

## Routine Physical Examinations for New Employees?

### To the Editor:

The series of articles on Infection Control and Employee Health has been useful for me in my capacity as employee health physician at Tampa General Hospital, a 650-bed university affiliated hospital in Florida.

However, there is one position which Dr. Valenti has taken which may not be applicable to our circumstance. Because of my observations I think that perhaps others, too, might want to carefully consider whether they would follow his suggestions. Valenti seems convinced that routine physical examinations of new employees are not useful. Although in Rochester, New York this may be the case, it is not in Tampa, Florida. Let me cite some examples. In the past month, during my rotation as employee health physician, rotating among the various members of our Infectious and Tropical Diseases Division, I have been doing routine physicals on new employees. In that time period I discovered one young lady who was six weeks to two months pregnant but who denied knowledge of this fact and was slated for employment in an area of the hospital where she might have had significant exposure to toxins of some potential consequence to her infant. Several days later I discovered a stony hard lobular mass in the breast of another young woman who deserved referral to a gynecologist for further study. On an almost daily basis I see new employees whose behavior

during the physical examination verifies my suspicion that many hospital employees do not have regular health care. Their employee health questionnaire forms do not indicate a family physician. They ask questions during the examination which indicate to me that they have not ever had physical examinations before, and they are particularly unknowledgeable about such important issues as dental care, the hazards of smoking, adequate diet and nutrition, and regular exercise. Since health care workers in general are frequently considered to be models for behavior of other individuals in the community, I think that it is important for us to try to establish in our hospital employees good patterns of health care. The physical examination can be a learning experience for a hospital employee, one which may not be reproduced in the community. This is another reason why regular physical examinations in our hospitals are valuable.

One final comment—about two years ago the Director of Employee Health Service, an occupational health nurse, and I began to survey all of the health records of new employees whom we had approved during the previous year. Our goal was to determine the numbers and frequency of detection of significant abnormalities as a result of our pre-admission laboratory screening and physical exams. We examine an average of slightly more than four new employees per day, so that this represented a reasonably large sample of individuals. After completing the review of records for six months of employment, we had discovered close to 100 significant lab-

oratory or physical examination findings including blood disorders, urinary infections, serious dental disease, possible malignancy, endocrine abnormalities such as hyperthyroidism, cardiac valvular disease, and one patient with previously undetected solitary bronchogenic carcinoma. The press of other duties forced us to discontinue this study, but I think that it serves to underscore our reasons for continuing the pre-employment physical as a necessary part of new employee screening.

The bottom line is that population characteristics differ from one urban area of the country to another, and it may be necessary for those establishing employee health programs to assess their own community practices before they make decisions about what constitutes proper pre-employment screening.

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*Dr. William Valenti, author of "Employee Health and Infection Control" was invited to respond to Dr. Craig's comments.*

Dr. Craig's comments illustrate the fact that there really is more than one correct way to run an employee health program or any other program, for that matter. The objectives of the employee health program will help determine whether or not a physical

examination should be done. If an objective is to assume responsibility for employees' personal health, then a physical examination should probably be included. On the other hand, if the objective of the employee health program is to maintain a safe environment for personnel, patients, and visitors, a health inventory would probably fulfill this objective. Other considerations are amount of time, money and personnel available to do physical examinations.

Obviously, at a time when all of us must deal with a relatively fixed pool of resources to manage programs such as employee health and infection control, it is imperative that programs establish certain priorities in an attempt to put their money where it will do the most good. The CDC Guideline for Infection Control in Hospital Personnel recommends that "for *infection control*, complete physical and laboratory examinations should not be routinely required for personnel but should be done when indicated; for example, need for examination or laboratory test may be determined from the results of the health inventory."<sup>1</sup> In general, it would seem unlikely that any additional infectious disease information would be obtained by a physical examination rather than a health inventory. Obviously, the decision to perform a physical examination for purposes other than infection control must be made by assessing the unique needs of the institution and its personnel as well as the program's resources.

#### REFERENCES

1. Williams WW: Guideline for Infection Control in Hospital Personnel. *Infect Control* 1983; 4:326-349.

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## AIDS Precautions for Other High-Risk Groups?

#### To the Editor:

Your recent Special Report, "A Hospitalwide Approach to AIDS,"<sup>1</sup> is an excellent summary of the logical steps

necessary in dealing with an AIDS patient, based on the current state of knowledge about this syndrome. However, there is one statement with which we must take exception. The report states "Patients who merely belong to one of the high-risk groups, but who do not have other clinical evidence of AIDS, do *not* need these precautions." This seems a bit dogmatic given the current state of knowledge about AIDS.

It appears that transmission of AIDS may occur from a person who is not necessarily ill with this syndrome.<sup>2</sup> In fact, it is not yet known at which stage the disorder may be most communicable. Hepatitis B, the disease which epidemiologically appears most similar to AIDS, clearly may be transmitted by an asymptomatic individual. In fact, most infectious diseases have a high asymptomatic to clinically apparent ratio among infected individuals.<sup>3</sup> Thus, it might be appropriate to maintain the same precautions among asymptomatic individuals belonging to a group at high-risk for AIDS as for individuals actually suspected of having AIDS. Again using Hepatitis B for comparison, our hospitals maintain blood and body secretion precautions for all individuals belonging to a high-risk group for Hepatitis B (eg, intravenous drug abusers, sexually active homosexual men, patients on hemodialysis, Southeast Asians, etc.), until hepatitis serology confirms the absence of Hepatitis BsAg. Unfortunately, no serological marker which has been shown to reliably predict the presence of the putative AIDS agent is currently available for routine use. It is therefore impossible to rule out the presence of the AIDS agent in an individual patient. The prevalence of infection with the AIDS agent, as opposed to the prevalence of disease, is completely unknown for high-risk populations. While the risk of in-hospital transmission of AIDS by any patient appears to be extremely remote, until the prevalence of the infection in high-risk populations is known and the most infectious stage established, it is pure speculation to state that the patient with documented AIDS is more of a risk for AIDS transmission than the well individual belonging to a high-risk group.

If the remainder of the report's rec-

ommendations are followed, the institution of blood and body secretion precautions in asymptomatic individuals belonging to high-risk groups for AIDS would be a simple and logical extension of the steps outlined to prevent potential transmission of a disorder which is as yet incompletely understood. Perhaps it would be more appropriate to suggest that hospitals handle this issue on an individual basis.

#### REFERENCES

1. American Hospital Association: A hospitalwide approach to AIDS. Recommendations of the Advisory Committee on Infections Within Hospitals. *Infect Control* 1984; 5:242-248.
2. Curran JW, Lawrence DH, Jaffe H, et al: Acquired Immunodeficiency Syndrome (AIDS) associated with transfusions. *N Engl J Med* 1984; 310:69-75.
3. Evans AS: Epidemiological concepts and methods, in Evans AS (ed): *Viral Infections of Humans. Epidemiology and Control*, ed 2. New York, Plenum Publishing Corp 1982, pp 19-21.

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*Dr. Theodore C. Eickhoff, Chairman of the Advisory Committee on Infections Within Hospitals, offers the following response to Drs. Klein and Friedland.*

Drs. Klein and Friedland have identified an issue that was of concern to the members of the Advisory Committee on Infections Within Hospitals as we prepared these recommendations, and continues to be of concern today. The introductory paragraphs to our report point out that the recommendations have not been clearly documented by controlled trials to be effective, nor to be ineffective, but that they represented at that time the best judgment of the Advisory Committee and its consultants. We further pointed out that these recommendations might need to be revised and updated as new information or experience indicated the need to do so. Indeed, the information that has emerged in