Infected health care workers and patient safety: A double standard

Jane L. Perry, MA, Richard D. Pearson, MD, and Janine Jagger, PhD, MPH
Charlottesville, Virginia

US policy regarding health care worker-to-patient transmission of bloodborne pathogens, issued in 1991, is flawed. We review current evidence of such nosocomial infections and conclude that a standardized national policy is needed, which includes improved surveillance and follow-up of blood exposures to patients and targeted practice restrictions for infected practitioners performing exposure-prone procedures. (Am J Infect Control 2006;34:313-9.)

From the Editor: The following is written in response to an article published in the June 2005 issue of AJIC by authors from the Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention (Tuboku-Metzger J, Chiarello L, Sinkowitz-Cochran RL, et al. Public attitudes and opinions toward physicians and dentists infected with bloodborne viruses: Results of a national Survey. Am J Infect Control 2005;33:299-303. This article is referred to throughout as Tuboku-Metzger et al.

The article by Tuboku-Metzger et al., “Public attitudes and opinions toward physicians and dentists infected with bloodborne viruses: results of a national survey,”1 reiterates the position of the Centers for Disease Control and Prevention (CDC) that infected health care workers (HCWs) pose an insignificant risk to patients. The results of the public opinion survey provide a platform to advance a revised policy on HCWs infected with hepatitis B virus (HBV), hepatitis C virus (HCV), or HIV. The authors call for “a less restrictive national health policy regarding infected health care providers,” maintaining that the policy in effect today is too stringent.

We agree that the current policy is in need of revision, and that practice restrictions of infected HCWs may have been, in some cases, arbitrary and harmful. However, rather than abandoning all restrictions, we believe the answer lies in improved surveillance and follow-up of patients’ blood exposures and a targeted, evidence-based approach to practice restrictions.

The current policy on infected HCWs was issued by the CDC in 1991. The recommendations stated that HIV-positive and hepatitis B e antigen (HBeAg)-positive HCWs “should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures.” The recommendations further stated that allowed procedures should only be performed after informed consent is obtained from the patient. A definition of “exposure-prone procedures” was provided but not a list of specific procedures meeting the definition.2

With regard to hepatitis C, in 1998 the CDC stated, “Currently, no recommendations exist to restrict professional activities of health-care workers with HCV infection.”3 However, in 2001, in reference more generally to bloodborne viruses, the CDC stated that “practice restrictions are appropriate when an infected health care worker is impaired and cannot safely practice, when a pattern of substandard infection control is shown, or when transmission of a bloodborne virus to a patient has occurred or is suspected.”4

In the article by Tuboku-Metzger et al., the authors state that, since 1991 “accumulated evidence” on HCW-to-patient bloodborne virus transmission has shown that such cases are “extremely rare,” and, for that reason, the current policy is outdated and should no longer be considered relevant.1 However, the accumulated evidence is not discussed in this article. Other researchers and clinicians,5-8 United States and European consensus panels,9,10 and national health agencies in other countries11-14 have called for greater restrictions for infected HCWs, based on a growing body of evidence regarding transmission risk. If we
are to engage in evidence-based policy making, a full rendering of the evidence is essential. Tables 1 to 3 list reported cases of HCW-to-patient transmission of HIV, HBV, and HCV, respectively, since 1991.

The 132 HCW-to-patient infections listed exclude cases linked to narcotics abuse or to syringe reuse or other breaches of infection control. Table 1 shows that 3 HIV-infected HCWs have infected 1 patient each.15-17 Two incidents occurred during surgery (a hip replacement and a cesarean section). The other case involved a nurse in a general surgery ward who had not assisted in exposure-prone procedures and for whom the transmission route remains unclear.

