REVIEW AND PRETEST
FOR NCCAOM EXAM
IN BIOMEDICINE
美國生物醫學執照考試
復習資料及題解

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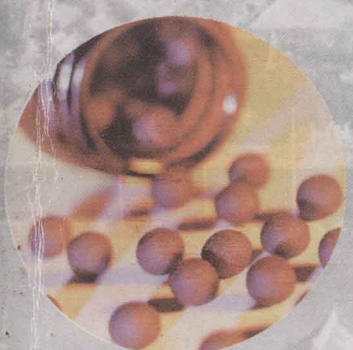

NCCAOM

REVIEW AND PRETEST FOR NCCAOM EXAM IN BIOMEDICINE

美国生物医学执照考试模拟试题及题解

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(1) For ***NCCAOM*** test application, contact NCCAOM at: 76 South Laura Street, #1290, Jacksonville, FL 32202. Tel: 904-598-1005
(2) For ***CNT*** (Clean Needle Technique), contact CCAOM at: 7501 Greenway Center Drive, Suite 820, Greenbelt, MD 20770. Tel: 301-313-0868

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祖國醫學,源遠流長。積千百年之功,億萬人之經驗,起沉去痾,救死扶傷。其辨证論治之系統完整性,及令人信服的臨床效果,使其屹立於風霜雨雪中千百年。不知有多少次,衷心感激中醫之列祖列宗,尤其是在美國的中醫開拓者,讓一介文弱書生,思想急轉彎。於是,操中式英文,揮一管灸條,舞幾十銀針,開百瓶中藥,赤手空拳,半路出家。然後,轉方位,辨風向,戰中西,橫車立針,闖出一方天地。

期望後來之人,善用此書,事半功倍,觸類旁通,盡快過關斬將,持证開業,在歐美繼續推廣普及中醫。若人盡其才,物盡其用,則我心安矣。

Sidong Chen 陳思東, M. D., L. Ac., M. M., M. A.
Dec, 2008, Kenosha, Wisconsin, U. S. A.

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** Most contents of this book come or modify from the above references. We strongly suggest that the students should study the above references if they have any question about this book.

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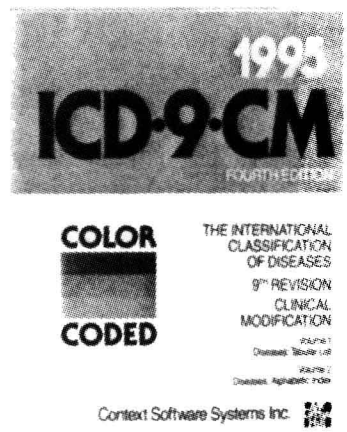
CHAPTER 1 LEGAL, SAFETY, AND CNT
法律，行醫安全，及潔針技術

SECTION 1. SPECLAL CONCEPTS 特別法律問題

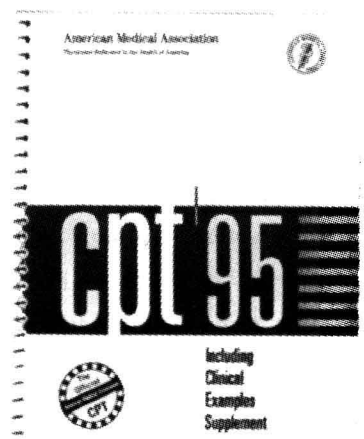
1. CPT 疾病治療代號



CPT(Physicians' Current Procedural Terminology) is a systematic listing and coding of procedures and services performed by physicians. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified. Inclusion of a descriptor and its associated specific five – digit identifying code number in CPT is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations.

Example: CPT code of Acupuncture is 97799, physical exam is 97700.

2. ICD – 9 – CM 疾病診斷代號



ICD – 9 – CM (The International Classification of Diseases, 9th Revision, Clinical Modification) is originally published by the United States Government in recognition of its responsibility to promulgate this classification throughout the United States for morbidity coding. The International Classification of Diseases, 9th Revision (ICD – 9), published by the World Health Organization (WHO) is the foundation of the ICD – 9 – CM and continues to be the classification employed in cause – of – death coding in the United States. The ICD – 9 – CM is completely comparable with ICD – 9. ICD – 9 is designed for the classification of morbidity and mortality information for statistical purposes, and for the indexing of hospital records by disease and operations, for data storage and retrieval. The ICD – 9 – CM is recommended for use in all clinical settings but is required for reporting diagnoses and diseases to all U. S. Public Health Service and Health Care Financing Administration programs.

