In the Spotlight

Web Expansion: Interview with Katherine West

By Courtney McCain

The summer 2008 issue of the IAFC's EMS Section newsletter, EMS Chief Advisor, featured an article about the Emerging Diseases Task Force. This online feature offers expanded statements from an interview with Katherine West, BSN, MSEd, CIC, an internationally renowned specialist in infection control and a member of the Emerging Diseases Task Force. West and her husband, James Cross, an attorney, operate the consulting firm Infection Control/Emerging Concepts near Washington, D.C. In addition to authoring several books about infection control, West is on the faculty at George Washington University School of Medicine and Health Sciences, and has served as adjunct faculty for the National Fire Academy.

Regarding her involvement with the IAFC's Emerging Diseases Task Force

I have been invited to participate and I'm really excited about it.

Educating prehospital providers about infection control issues

The education part has been a concern for a long time. Over the years, first there was a real interest and the textbooks started jumping on it, and then things seemed to drift away.

Education has got to turn around. And I have been beating my head against this wall since 1978.

OSHA, in the bloodborne pathogen regulations, hit on a key point about education, that there needs to be a qualified instructor, and that has not been complied with in most departments. They've told someone, 'you're the trainer, so you teach this' and when they don't understand what they're teaching, that's a problem. That's part of why there's so much misinformation out there.

Because people don't understand the diseases, they've focused on PPE. No one is focused on post-exposure management, understanding the diseases, understanding the actual risk. And they blow risk out of proportion.

Improperly trained people have been put in charge of training a subject that they don't know well, and don't understand. I think they were teaching to scare, thinking that if they scared people it would change their behavior. Butif you look at educational studies, especially (Abraham) Maslow's work, fear is not a good motivator for change. It paralyzes people. And that's exactly what's happened.

On the importance of good, post-exposure management

There's been a focus that you're going to take these diseases home to your family, and that's troubling and unfair because that's what post-exposure management is all about. That's where the designated infection control officers play a key role.

The chiefs need to have insight into what's appropriate. According to OSHA, the employer must ensure proper care and counseling post-exposure. So the department is on the line, and if a department is relying on care solely from the emergency department, then the emergency physician is only acting as an agent for that department.

About what happened to the notification clause of the Ryan White Act

It was tacked onto a funding bill. The funding part has to be reauthorized every 5 years, and every time it went up for reauthorizations, we'd get calls to see if anything had changed. And this last go-around, we got our usual call, 'Did it change?' So Jim made some calls and discovered that it had been deleted, but he kept getting conflicting information. He spent probably two or three weeks confirming that, in fact, that subtitle was gone.

The reason it happened was that groups of staffers had been sitting in the reauthorization meeting and wondered why it was there. Instead of calling the original people involved in the bill, they just deleted it. Nobody was there to speak up for it. We couldn't believe it.

On wishes for a new notification law

You cannot tell people that a law exists when it doesn't. You cannot be dishonest in your representation. We need to get the law back, and I think in an improved version. Tacking it back onto the original is shortsighted. I think it should be a separate law. There needs to be a stand-alone law so we don't risk this happening again.

It's easier to get rid of a law than it is to get it back. We have a much-needed law that needs to be improved on and expanded, because it doesn't cover everything. And OSHA certainly doesn't help us out. In many states, there's no coverage at all for fire/EMS, and certainly no coverage for volunteers. The Ryan White Law explicitly covered volunteers. OSHA does not.

We've been getting calls for months by departments being told by hospitals that they don't have to do source testing for them because they aren't hospital employees.

We've tried to fight it on 'it's the right thing to do'. There's been a healthcare worker exposure, and the CDC guidelines are the medical standard of care, so that's what we've been pushing.

Differences between state testing laws

Both the Ryan White Law and the OSHA regulations defer to the state testing laws, and I don't know if people truly realize what that means. There are some really bad state laws out there that need to be redone. The time is right to bring these issues into more uniformity.

Maine, Ohio, Florida, they have some real issues. The former Florida governor essentially abolished the department of labor and made compliance with OSHA voluntary.

Look at Ohio. In Ohio, OSHA only applies to federal employees. It has no coverage for state and local employees. And they don't really have a state testing law, so they're left with virtually nothing.

Some states, but not all of them, do have testing laws but they also need to be redone because most of them are very old. Most of them were written back in the early age of HIV and are very difficult to deal with.

In California, there's a regulation that first response personnel must prove they have tested negative for HIV before the patient is even tested. Now, that's absurd! There are a lot of state laws like that. New York has a 21-page law that says if the patient doesn't consent to testing, you're out of luck.

Virginia has "deemed consent", where if a healthcare worker is exposed, the patient cannot refuse. So that's more where we need to be.

About antiretroviral medications

Rapid testing needs to be done, and hospitals are to do those rapid tests or its an OSHA violation. And then we won't have as many people put on these drugs.

We really don't have a lot of proof that antiretrovirals given prophylactically are effective, and we have had cases where they didn't work. Also, we know nothing about the long-term effects of giving these drugs to healthy people. These are mostly inappropriately prescribed, and that's dangerous, as well as costly.

That makes the counseling portion so important. If the exposure meets the criteria, the provider is to decide, without any pressure from the physician, whether to take these medications.

Concern about drug-resistant strains

Overall, my concern would be the development of multi-drug resistant organisms, and that has happened because we are not doing things properly. Thinking needs to change. We have an overuse of gloves and development of glove-sensitivity because we can't do one simple thing of washing our hands. People are going off and spending money on things when basics are the best.

We are over-prescribing drugs when they are not needed. Everybody wants to be scared, but nobody will do the basic things, like washing our hands. We need a basic understanding of disease transmission and risk. The disease process has got to be part of training so we can build a comfort level.

There is a new strain that is community-acquired. Most MRSA can be treated with excision and drainage, and it doesn't even require antibiotics. It's when it goes for a long time that it becomes a serious issue.

We have transmission from family pets to people with MRSA. We know it can be sexually transmitted. And a lot of our own behaviors, such as not showering after exercise, not cleaning exercise equipment in stations, can contribute to that.

Common errors during responses

Putting gloves on before you arrive on scene is a bad idea. If you put gloves on before arrival, then you'll get out of the truck, and you are pulling out equipment and getting contaminated. Then you're touching my open wound with your contaminated gloves, and you're setting me up for infection.

Compliance monitoring essential but often neglected

We cannot completely eliminate exposures in healthcare. That's not realistic.

The main thing that needs to be done is compliance monitoring. It is an OSHA regulation to make spot checks, and make sure vehicles are being cleaned, and make sure people are using needle-safe devices. All these things to make sure that staff is doing it.

Georgetown released a study this year, in which they cultured 21 ambulances. Ten of them had MRSA. That tells you they're not cleaning their vehicles. ✠