Tables 2 and 3 show HCW-to-patient transmissions of HBV and HCV, respectively. Worldwide, published incident reports indicate that a total of 12 HBV-infected HCWs have infected 91 patients18-25 and that 11 HCV-infected HCWs have infected 38 patients.26-49 The largest reported cluster of HBV infections is 28; for HCV, 14. In all cases, the infected HCW was a surgeon performing an exposure-prone procedure, ie, a procedure requiring the HCW’s hands to be in a body cavity in proximity to a sharp instrument, a cut or fractured bone, or other sharp object. Investigations of the two most recent incidents in the United Kingdom of HCW-to-patient HCV transmission48,49 have identified more than one infected patient in each case, but the final numbers have not yet been published and are not referenced here (personal communication, Fortune Ncube, Health Protection Agency/Centre for Infections, November 2005). Another case of HCV transmission, involving an anesthesiologist in the United States, was documented in 2002 but is excluded from Table 3 because narcotics abuse could not be ruled out as a possible cause.50

Two authors of the Tuboku-Metzger et al1 article have elsewhere stated—and rightly so—that “public health policies must be grounded in science.”51 What the data tell us is that HCW-to-patient transmission of bloodborne pathogens continues to occur and that such incidents are highly concentrated within a predictably narrow scope of health care—the most invasive surgical subspecialties, including cardiothoracic surgery, obstetrics and gynecology, orthopedics, and general surgery. Additionally, although hepatitis B infection has been dramatically reduced as an occupational risk, Table 2 reminds us that it remains a risk for a sizable population of susceptible patients. Older surgeons who were infected before the hepatitis B vaccine became available are still operating. Other surgeons who were infected in utero or were previously infected in countries with high-prevalence rates of hepatitis B can still enter the field of surgery.

The cases in these tables do not fully account for incidents that have occurred, especially in the United States where it is more likely than not that cases will fall through the cavernous gaps in our case identification methods. Most cases are likely to go undetected because patients infected with HIV, HBV, or HCV often remain asymptomatic for years. Furthermore, there is little incentive for hospitals in the United States to investigate potential HCW-to-patient infections or to publish a report of an investigation. It is no coincidence that the majority of reported cases of provider-to-patient HCV and HBV transmission are from the United Kingdom, where surveillance and follow-up are more thorough. A reportable case of HCV infection in the United Kingdom requires only that anti-HCV status be confirmed.52,53 Epidemiologic investigations are routinely carried out in the United Kingdom when a new case has had a surgical intervention and has no other risk factors for infection.18,27 In the United States, acute HCV infection is defined as the abrupt onset of illness and alanine aminotransferase (ALT) levels higher than 7 times the upper limit of normal (the ALT cutoff was raised from 2.5 in 2000).54,55 Even when an individual with acute HCV meets the CDC case definition, there is rarely any follow-up to determine whether the infection was due to nosocomial transmission. Thus, the likelihood of an HCW-to-patient infection being detected, reported, documented, and published in the United States is extremely small. Tuboku-Metzger et al1 point out that “the current policy has been inconsistently applied and has led to discrimination against health care providers, who

### Table 1. Worldwide cases of health care worker-to-patient transmission of HIV, 1991-2005*

<table>
<thead>
<tr>
<th>Year reported</th>
<th>Reference</th>
<th>Country</th>
<th>Occupation/procedure performed (if available)</th>
<th>No. patients infected</th>
<th>No. patients tested in look-back studies</th>
<th>% Patients infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>Lot et al18</td>
<td>France</td>
<td>Orthopedic surgeon; hip replacement</td>
<td>1</td>
<td>983</td>
<td>0.10%</td>
</tr>
<tr>
<td>2002</td>
<td>Astagneau et al18</td>
<td>France</td>
<td>Nurse, general surgery, gynecology; did not assist exposure-prone procedures</td>
<td>1</td>
<td>2294</td>
<td>0.04%</td>
</tr>
<tr>
<td>2003</td>
<td>Bosch17</td>
<td>Spain</td>
<td>OB/Gyn; cesarean section</td>
<td>1</td>
<td>250</td>
<td>0.40%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>3 HCWs</td>
<td>3527</td>
<td>0.09%</td>
</tr>
</tbody>
</table>

*The Florida dentist case, reported in MMWR in 1990 and 1991, is excluded because the infections occurred between 1987 and 1989.
Table 2. Worldwide cases of health care worker-to-patient transmission of hepatitis B virus, 1991-2005