Example: ICD code for Lower Back pain is 724.5

3. INFORMED CONSENT 病人同意書

Self-determination, the concept that "every adult of sound mind has the right to decide what shall be done with his own body," is the foundation of the legal and ethical doctrine of informed consent. The patient asks questions about his condition and treatment options, and the doctor shares facts and insights along with support and advice. When a person's decision regarding treatment is based on information about risks, benefits, and alternative treatments gained from discussion with a doctor and incorporates the person's preferences, consent or refusal is said to include medical intervention. Along with the right of informed consent comes the right of informed refusal. A decision to refuse treatment, even if puzzling, does not mean that a person is incompetent. In many cases, however, a person refuses treatment based on misunderstanding or lack of trust. A refusal of care should prompt the doctor to initiate further discussion. Doctors are ethically bound to encourage acceptance of the therapeutic recommendation judged to be in the person's best interest. Nevertheless, a person's refusal of treatment is not considered to be attempted suicide, nor is the doctor's compliance with the person's wishes considered physician – assisted suicide. Rather, the subsequent death is considered to be a natural consequence of the disease process itself.

4. COMPETENCY & INCOMPETENCY 完全行爲能力

Laws recognize that adults, in most states people over age 18, have the right to manage their own affairs, conduct business, and make health care decisions. The legal status is called Competency. Competency and all the rights that go with it remain in effect until death, unless a court of law determines that a person can no longer manage personal affairs in his own best interest (a status called Incompetency 非完全行爲能力) or unless the person willingly transfers those rights to someone else.

5. CONFIDENTIALITY & DISCLOSURE 病人資料的保密及透露

Communication between the patient and doctor is strictly confidential. Even well – meaning family members are not automatically privy to such information. All people are entitled to confidentiality unless they give permission for disclosure or they clearly can no longer express a preference (for example, if they are severely confused or comatose). Health care professionals are sometimes required by law to disclose certain information, usually because the condition may present a danger to others.

For example, certain infectious diseases, such as syphiles and tuberculosis, must be reported to state agencies. Conditions that might seriously impair a person's ability to drive, such as dementia, must be reported to the Department of Motor Vehicles in some states.

6. FDA RULING ON EPHEDRA 麻黄禁令

FDA has issued a final ruling prohibiting the sale of dietary supplements containing ephedrine alkaloids because, in its estimation, such supplements present an "unreasonable risk of illness or injury" to the general public. The complete 263 – page ruling was published in the Federal Register Feb. 11, and becomes effective April 12, 2004, 60 days from the date of publication. According to Section III B of the final rule, the ban applies only to dietary supplements containing ephedrine alkaloids, including, but not limited to, those from the botanical species ephedra sinica Stapf, equisetina Bunge, intermedia var. tibetica Stapf, distachya L., sida cordifolia L., and pinellia terneta (Thunb.) Makino or their extracts. However, "conventional food products" that contain ephedrine alkaloids are exempted, as are "OTC (over – the – counter) or prescription drugs that contain ephedrine alkaloids". Section III B also includes a caveat for the use of ephedra as it applies to "traditional Asian medicine": Several ephedra species (including Ma Huang) have a long history of use in traditional Asian medicine. These products are beyond the scope of this rule because they are not marked as dietary supplements. The use of ephedrine alkaloids in traditional Asian medicine is discussed in more detail in Section V B 5 of this document. As we describe there, this rule does not change how these products are regulated under the act. The FDA stated in Section V B 5: This final does not affect the use of ephedra preparations in traditional Asian medicine, although we considered the comments' views and information on the use of ephedra in Asian medicine in the context of their possible relevance to the risks of dietary supplements containing ephedrine alkaloids. The rule applies only to products regulated as dietary supplements.

7. LIVING WILL 生存遺囑(生前醫療意願書)

A document, sometimes called a directive to doctors, that expresses a person's wishes regarding medical intervention when very ill or near death.

8. DURABLE POWER OF ATTORNEY FOR HEALTH 醫療決定委託書(授權書,意願書)

A document that allow a person to designate someone else to make medical treatment decisions on his behalf.

