We urge that the hepatitis B vaccine, which has an excellent safety and effectiveness record to date,[5,6] and which may pay for itself in the long-run,[3,7] be offered to high-risk hospital employees at no personal expense.

REFERENCES

1. Immunization Practices Advisory Committee (ACIP): Recommendation of the Immunization Practices Advisory Committee (ACIP): Inactivated hepatitis B virus vaccine. *MMWR* 1982; 31:317-322, 327-328.
2. Hepatitis B vaccine. *Med Lett Drugs Ther* 1982; 24:75-76.
3. Mulley AG, Silverstein MD, Dienstag JL: Hepatitis B vaccine: Indications based on cost-effectiveness analysis. *N Engl J Med* 1982; 307:644-652.
4. Sampliner RE, Bozzo PD, Murphy BL: Frequency of antibody to hepatitis B in a community hospital laboratory. *Laboratory Medicine* 1984; 15:256-257.
5. Centers for Disease Control: The safety of hepatitis B virus vaccine. *MMWR* 1983; 32:134-136.
6. Centers for Disease Control: Hepatitis B virus vaccine safety: Report of an inter-agency group. *MMWR* 1982; 31:465-467.
7. Hamilton JD: Hepatitis B virus vaccine: An analysis of its potential use in medical workers. *JAMA* 1983; 250: 2145-2150.

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Establishment of International Federation of Infection Control

A world-wide effort to bring together representatives in infection control was accomplished at the multidisciplinary International Conference in 1978 at the World Health Organization, Regional Office—Copenhagen, Denmark. International secretaries representing various infection control organizations have, as a result of this meeting, formed a Planning Committee to develop a strategy for establishing a multidisciplinary International Federation of Infection Control (IFIC).

The aim of IFIC is proposed to be:

To promote international exchange of knowledge, information, ideas and support in the control of hospital-associated infections by:

a) gathering and disseminating resource information among the associations, societies and other groups forming the Federation,

b) regularly arranging international multidisciplinary congresses,

c) providing individuals, in countries without infection control organizations, with information and assistance for forming such organizations.

Organizations and groups wishing to be placed on a mailing list for future information should send the name and address to:

Mrs. Kirsten Engler
Secretary, Planning Committee
International Federation of
Infection Control
Store Kongensgade 23
1264 Copenhagen K
Denmark

Non-random or Non-uniform?

To the Editor:

I read with interest the Editorial by Allen B. Kaiser, MD in the August 1984 issue of *Infection Control*. I agree with his conclusion that rise and fall of infection rates may well occur independently of the activities of the infection control or other personnel and that unidentified factors influence this rise and fall. The use of the word "non-random" is, however, unfortunate. I believe that Dr. Kaiser means "non-uniform" distribution of infections. His point, in fact, is that the distribution of infections is random and that the fluctuation is consistent with a randomly occurring event. Hypothesis testing often addresses the question whether a degree of observed fluctuation is, in fact, consistent with random occurrence.

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Allen B. Kaiser, MD, was invited to respond to Dr. Spalter's letter.

I appreciate Dr. Spalter's expressed interest in my evaluation of postoperative infections. In describing the rise and fall of infection rates which have occurred at Saint Thomas Hospital over the past several years, the use of the word "non-random" was carefully chosen. As noted in the Editorial, "apparent clusters of infections" characterized the plot of sternal wound infections.[1] It is precisely because the infections appeared to be "non-random" that causes were sought. One point of the Editorial was to emphasize that state of the art surveillance techniques are inadequate to identify many of the causes of clusters of wound infection.

Dr. Spalter has, however, emphasized an important problem in hospital epidemiology. Namely, when do we decide whether an increase in the rate of infection represents merely a "non-uniform" distribution of infections or, in fact, a "non-random" occurrence or outbreak? In the majority of instances, currently available statistical techniques are simply unable to distinguish "non-uniform" from "non-random" changes in nosocomial infection rates. Although the recent literature has discussed this problem and offered possible solutions,[2-4] the hospital epidemiologist is often left to his/her own devices (ie, "eye-balling the data") before deciding whether to launch an intensive investigation. Hopefully, as epidemiologists begin collecting prospectively identified risk factors on hospitalized patients, the observed fluctuations in infection rates will be amenable to sound statistical evaluation.

REFERENCES

1. Kaiser AB: Risk factors for infection in cardiac surgery: Will the real culprit please stand up? *Infect Control* 5:369-370.
2. Dixon RE: Investigation of endemic and epidemic infections, in Bennett JV, Brachman PS (eds): *Hospital Infections*. Boston, Little Brown & Co, 1979, pp 63-80.
3. Stamm WE, Weinstein RA, Dixon RE: Comparison of endemic and epidemic nosocomial infections, in Dixon RE (ed): *Nosocomial Infections*. New York, Yorke Medical Books, 1975, pp 9-13.
4. Weinstein RA, Stamm WE: Pseudoepidemics in hospital. *Lancet* 1977; 2:862-864.

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Note: The affiliation of T. Donald Marsh, PharmD, was incorrectly listed in "Clinical Pharmacology of Antibiotics" in the February issue of *Infection Control* 6(2):83.

Dr. Marsh's correct affiliation is: Clinical Pharmacist, Mercy Hospital, Charlotte, North Carolina. We regret any inconvenience this may have caused Dr. Marsh or Mercy Hospital.