<table>
<thead>
<tr>
<th>Year Reported</th>
<th>Reference</th>
<th>Country</th>
<th>Occupation/procedure performed (if available)</th>
<th>No. patients infected</th>
<th>No. patients tested in look-back studies</th>
<th>% Patients infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>CDR review</td>
<td>United Kingdom</td>
<td>I Junior cardiothoracic surgeon; assisted on coronary artery replacement or aortic valve replacement</td>
<td>20</td>
<td>304</td>
<td>6.57%</td>
</tr>
<tr>
<td>1996</td>
<td>CDR review</td>
<td>United Kingdom</td>
<td>I General surgeon; hernia repairs</td>
<td>2</td>
<td>16</td>
<td>12.50%</td>
</tr>
<tr>
<td>1996</td>
<td>Harpaz et al</td>
<td>United States</td>
<td>I Thoracic surgeon (resident); assisted on coronary artery bypass, orthotopic heart transplants, repair of congenital heart defects, other procedures</td>
<td>19</td>
<td>144</td>
<td>13.19%</td>
</tr>
<tr>
<td>1997</td>
<td>Incident investigation team</td>
<td>United Kingdom</td>
<td>Four HBeAg-negative surgeons investigated:</td>
<td>General surgeon (infected 1 patient in 1988 so is excluded from this count)</td>
<td>1 confirmed, 2 probable</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I OB/Gyn trainee; cesarean section</td>
<td>1</td>
<td>111</td>
<td>0.90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I OB/Gyn trainee; hysterectomy</td>
<td>1</td>
<td>21</td>
<td>4.76%</td>
</tr>
<tr>
<td>1997</td>
<td>Sundkvist et al</td>
<td>United Kingdom</td>
<td>I Orthopedic surgeon; hip hemiarthroplasty</td>
<td>1</td>
<td>189</td>
<td>0.53%</td>
</tr>
<tr>
<td>1997</td>
<td>Oliver et al</td>
<td>United Kingdom</td>
<td>Three surgeons investigated:</td>
<td>I General surgeon; hernia repair</td>
<td>1 confirmed, 10 possible</td>
<td>514</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I General surgeon/orthopedics; N/A</td>
<td>2</td>
<td>1 possible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I Urology; N/A</td>
<td>1</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>Molyneaux et al</td>
<td>United Kingdom</td>
<td>I Cardiothoracic surgeon; coronary artery bypass</td>
<td>2</td>
<td>124</td>
<td>1.61%</td>
</tr>
<tr>
<td>2002</td>
<td>Spijkerman et al</td>
<td>The Netherlands</td>
<td>I General surgeon; intestinal resections, hernia repairs, perianal or anal surgeries, tumor excisions, vascular procedures</td>
<td>1 confirmed, 2 probable</td>
<td>1564</td>
<td>1.78%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I General surgeon/orthopedics; N/A</td>
<td>1</td>
<td>1 possible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I Urology; N/A</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>12 HCWs</td>
<td>91</td>
<td>3079</td>
<td>2.96%</td>
</tr>
</tbody>
</table>

*Excludes cases in which transmission was attributed to intravenous drug use/narcotic tampering/improper infection control practices on part of infected HCW.

1 In 1991, the US Occupational Safety and Health Administration mandated, through the bloodborne pathogens standard, that health care employers make hepatitis B vaccine available to HCWs with potential exposure to patient blood and body fluids. In the United Kingdom, hepatitis B vaccination for HCWs was recommended in 1990 and became mandatory for HCWs who perform exposure-prone procedures in 1993. The 1993 guidance stated that HCWs who were found to be HBeAg positive must stop performing exposure-prone procedures. Although reports regarding HCW-to-patient HBV transmission appeared in the medical literature in 1991 (CDR Rev 7/19/91. 1991;1:R81.), 1992 (Prentice, BMJ 1992;304:761-4.), and 1994 (Johnston, Infect Control Hosp Epidemiol 1994;15:332.), they were excluded because they described cases occurring prior to 1991. The first article cited above, published in 1996, describes investigations conducted in 1992 and 1993.

virtually pose no risk for transmission to patients. We support the practice rights of infected HCWs who pose no risk to patients—those who do not perform exposure-prone procedures. However, this statement presents only one side of the picture. The flip side is that the inconsistency of the current policy has also permitted the unimpeded exposure of patients where risk has been established.

The heart of the problem is that the current policy places the onus on local “expert review panels” to determine what, if any, restrictions should be imposed on infected HCWs. Leaving decisions to local authorities has led to a capricious process that is all too vulnerable to local interests and conflicts of interest. It is a loophole through which all measures to insulate patients from exposure to infected providers can vanish.

