. Notably absent from the list of recommended collaborative priorities is the American Society for Quality Control (ASQC). ASQC is America's oldest and foremost interdisciplinary authority on quality methodology.[3] Its April 1992 special issue of *Quality Progress* is devoted to quality in healthcare.

It can be argued that we got into this mess under the direction of clinicians and their "quality" review committees. Interdisciplinary application of a CQI-like approach advocated long before the CQI philosophy became popular may be a good starting point to confront the cost-quality conundrum.[4] However, the paper prepared for SHEA contains important disincentives to attracting the collaboration of nonphysicians active in this field.

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The authors reply,

The editorial was not intended to imply exclusivity. Rather, our intention was to encourage hospital epidemiologists to consider the unique opportunities for providing leadership in quality management precisely because their work is inclusive by nature, not exclusive.

SHEA plans to interact with several "nonclinician" organizations, including the Institute for Healthcare Improvement, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Policy and Research, the Association for Practitioners in Infection Control, and the National Association of Quality Assurance Professionals. Some of these organizations do include nurses and physicians involved in clinical practice, but these organizations certainly are not dominated by clinicians, as described by Dr. Birnbaum.

We see "hospital epidemiologists" as key players in any hospital quality improvement effort. Clinicians too should be involved, but are not discussed at all in our editorial.

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Cooperation Needed to Control TB

To the Editor:

I read with interest Dr. John McGowan's recent editorial (1992; 13:575-578), "Resurgent Nosocomial Tuberculosis: Consequences and Actions of Hospital Epidemiologists." The editorial was a generally thoughtful and impassioned plea for steps that any informed healthcare professional would endorse. However, there was at least one comment that lends itself to some misinterpretation and is potentially divi-

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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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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.

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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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The author replies.

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

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