continued from page 192

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.

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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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