One case illustrates the degree to which this process can, and has, gone wrong. In March 2002, Newsday, a Long Island daily, reported that an HCV-infected cardiac surgeon had likely infected 3 patients. Participating in the investigation of the cluster outbreak were officials from the hospital, the county health department, the state health department and the CDC. It was determined that the surgeon had likely been infected for at least 10 years; according to the state health department, the hospital knew of the surgeon’s infection since 1995. The hospital also knew, as far back as 1994, that 2 patients had acquired HCV after cardiac surgery performed by the same infected surgeon, but no investigation was conducted at that time. A look-back study was initiated in 2002 that attempted to contact the 4200 patients he operated on during a 10-year interval. It concluded that he “likely transmitted HCV to as many as 14 of 937 [1.5%] patients who could be evaluated.” Because only 22% of his prior patients could be contacted, the total number
of patients he infected is likely to have been higher than 14.

This is the largest outbreak on record, worldwide, of surgeon-to-patient transmission of HCV, yet the surgeon is still operating, with no restrictions placed on the procedures he may perform. In light of the CDC’s prior position that “practice restrictions are appropriate when … transmission of a blood-borne virus to a patient has occurred or is suspected,” it appears that the bar has been precipitously lowered. Or has it been dropped altogether? Is there any limit to the number of patients that a HCW can infect before that worker’s right to perform exposure-prone procedures is suspended?

The position taken by Tuboku-Metzger et al in 2005 was previously articulated in a 2002 commentary (by two authors of the 2005 article) in response to another cluster of infected surgical patients. In that case, an HBV-infected surgeon in The Netherlands was reported to have infected multiple patients (8 confirmed, 2 probable, 18 possible) over a 10-year period. Despite the number of patients infected, the CDC commentators did not endorse practice restrictions for the Dutch surgeon, either. Rather, they argued, as in the 2005 article, that practice restrictions should be abandoned.

The proposal to eliminate practice restrictions is based on the premise that “exposures during health care that could lead to transmission are preventable.” In place of restrictive policies, the authors would rely instead on safer devices (such as blunt suture needles), safer practices (such as hands-free passing of sharp instruments), and use of personal protective equipment (such as double gloving) to prevent percutaneous injuries and blood contact between providers and patients in surgical settings. Although such safety measures are required by the Occupational Safety and Health Administration (OSHA) under its blood-borne pathogens standard, their implementation in surgical settings has lagged behind other clinical settings. This is reflected in market data: by 2004, 4 years after the passage of the Needlestick Safety and Prevention Act, safety-engineered intravenous (IV) catheters, used primarily in nonsurgical settings, had gained 94% of the US market compared with conventional IV catheters (personal communication, Healthcare Products Information Services, Philadelphia, PA). In contrast, by 2004, blunt suture needles—which can prevent the largest fraction of percutaneous injuries in surgical settings—had gained only 3% market share in relation to sharp suture needles (personal communication, Ethicon Inc.). Also, despite having the highest percutaneous injury rates of all HCW groups, operating physicians have the lowest level of compliance in

