SHEA Newsletter

Edited by Robert A. Weinstein, MD

The Society of Hospital Epidemiologists of America

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READERS' VIEWS

This issue of the Newsletter includes a new section, Readers' Views. It is hoped that this section will be used by our membership to bring attention to, and air concerns about, issues important to hospital epidemiology; to promote interchange of ideas, and if needed, to call for straw polls on controversial subjects; to present solutions to common and/or vexing problems that our membership faces; and, when necessary, to challenge conventional wisdom.

SHEA members are urged to contribute to this section. Submissions should be typed, double-spaced; may be up to five pages in length; and should be submitted to the Newsletter Editor at the address noted below. A relatively short "turn-around" time shouid allow prompt publication of contributions.

Dr. Robert W. Haley, a well-known epidemiologist and SHEA member who has extensive experience dealing with topical and controversial issues, has kindly agreed to initiate this section with the following contribution.

Who Will Generate Surgeon-Specific Rates? The Gauntlet Is Down

In the February 1988 issue of *Archives of Surgery* the Surgical Infection Society (SIS) published a remarkable "Standard on Wound Surveillance for Infection," urging that surgeon-specific wound infection rates, stratified by a wound index, be provided on a regular basis to surgeons throughout the country.' The statement, adopted unanimously at a May, 1987 meeting of the SIS, reads as follows:

> In hospitals conducting 2000 or more operations per year involving surgical incisions through skin with subsequent primary closure, prospective wound surveillance will be conducted by the hospital epidemiologist (or other qualified person) of every such wound on a sufficiently frequent basis to determine if the wound heals primarily or if an infectious complication develops. Direct observation of surgical wounds by the surveyor is necessary to fulfill the requirements of this standard.
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> The surveyor will be responsible to and will report directly to the chief or director of surgery
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> Patients discharged from the hospital without apparent infectious wound complications will be followed up on or about the 30th day after surgery to determine if the wound has continued to heal without apparent complication. Such follow-up may be conducted by any method that will yield reliable data. The percentage of successful follow-up will be recorded.
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> Surgeon-specific and specialty service-specific wound infection rates will be determined by infection risk class and will be reported confidentially and in timely fashion to the chief or director of surgery. Personal surgeon-specific infection rates will also be reported confidentially and in timely fashion to each member of the surgical staff. It is recommended that data be appropriately coded to maintain confidentiality. Each hospital will determine the infection risk classification to be used in recording its data.1

Actually, to those who have been closely following the aggressive young society of surgeons interested in infection prevention, the statement itself was not surprising -- merely the playing out of a growing interest of surgeons in the preventive power of specific epidemiologic feedback. What was surprising were the results of a straw poll of the SIS membership indicating great dissatisfaction with the kind of information on wound infections they are presently receiving and with the quality of the job being done by the infection control programs in their hospitals.'

So frustrated was the SIS membership with the inability to get their hospital epidemiologists to provide quality data and specific rates that they called for accurate surgeon-specific rates to be mandated by the Joint Commission and to have the surveillance activity and personnel report to the surgical staffs rather than to the infection control committees. Thus, the surgeons of the SIS have thrown down the gauntlet. Who is going to generate accurate, specific wound infection rates?

In view of this challenge one wonders what is the position of SHEA on this issue. Reduction of wound infection rates following the feedback of surgeon-specific rates was first reported around the turn of the century, was rediscovered by Cruse in the 1970s, was validated in a controlled epidemiologic study in the SENIC Project, and has since been reported from at least ten hospitals in several countries. At a meeting of the American Hospital Association's Technical Panel on Infections Within Hospitals, Walter Hierholzer, Jr., MD concluded, "This result has come up in too many studies with different designs to be

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