9. MEDICAID 醫療補助計劃

Medicaid is a medical care program aided by the United States Federal Government, but operated and administered by State Government for certain low – income individuals.

10. MEDICARE 醫療照顧計劃

Medicare is a health insurance program sponsored by U. S. Government for people over age 65, some younger disabled persons, and persons with end – stage renal disease. American Medicare consists of two parts: (1) Medicare Part A provides hospital insurance; (2) Medicare Part B (an option some participants choose to purchase) provides general medical insurance. In the United States, medicare also administers its own managed care plan. In Canada, Medicare is administered by the provinces.

11. REPORTABLE DISEASES AND CONDITIONS 向政府報告的臨床疾病及症狀

Reporting infectious diseases and outbreaks to state and federal government is part of record keeping.

Dr. Chen's Table 1-1 Diseases and conditions reportable by health care providers and others
向州政府和聯邦政府報告的臨床疾病及症狀

AIDS	Amebiasis	Animal bites * *	Anthrax * *	Botulism * *	Brucellosis
Chancroid	Cholera * *	Diphtheria * *	Encephalitis	Gonococcal infection	
Haemophilus influenzae * *		Viral hepatitis	Kawasaki syndrome		Legionellosis
Leprosy	Leptospirosis	Lyme disease	Malaria	Measles * *	Meningitis
Menigococcal diseases		Mumps	Mycobacteriosis	Pertussis * *	Pertussis vaccine adverse
reactions	Plague * *	Poliomyelitis * *	Psittacosis	Rabies * *	Rocky mountain spotted
fever	Rubella * *	Salmonellosis	Septicemia in newborns		Shigellosis
Syphilis	Tetanus	Trichinosis	Tuberculosis	Tularemia * *	Typhoid fever

* * Report immediately by telephone

12. SOAP NOTE 簡易病歷

Mnemonics to remember SOAP note

Follow – Up Visit Note: Carefully review all SOAP notes on a regular basis to detect the emergence of a condition that accounts for many or all of the patients complaints:

S	Subjective	***O***	Objective	***A***	Assessment	***P***	Plan

13. CHILD ABUSE AND NEGLECT 兒童虐待及疏忽

Child abuse is the maltreatment, physical/mental injury or sexual abuse of a child. ***Child neglect*** is the failure to provide adequate food, clothing, shelter, or love to a child.

[**There are 4 causes of abuse**] (1) The parent may have psychiatric problems such as a personality disorder, low self – esteem, drugs or alcohol abuse; (2) The child may be different from others (irritable, demanding, hyperactive, or handicapped); (3) Emotional support from family, neighbors, or friends may be inadequate; (4) A crisis may occur, such as loss of money or a job.

Neglect often occurs in families that have many problems. Drug or alcohol abuse or a chronic medical condition may cause financial hardships, leading to the inadequate feeding, care, and attention of a child. Desertion by one parent may result in neglect by the other.

Symptoms

Abuse may lead to recognizable behavioral changes in both the child and the abuser. For instance, a parent may seem unconcerned, even when a child has obviously been injured. The parent may be reluctant to describe to the doctor or friends how the injury occurred, and the description may change each time. The injury may be unusual for the age of the child. A child who is repeatedly physically abused may show signs of new/old injuries. Bruises, burns, welts, or scrapes are often evident. Cigarette or scald burns may be visible on the arms or legs. Severe injuries to the mouth,

eyes, brain, or other internal organs may be present but not visible. The child may also have evidence of broken bones.

A young child who has been sexually abused may have difficulty in walking or sitting. A urinary tract infection, vaginal discharge, or sexually transmitted disease may develop. Often, no physical injury is apparent. Rather, the child may be irritable or fearful or may have sleep difficulty.

A neglected child may be malnourished, tired, dirty or may lack appropriate clothing. The child may live alone or with siblings without adult supervision. Neglected children may die of starvation. A parent may fail to obtain preventive dental or medical care for the child, such as immunizations and routine physical exams. The parent may also delay seeking medical care when the child is ill.

Health professionals' response

Health professionals are required by law to promptly report cases of suspected child abuse or neglect to a local child protective service. Prompt reporting is also required by all those who are responsible in their employment for the welfare of children under age 18, such as teachers, day care workers, police, and legal services personnel.