---

**Table 3. Worldwide cases of health care worker-to-patient transmission of hepatitis C virus (HCV), 1991-2005**

<table>
<thead>
<tr>
<th>Year Reported</th>
<th>Reference</th>
<th>Occupation/procedure performed (if available)</th>
<th>No. patients infected</th>
<th>No. patients tested in look-back studies</th>
<th>% Patients infected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>CDR Weekly26</td>
<td>United Kingdom</td>
<td>1 Cardiothoracic surgeon; coronary artery replacement</td>
<td>N/A</td>
<td>278</td>
</tr>
<tr>
<td>1996</td>
<td>Esteban et al28</td>
<td>Spain</td>
<td>1 Cardiac surgeon; N/A</td>
<td>5</td>
<td>222</td>
</tr>
<tr>
<td>1999</td>
<td>CDR Weekly29,30</td>
<td>United Kingdom</td>
<td>1 Ob/Gyn; hysterectomy</td>
<td>7</td>
<td>3628</td>
</tr>
<tr>
<td>2000</td>
<td>CDR Weekly31</td>
<td>United Kingdom</td>
<td>1 General surgeon; N/A</td>
<td>4</td>
<td>1370</td>
</tr>
<tr>
<td>2000</td>
<td>CDR Weekly31</td>
<td>United Kingdom</td>
<td>1 General surgeon; N/A</td>
<td>2</td>
<td>750</td>
</tr>
<tr>
<td>2001</td>
<td>Rabin32-42</td>
<td>United States</td>
<td>1 Cardiac surgeon; N/A</td>
<td>14</td>
<td>937</td>
</tr>
<tr>
<td>2001</td>
<td>CDR Weekly43</td>
<td>United Kingdom</td>
<td>1 Ob/Gyn; cesarean section</td>
<td>1</td>
<td>228 contacted</td>
</tr>
<tr>
<td>2002</td>
<td>Ross et al36</td>
<td>Germany</td>
<td>1 Orthopedic surgeon; hip arthroplasty/trochanteric osteotomy</td>
<td>1</td>
<td>207</td>
</tr>
<tr>
<td>2002</td>
<td>Ross et al37</td>
<td>Germany</td>
<td>1 Ob/Gyn; cesarean section</td>
<td>1</td>
<td>2286</td>
</tr>
<tr>
<td>2005</td>
<td>CDR Weekly48,49</td>
<td>United Kingdom</td>
<td>1 Ob/Gyn; N/A</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2005</td>
<td>CDR Weekly49</td>
<td>United Kingdom</td>
<td>1 Ob/Gyn; N/A</td>
<td>1</td>
<td>2350 contacted</td>
</tr>
<tr>
<td>2005</td>
<td>CDR Weekly49</td>
<td>United Kingdom</td>
<td>1 Ob/Gyn; N/A</td>
<td>1</td>
<td>9678</td>
</tr>
<tr>
<td>Total</td>
<td>CDR Weekly50</td>
<td>United Kingdom</td>
<td>11 HCWs</td>
<td>11</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Excludes cases in which transmission was attributed to intravenous drug use/narcotic tampering/improper infection control practices on part of infected HCW.

*Personal communication, Fortune Ncube, UK Health Protection Agency, Centre for Infections, November 2005 (information updated from published reports).

*Investigations of the two most recent incidents in the UK have identified more than one infected patient in each case, but the final numbers have not yet been published and are not referenced here (Fortune Ncube, UK Health Protection Agency, Centre for Infections).

*Cases characterized by investigators as “may have transmitted” or “likely transmitted” by the surgeon.

*Excludes data from reports not providing number of patients tested.
reporting their injuries: in one CDC study, only 27% did so.\(^5\) Although implementing the full array of safer devices and practices in surgery would be an important advance in both HCW and patient safety, and one we have long advocated, it would be unwise for a new patient safety policy to rely solely on measures that have yet to be put into widespread practice.

We maintain that the new, less restrictive policy proposed by Tuboku-Metzger et al is not based on evidence of "exceptionally low risk"; it is based on deficient evidence resulting from exceptionally low levels of surveillance and reporting. A revised policy to protect patients from HCW-to-patient transmission of bloodborne pathogens must first acknowledge that a blood exposure to a patient is of equal medical significance as a blood exposure to a HCW. Patient exposures to the blood of HCWs are not rare events. A CDC multicenter study found that, in 32% of sharps injuries to surgeons, the device causing injury (contaminated with the surgeon's blood) reconnected the patient.\(^5\) Another multicenter study indicated that 25% of sharps injuries to surgical personnel occurred while their hands were in contact with the surgical site.\(^5\)

However, these incidents most often are not reported, the patients are unaware they have been exposed, and follow-up is rarely provided.

What are patients deprived of as a result of this "don't ask, don't tell" course of action? With the availability of hepatitis B vaccine, there is no justification for allowing unvaccinated patients to be put at risk of infection from an HBV-infected physician during an elective exposure-prone procedure. Our current policy, however, allows HBV-infected physicians to ignore their infection status, ignore the hepatitis B immune status of their patients, expose patients to their blood, and take no steps after exposure to prevent patients from becoming infected. By neglecting to document blood exposures to patients, we deprive them of the benefits provided to blood-exposed HCWs: prophylaxis that could prevent HIV or HBV infection, or timely treatment for HCV infection.

