

Susan Bryant, R.N., BSN, CIC  
Infection Control Practitioner  
New Rochelle Hospital Medical Center  
16 Guion Place  
New Rochelle, New York 10802

July 21, 1994

NIOSH Docket Office  
Robert A. Taft Laboratories  
Mail Stop C34  
4676 Columbia Parkway  
Cincinnati, OH 45226

To Whom It May Concern,

*I am writing because of my concern regarding required personal respirators that healthcare workers must wear while treating those with infectious or suspicion of tuberculosis. During the past four years the healthcare industry has been bombarded with conflicting recommendations and mandates from CDC, OSHA and NIOSH. The latest turn around concerns the proposed new certification process for personal respirators to be used in healthcare, which may result in more comfortable and less costly equipment. My comment on this proposal follows.*

*First and foremost the epidemiology of pulmonary TB needs to be clearly understood by NIOSH and required PPE needs to be based on scientific fact and common sense! I realize scientific opinion is often contradictory making judgements based on scientific fact difficult but what ever happened to common sense? While your technicians work on certification of respirators please let the testing include three consecutive days of working 12 hour shifts lifting 125 to 250 pound patients, giving treatments & bed baths, cleaning and disinfecting the environment as well as making beds. Then maybe you will understand the need for common sense. I am also concerned about the protection of healthcare workers from the dangers of infectious TB, but making the HCW wear an unwieldy, suffocating particulate respirator is not the answer. It is difficult to maintain compliance with the use of respirators when the benefit to the employee is not clear and the discomfort is glaring (not to mention patient alienation). This is especially true when the work practice controls and engineering controls that are ( and have been) in place have been proven effective. My institution has an extremely low PPD conversion rate with no significant difference before or after respirators were required. My fear is that staff will wear respirators inappropriately in order to breath comfortably and to cool down; putting*

JUL 26 1994

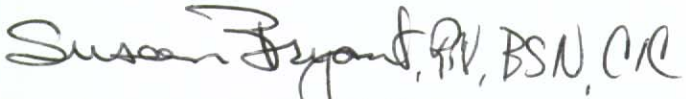
them at greater risk than if they were wearing a surgical mask or level 1 respirator that is left in place during the entire patient contact.

Lastly, I feel it is important that healthcare institutions be given greater latitude in choosing a level of protection for employees based on past known exposures and the resulting number of PPD conversions. Making a level 3 respirator the minimum level allowable under any circumstance is unreasonable. The healthcare industry is being hit with an extremely high financial burden that does not appear equal to the benefits gained from requiring the use of respirators during any contact (opposed to selected high risk procedures) with infectious or suspect TB patients.

The level of confidence in CDC, OSHA, and NIOSH by the healthcare industry (including employees as well as administrators) has decreased as a result of the waffling seen over the past four years in regard to particulate respirators. Last year, just as I completed training and fit testing over 1,500 employees to use a level 2 respirator when the latest edict came down from OSHA that only level 3 and above would be acceptable! Do your agencies realize the American public is ultimately footing the bill when the expense of respirators and training (and retraining) is tallied up?

I believe your agency and the healthcare industry have common goals; the protection of all Americans. Please continue your research on determining how TB is transmitted and then remember to use some common sense when mandating a form of protection.

Sincerely yours,



Infection Control Practitioner