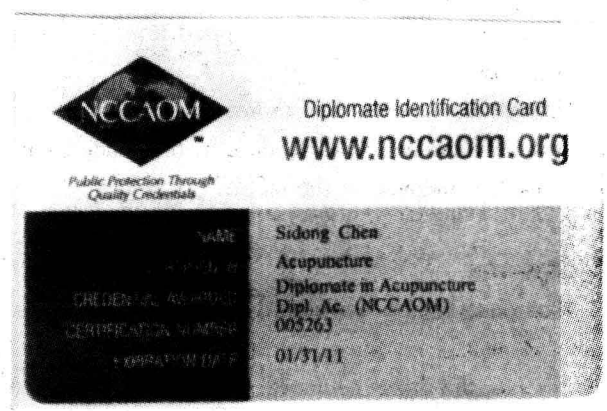
14. NCCAOM, ACAOM, CCAOM 美國針灸考試委員會

Most states require Acupuncturists to pass a comprehensive national licensure exam administered by the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM), following graduation from a college in candidacy status or accredited by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM).

The Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) is a membership organization for Acupuncture and oriental medicine colleges throughout the States. The members of CCAOM have reached accredited or candidate status through the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM).

NCCAOM's certification is issued and belongs to NCCAOM. NCCAOM is a non - profit organization established in 1982. It currently operates under Section 501 (c)(6) of the internal Revenue code. Its mission is to promote nationally recognized standards of competence and safety in Acupuncture and Oriental medicine for the purpose of protecting the public. NCCAOM Certification makes an important statement about professional competency that is recognized by regulatory bodies, third - party payers, the profession, and the public. The Certification is valid for 4 years. To retain the certification, you must submit a recertification application every 4 years. Certification is a form of self - regulation, a voluntary program set up by a private nonprofit organization to evaluate those practicing in a particular profession or business. The goal of the certification organization is to serve the public by distinguishing among individual practitioners, using objective evaluation criteria, including but not limited to, educational achievements and performance, experience, and scores on standardized tests. Obtaining certification is a voluntary decision by a practitioner and is not necessarily required for one to practice his/her profession.

However, obtaining a license in order to practice a profession or conduct a business is mandatory, and states can assess fines or other penalties on those that practice or operate without a license. Usually, a state regulatory or licensing board is established to oversee the licensing process. In most states, passing NCCAOM's certification exam and/or obtaining certification is just one of the requirements that must be met by a practitioner be fore he or she can obtain a license.



15. MEDICAL RECORDS 醫療檔案

Medical records are both clinical and legal documents, and must be treated with care and accuracy. From a legal perspective, if an action, observation or conversation isn't charted, it is assumed not to have happened. Failure to adequately document patient care can be deemed evidence of negligence. For example, the federal Department of Health & Human Services, that administers Medicare, requires that records be sufficient to identify the patient and to justify the diagnosis and treatment. The American Health Information Management Association (AHIMA 1992), and Joint Commission on Accreditation of Healtbcare Organizations (JCAHO 1995) publish detailed professional guidelines. These guidelines apply to medical records practices by the Acupuncturists. A complete record provides: (1) ID; (2) Prior medical history; (3) Dated consent forms; (4) Assessment; (5) Plan of care; (6) Date, time, and descriptive record of each treatment; (7) Progress notes, observations and clinical findings; (8) Discharge summary with final diagnosis, prognosis; (9) Clear authorship of all medical record entries.

It is best to limit record contents to the therapy and procedures. Personal assessments of the patient's character have no place in the medical record. Chart notes are written in a formalized style, limited to recording essential information. The letters SOAP are a useful way to remember the section titles used in recording each patient's visit: (a) Subjective; (b) Objective; (c) Assessment; (d) Plant.

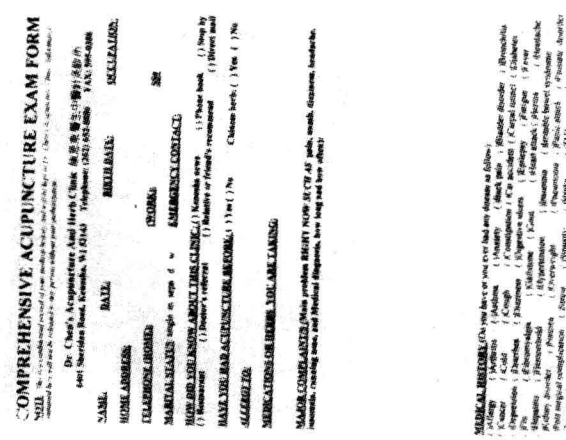
(a) Subjective section: the patient's experience and perceptions of their problem are recorded. This includes each complaint with its history, progression, symptom, duration and quality, aggravating and alleviating factors, responses to treatments, and the effects these factors have had on the patient's life.