We recognize that the vast majority of HCWs infected with bloodborne pathogens do not perform exposure-prone procedures and pose no risk to patients. Restrictions on them would indeed be senseless and harmful. They should be protected from arbitrary administrative decisions to restrict their practice rights. Practice restrictions should be limited to HCWs performing exposure-prone procedures—a small fraction of the health care workforce. Over 12 million HCWs are employed in the United States,\(^6\) of those, some 107,000 (0.9%) work in specialties that have been linked to physician-to-patient bloodborne pathogen transmission.\(^6\) An evidence-based system for identifying at-risk procedures and the level of practice restriction appropriate to each has been proposed by a US consensus committee composed of experts from the fields of medicine, surgery, law, and biomedical ethics.\(^10\) Their recommendations for restrictions are specific to the pathogen involved and the degree to which procedures are exposure prone. The adoption of such a system nationally would be an appropriate first step toward targeting patient safety measures where specific risks lie.

Testing of physicians for bloodborne pathogens need not involve routine screening but, instead, can be narrowly focused. First, testing of physicians should precede admission to residencies in specialties in which exposure-prone procedures are performed; infected medical students or residents can be redirected to other specialties in which such procedures are not performed. This is a long-term strategy that will spare these individuals the possibility of having their practice rights suspended midcareer. Infected physicians who no longer perform exposure-prone procedures should be reassured that their practice rights will not be threatened in the future.

For physicians already in practice, it is only necessary to enforce policies that are consistent with OSHA's bloodborne pathogens standard. Institutions can more effectively achieve compliance in reporting percutaneous injuries sustained by surgeons by requiring sign-off and verification by other members of the surgical team at the end of each case as to whether a percutaneous injury has occurred. In this way, blood-exposed patients would systematically receive the same postexposure follow-up and management that HCWs are entitled to, and physicians would be tested only at the time of at-risk events. The terms under which deemed consent applies to patients should apply equally to physicians. If a physician reporting an exposure is found to be infected with a bloodborne pathogen, appropriate practice restrictions should be imposed, depending on the pathogen involved and the types of procedures he or she performs.

Stricter enforcement of institutional reporting requirements may have the beneficial effect of motivating surgical personnel to adopt more rapidly injury-preventing devices, such as blunt suture needles, surgical stapling devices, and scalpels with blade-shielding features, which will ultimately protect them from occupational infection. In addition, physicians who have avoided knowing their bloodborne pathogen status will have the opportunity, if infected, of being treated.

Obtaining informed consent from patients to be operated on by infected physicians—as recommended under current guidelines—does not justify exposing them to the risk of infection from a bloodborne pathogen. Informed consent does not protect patients from infection; rather, it is a legal shield to protect institutions from liability if an infection occurs. It should not be
the responsibility of patients to protect themselves. It is the responsibility of policy makers to make difficult decisions in the best interest of patients.

We concur with Tuboku-Metzger et al that a revised policy for infected HCWs is needed—one that takes into consideration the accumulated evidence since 1991. We propose policy modifications for the United States; additional factors may need to be taken into account in other countries. A revised US policy should include the following:

- Be based on the premise that a blood exposure to a patient is of equal medical significance as a blood exposure to a HCW;
- be based on a national standard, to avoid inconsistency in local decision making, that provides clear definitions of exposure-prone procedures and levels of practice restrictions specific to different pathogens and procedures;
- protect the practice rights of infected HCWs who do not perform exposure-prone procedures;
- include a provision for testing of medical students and residents so that those infected with bloodborne pathogens can orient their careers toward specialties that do not involve performing exposure-prone procedures;
- mandate institutionally enforced reporting of blood exposures to patients during performance of exposure-prone procedures, and guarantee the same postexposure management and follow-up that is provided to blood-exposed HCWs, including testing of source HCWs;
- require that, when a blood exposure to a patient is reported and the source HCW tests positive for a bloodborne pathogen, the appropriate practice restrictions specific to the pathogen involved and the procedures performed be imposed on the infected worker; and
- establish a national reporting system to monitor infection rates of patients exposed to HCWs’ blood during invasive procedures. Such a system would provide a foundation for future evidence-based policy decisions.

Today, we are operating under a double standard—one that recognizes and protects HCWs from the risks of bloodborne pathogen exposure while largely neglecting the same risk to patients. Can we justify a policy that would do less for the health of patients than for their caregivers?

The authors thank Dr. Fortune Ncube (Consultant Epidemiologist, UK Health Protection Agency, Centre for Infections) for his generous help in providing updated information on cases of health care worker-to-patient transmission of hepatitis C in the United Kingdom.

References


