

must have two skin tests, and that an average hourly wage for hospital workers is \$17, then the lost personnel time for skin testing alone would have cost \$4,777 (1 hour \times \$17 \times 281 employees), enough to cover the costs of an additional 59 days (at \$81 a day) in isolation. This would have covered the added costs of 2.3 days in isolation for each of the 26 patients—both case-patients and rule-out TB patients—who were unisolated.

Clearly, the incidence and epidemiology of TB and the isolation resources differ from hospital to hospital. The balance between cost and benefit of aggressive isolation will be different at different institutions. However, over many years and in many situations, trying to figure out at the door if a patient has TB hasn't worked and will continue not to work. We need a new approach. Or to quote Dixie Snider, "keep doing what you've always done, and you'll get what you always got."⁷

REFERENCES

1. Menzies D, Fanning A, Yuan L, Fitzgerald M. Tuberculosis among health care workers. *N Engl J Med* 1995;332:92-98.
2. Pegues CF, Johnson DC, Pegues DA, Spencer M, Hopkins CC. Implementation and evaluation of an algorithm for isolation of patients with suspected pulmonary tuberculosis. *Infect Control Hosp Epidemiol* 1996;17:412-418.
3. Fridkin SK, Manangan L, Bolyard E, the Society for Healthcare Epidemiology of America, Jarvis WR. SHEA-CDC TB survey, part I: status of TB infection control programs at member hospitals, 1989-1992. *Infect Control Hosp Epidemiol* 1995;16:129-134.
4. Centers for Disease Control and Prevention. Guidelines for preventing the transmission of *Mycobacterium tuberculosis* in health-care facilities, 1994. *MMWR* 1994;43(RR-13):1-132.
5. Beekman SE, Fahey BJ, Willy ME, Collins AS, Koziol DE, Henderson DK. Resource utilization impact of empiric respiratory isolation for suspected tuberculosis. *Infect Control Hosp Epidemiol* 1995;16(S):P34.
6. Fazal BA, Telzak EE, Blum S, et al. Impact of a coordinated tuberculosis team in an inner-city hospital in New York City. *Infect Control Hosp Epidemiol* 1995;16:340-343.
7. De Cock KM, Wilkinson D. Tuberculosis control in resource-poor countries: alternative approaches in an era of HIV. *Lancet* 1995;346:675-677.

OSHA's Susan Harwood Dies

Gina Pugliese, RN, MS
Martin S. Favero, PhD
Medical News Editors

Susan Eileen Harwood, Director of the Office of Risk Assessment, Health Standards Program at the Occupational Safety and Health Administration (OSHA) passed away on April 15, 1996, following a brief illness. Susan became well known to the infection control community through her leadership in the devel-

opment of the Bloodborne Pathogen Standard. For the past 3 years, she has been involved in the development of a standard for tuberculosis. Susan also was responsible for implementing innovative strategies at OSHA, including a series of stockholders' meetings to obtain input on the proposed tuberculosis standard from a number of organizations, including SHEA and APIC. Susan was committed to the protection of employee health and, in furthering that goal,

she was able to bridge the gap between workers, management, and regulatory and nonregulatory government agencies. She always was ready and willing to listen to another point of view or additional documentation to support a different approach in assuring worker safety and health. As a physician with an interest in biologic hazards to workers, Susan was particularly in tune with many of the concerns of the infection control community. Susan truly will be missed.