(b) Objective Section: the health provider's observations are recorded, including vital signs, results of physical exam, and tests. Acupuncturists record pulses, palpation, tongue and visual findings.

(c) Assessment section: the problems are listed by priority, weighing medical urgency and the patient's priorities. Each problem is then described, with indications of severity, acuteness or chronic factors, risks, causes, and current status of the disease and its progression. Diagnostic are entered, as are potential diagnoses that have been, or need to be, ruled Out.

(d) Plan section: It contains a record of the treatment performed, directions for future care. It includes a description of therapeutic procedures performed, patient and family education, and specify follow – up visit plans. It includes data and records of medical tests ordered or advised, and the rationale for the tests. If a referral is made, identify to whom, where and when, and supply a reason for the referral.

Medical records are best written or recorded immediately after treatment, or at least by the end of the same day. They should be legible, and some states require that they be written in English. Professional charting gives the impression of proper standards of practice. Typewritten charting notes are preferable. As speech recognition and transcription software improves, it may soon be more frequently used. They records are legal records. Entries may not be altered or obscured. In legal proceedings, altered medical records may suggest an intent to cover up significant facts in the record. In the event of a charting error, circle the error or draw a single thin line through the error in such a way that it can still be read. Write ERROR to the side and then add the date, time and your initials by this entry. Explain the error in detail, and indicate the correction. Only the person who made the error should correct it, and a reference should be made where it can be found. Authorship of medical record entries must be provided. Every entry should be signed by its author. If transcription is used, the clinician authenticates the entry as accurate by initialing It.


COMPREHENSIVE ACUPUNCTURE EXAM FORM

KEY POINTS: Medical records should be complete, legible, in English, and signed. Use the SOAP notes format to record each patient visit. Never obscure or delete chart entries. Chart corrections should only be entered by the individual who made the erroneous entry.

16. CONFIDENTIALITY & RELEASE OF MEDICAL RECORDS 醫療檔案的保密和調閱

The confidentiality is a right owned by each patient. With certain exceptions, the release of records without waiver of that right by the patient is legally actionable as a breach of privacy. They should be kept secure and protected. Good practice is to use locking file cabinets and computer passwords. However, some exceptions exist. If other providers in the same institution have a legitimate need to know the contents of a patient's chart that information may be shared without patient waiver, but obviously, these other providers are also bound by the rule of confidentiality. Licensing and accrediting bodies in some states have a right to access medical records to assess charting and care. In a few states, the patient's employer has a right of access to their chart without a waiver, for related workers compensation claims. Finally, courts may gain access to copies of all or portions of a patient's medical records by court order or subpoena duces tecum. In this event, contact an attorney for advice on how to proceed. Even when subpoenaed, portions of the record may be protected.

If it is necessary to share a patient's records beyond the noted exceptions, a written patient's waiver of confidentiality is needed. That release should be kept with the patient's.

The standard release form should: (1) Be addressed to the Acupuncturist or practice directed to release information; (2) Identify the patient; (3) Define what information is to be released; (4) Authorize the release; (5) Identify who is to receive the information; (6) Identify a time limit for the authorization (90 days maximum); (7) Contain the patient's dated signature.

Certain portions of the medical record are accorded an exceptional level of confidentiality. Records associated with drug and alcohol treatment programs; mental health care, record of "oathsome diseases" and STD's (particularly HIV) require specific release consent by the patient. (42 USC 290 dd - 3 & ee - 3). A release form should be designed so that patient's can properly specify the types of information authorized for release. Substance abuse releases have special considerations.

When supplying medical records and releases that do not name these most protected informational areas, they should not be included. Such information may be recorded on a separate chart that would not be transmitted, or by blocking out the information when they are duplicated. Requests for any patient information related to these protected areas must be handled with utmost discretion. As a form of polite refusal, a practitioner may judge that it is wise to nether confirm or deny that a person is a patient, in response to any inquiry.

