Letters to the Editor

Institutional Liability for Needlestick Injury

To the Editor:

A Connecticut jury recently found Yale University School of Medicine negligent in its training and supervision of a first-year resident who was infected with human immunodeficiency virus after sustaining an injury from a needle used on an acquired immunodeficiency syndrome patient in 1988. The jury awarded the infected physician $12.2 million (*Rocky Mountain News.* December 9, 1997:A27; *Doe v Yale University.* Superior Court of New Haven, CT. Docket no. CV 90-0305365 S). This verdict illustrates the catastrophic consequences a needlestick injury can have on both the injured party and the affiliated training institution.

This is a landmark case not only because of the verdict but also because of the legal means by which the verdict was obtained. Generally, workers' compensation is the exclusive remedy available to employees who contract a disabling occupational disease and who are covered under workers' compensation programs.[1-3] In return for guaranteed benefits for qualifying diseases, regardless of fault or an omission on the employee's part, state laws preclude employees from bringing civil suit against their employers.[1,2] In this case, the physician was able to circumvent workers' compensation exclusivity provisions by bringing suit against Yale University School of Medicine, rather than the hospital where she was a contractual employee covered under workers' compensation.

Because the residency program was advertised under the university's name and correspondence related to the residency program was sent under Yale University School of Medicine's name, the plaintiff successfully argued that the university also had a duty to assure that she was trained and supervised adequately and that it was negligent in meeting that obligation.

In the past, university-affiliated medical schools considered that they assume limited liability for employees who contracted bloodborne pathogens as a result of an occupational exposure.[1] Following this verdict, the potential for liability is increased significantly if residents in training can circumvent the exclusivity provisions of workers' compensation laws, which apply to the hospital where they are employed, by bringing suit against the affiliated university.

This verdict underscores (1) the importance of adequate training and supervision in the appropriate use of needle devices that have the potential for transmitting bloodborne pathogens; (2) the need for institutions to reduce the risk of injury by using safer needle devices that have become available recently; and (3) the immediate need for universities to seek legal counsel in carefully structuring promotion of their residency programs.

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Statewide Program for Infection Control and Epidemiology Spreads Computer Virus

To the Editor:

Your response may be, "Computer virus! Why should readers of *Infection Control and Hospital Epidemiology* be concerned about that type of virus?" However, as infection control professionals increasingly depend on computers for word processing, surveillance data analysis, maintaining policies, and other job tasks, they must ensure that important information on computers is not lost because of computer viruses.

The North Carolina Statewide Program for Infection Control and Epidemiology (SPICE) offers education, consultation, and assistance in the prevention of transmission of infections. We take pride in having resources and knowledge available to assist people all across the state. However, we admit, with great regret, that our diligence in preventing infections has not been practiced as far as our office computer is concerned.

When our office computer began exhibiting inappropriate responses, we undertook an investigation of the cause of the computer's malfunctioning. We spent many hours checking the software program, evaluating the computer users' work habits, and finally confirmed the diagnosis that our computer was infected with a virus. Using virus detection software, we identified the agent as a Word macro virus and applied appropriate treatment, disinfection of the computer. But we were faced with the questions of how our computer became infected, and whether we had been responsible for transmitting this virus to other computers. A careful investigation revealed that the source of the infection was a disk containing a manuscript that was sent to us by the largest infection control professional organization in the country, the Association for Professionals in Infection Control National. Once our computer was infected, disks we shared with other users then infected their computers. We discovered that we were guilty of transmitting the virus statewide from Orange County to Brunswick County. We notified these contacts and recommended appropriate postexposure strategies.

By February 1996, the US Department of Energy Computer Incident Advisory Capability reported that Word macro viruses no longer

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