Most commonly, records are mailed. It is good practice to include a cover sheet if records are faxed or mailed. Recipients should be told that confidential records are enclosed, and that conviviality must be maintained. Such records should be returned or destroyed when they have served their purpose. Practitioners should realize that e - mail is not secure unless done in encrypted form. Verbal transmission of patient information by telephone should be preceded by signed patient release, and by verification of the name and position of the recipient.

Patients have a right of access to the information in their record, but the record itself is the healthcare provider's property, and only copies should be released. It is the responsibility of the health care provider to maintain and preserve the original record. By custom, no fee is charged for records sent to other healthcare providers. Attorneys are billed a nominal fee for copies of records.

Key points: (a) Learn and annually update the medical records access and reporting requirements that apply to acupuncturists in your state; (b) Share patient information with providers and staff only on a need - to - know basis; (c) Require signed authorization for all (non - mandated) releases of patient records; (d) Require specific consents for release of records associated with drug & alcohol treatment programs, mental health care, and STD's; (e) Refuse to confirm or deny that a person is a patient, in response to any inquiries at substance abuse, mental health and STD clinics; (f) Chart time, date and means of record transmission; (g) Send copies - never release the original record.

17. RETENTION & DESTRUCTION OF MEDICAL RECORDS 醫療檔案的保存和消毀

States regulate the length of time medical records must he retained. They also define the conditions for the transfer and disposal of medical records.

When a practice is sold to a new owner, the transfer of medical records (and the responsibility for their retention) should be included as an item in the sales agreement. Notify former patients of such a transfer by letter, perhaps augmented by a notice in the local newspaper. Certain states require notification of the Acupuncture licensing board when records are transferred.

When medical records are slated for disposal, never dispose of them intact into the garbage or recycling, as confidentiality could be breached. Shred or burn disposed records. Note that the duty of confidentiality does not end, enduring even after the death of a patient! Records of cases actively involved in litigation should not be destroyed. Make a document identifying destroyed charts, along with the notation that they were destroyed in the normal course of business.

Key points: (a) Retain medical records as required by state regulations; (b) Document medical record transfers with the sale of a practice; (c) Shred or burn charts that are to be disposed.

There are two types of records required by the bloodborne pathogens standard: (1) medical, and (2) training.

(1) **Medical record**: must be established for each employee with occupational exposure. This record is confidential and separate from other personnel records. The medical record contains the employee's name, social security number, hepatitis B vaccination status, including the dates of vaccination and the written opinion of the health care professional regarding the hepatitis B vaccination. If an occupational exposure occurs, reports are added to the medical record to document the incident and the results of testing following the incident. The post – evaluation written opinion of the health care professional is also part of the medical record. The record must document what information has been provided to the care provider, and must be maintained 30 years past the employment of the employee. Emphasis is on confidentiality of medical records. No medical record or part of a medical record should be disclosed without direct, written consent of the employee or as required by law.

(2) **Training record**: The documents of each training session are kept for 3 years. Training records must include the date, content outline, trainer's name and qualifications, and names and job titles of all persons attending the training sessions. If there is no successor employer, the employer must notify the Director of the National Institute for Occupational Safety and Health Department of Health and Human Services, for specific directions regarding disposition of the records at least 3 months prior to disposal.

18. PRIVACY & MODESTY 病人隱私和行醫禮貌

Robbing and disrobing are considered private acts and are to be stricdy respected as private acts in clinical settings. When patients need to undress to allow access to Acupuncture points or areas, give them clear instructions about what clothes may remain on, and provide them with a gown and/or draping sheets. Always knock before entering a treatment area and inquire if the patient is ready, so that you do not intrude on disrobing or robbing. Being naked or exposed in the view of another is considered a breach of modesty values, particularly when the viewer is of the opposite sex. Always attempt to minimize viewed nakedness. When asking a mostly naked patient to reposition themselves on the table during treatment, turn away so as not to view them until they have again draped themselves.

Key points: (a) Leave the treatment area when patients are to robe/disrobe, so that these actions may be accomplished in privacy; Knock/inquire before entering the room; (b) Provide gowns, draping sheets, and clear instructions; (c) Always act to minimize discomfort that might be caused by nakedness.

19. SEXUAL BOUNDARIES 醫患之間的性界線

Sexual behavior between practitioner and patients is a violation of the practitioner's legal duty to maintain a fiduciary relationship, which is to say it is one of trust, and it is considered unethical conduct. The practitioner is trusted to act in the best interests of the patient, and to take no advantage of patient vulnerability in any way. Imbalances of patient/practitioner power and the extent of regard and trust a patient may be presumed to have for the practitioner, may contribute to patient's vulnerability to a practitioner's sexual advances. Regardless of whether sexual behavior is initiated by patient or provider, the provider is always strictly accountable for engaging in sexual behavior with patients. If necessary, follow through by using a chaperone or by referring the patient to another health care provider.

It might be advisable to note in the chart such behavior on the part of a patient. In any case the strategy of having a chaperone present in the treatment area is desirable. Another strategy is to consider an alternate selection of points in place of points near the sexual organs. Finally, whenever treatment is directed to work on the lower pelvic area (regardless of gender), put on latex exam gloves first. In addition to the hygienic benefits, the glove barrier psychologically reinforces the perception of the activity as clinical, for both patient and provider.

Key points: (a) Be aware and in control of your own sexual intent and behavior – refrain from provocative conversation and/or sexual touch, and do not become romantically involved with patients; (b) Tactfully confront seductive patients; (c) Have a chaperone present during treatment of patients who you consider at high risk for "perceived sexual impropriety"; (d) Inform patients that they may bring a friend with them into the treatment area; (e) Consider alternate points in place of points near the sexual organs; (f) Whenever you work on the lower pelvic area of a patient (regardless of gender), put on latex exam gloves first.

SECTION 2. OSHA AND CNT 美國職業安全及健康管理局規定和潔針技術

OSHA 美國職業安全及健康管理局(Occupation Safety and Health Administration) is a U. S. government regulatory agency concerned with the health and safety of workers.

OSHA standards protect employees, who may be occupationally exposed to blood and other potentially infectious materials, which includes but is not limited to health professionals and employees in clinics, offices, hospital, labs, health care facilities, hospital/commercial laundries, tissue banks, blood banks, plasma centers, institutions for the developmentally disabled, hospices, home health care, nursing homes and long - term care facilities, funeral homes and mortuaries, medical equipment services, fire stations, and law enforcement.

Blood means human blood, blood products, or blood components (plasma, serosanguineous fluids, and platelets), and other potentially infectious materials including human body fluids (saliva in dental procedures; semen; vaginal secretions; cerebrospinal, synovial, pleural, pericardial, peritoneal, and amniotic fluids; body fluids visibly contaminated with blood; unfixed human tissues or organs; HIV - containing cells or tissue; and HIV - or HBV - containing culture media.)

Occupational exposure means a "reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of the employee's duties."

Part 1: WHO HAS OCCUPATIONAL EXPOSURE 職業易感性

Where all employees are occupationally exposed, it is not necessary to list specific work tasks. Some examples include phlebotomists, lab technicians, physicians, nurses, nurse's aides, surgical technicians, and E. R. personnel. Where only some of the employees have exposure, specific tasks and procedure causing exposure must be listed. Examples include ward clerks or secretaries who occasionally handle blood or infectious specimens, and housekeeping staff who may be exposed to contaminated objects and/or environments some of the time. When employees with occupational exposure have been identified, the next step is to communicate the hazards of the exposure to the employees.

Dr. Chen's Table 1-2 Universal precautions 預防感染的一般措施

(1) Wear gowns, gloves, protective eyewear, face masks, and protective clothing (including lab coat) whenever exposed to blood or other body fluids;

(2) If the health care worker's skin is opened, gloves should be worn whenever direct patient care is performed;

(3) Mouth - to - mouth emergency resuscitation equipment should be available in strategic locations. The mouthpieces should be individualized for each health care worker. Ambu bags are preferable. Saliva is considered an infectious fluid;

(4) Dispose of all sharp items in puncture - resistant containers; Do not "recap", break, or remove needles from syringes;

(5) Immediately remove gloves that have a hole or tear in them;

(6) All disposed patient - related wastes must be labeled as a "biohazard";

(7) All specimens must be transported in leakproof containers;

(8) Eating, drinking, applying cosmetics, or handling contact lenses is prohibited in patient care area;

(9) Presume all patients have HBV and HIV infection;

(10) If a health care worker has experienced an exposure incident to blood or other body fluids (i. e., needlestick), testing of the health care worker and the patient for HBV and HIV is necessary