Letters to the Editor

Surgeon-Specific Infection Rates

To the Editor:

I read with interest the editorial "Surgeon-Specific Wound Infection Rates -- A Potentially Dangerous and Misleading Strategy" by William E. Scheckler, MD. The subject is controversial, and it is a matter of interest to surgeons and infection control committees.

Of course it is difficult to support that a decline in the surgical wound infection rate after reporting surgeon-specific infection rates constitutes a relationship of cause and effect. On the other hand, we must admit that education is the most efficient tool in order to modify habits and achieve an infection rate reduction.

As a surgeon and professor of surgery, I know how difficult it is to educate health care personnel; surgeons and anesthesiologists have been particularly difficult in our teaching hospital. We have used this strategy for clean cases in our hospital for eleven years and the most important effect, in our opinion, is the educational feedback. This relationship makes it possible to keep the surgeon and the other members of his team informed of his monthly infection rates for different types of surgery and enables him to compare them with those of his colleagues in the same working conditions. The surveillance generates a salutary control and it was so useful that we started the same strategy with the anesthesiologists, analyzing the relationship between postoperative respiratory infection and the anesthetist who administered general anesthesia to the patient. I am sure that the data collected during this experience enabled us to convince more appropriately these professionals to change their attitudes. As the strategy of infection control is basically supported by education, we believe, based on our own experience, in the good results of such a strategy.

Edmundo M Ferraz, MD, FACS
Professor of Surgery
Federal University of Pernambuco
Brazil

Informed Consent

To the Editor:

I am writing in response to the editorial "Sacred Secrets" (May 1988) by Richard E. Dixon, MD.

I read the article with great interest because a central AIDS coordinating committee devoted an enormous amount of energy to developing, approving, and implementing a written informed consent policy in the Detroit Medical Center (DMC). This was not a small feat logistically or politically, since the DMC consists of seven institutions and is affiliated with a university (Wayne State). Although I am not a physician, I appreciate the points that were made with great sensitivity to the issue of "therapeutic privilege." There was much food for thought in the commentary.

I would like to address the example chosen to demonstrate the instance when a physician may need to withhold selected information because of a patient's well being, ie, "needlestick exposures of personnel to patients who are infirm, very ill and who have few identifiable risk factors for HIV infection. Rather than burden the patient with yet another fear (. . . by obtaining informed consent . . .) many physicians will elect to forego testing altogether. The practical effect of that refusal is that the exposed staff member suffers prolonged anxiety and uncertainty."

This is an issue that infection control and infectious disease practitioners considered seriously in Michigan during the development of state guidelines. Our concern was indeed the anxiety level of health care workers (HCW) in event of needle punctures, and the polarization of "patients' rights versus the rights of HCW," as if there was a choice. We believed that management of the HCW should not depend on the serology status of the patient since the only action that can be offered at this time is testing. The guidelines from the Centers for Disease Control (CDC) (*MMWR* 36:2S, August 21, 1987) recommend testing the patient source but indicate need for contingency planning in the event of patient refusal. We think there is insufficient emphasis on the testing problems outlined so well earlier in the same recommendations for patients. Why should negative results not require follow-up? If HCW behavior is expected to be different if a patient tests positive, what disservice may be done because the patient was negative at the time of testing (we know of several seroconversions at a later time)? Risk assessment should still be done by infection control or

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HOSPITAL EPIDEMIOLOGY:

New Challenges and Controversies

Hyatt Regency Baltimore Hotel
March 10 to 12, 1989

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The Society of Hospital Epidemiologists of America (SHEA) and *Infection* Control *and Hospital Epidemiology*, are co-sponsoring a meeting. "Hospital Epidemiology: New Challenges and Controversies." The meeting will be held at the Hyatt Regency Hotel in Baltimore on March 10-12, 1989. The program will focus on three important areas: AIDS. the expanding roles of hospital epidemiology. and new problems for infection control. A brochure describing the conference and topics for discussion is included in this issue of the Journal. There will be presentations by an expert group of nationally-known contributors to the held of hospital epidemiology. There will also be a poster session for attendees who would like to participate in this conference. We encourage you to submit an abstract describing some aspect of your work in AIDS or hospital epidemiology.

We hope that you will join us in Baltimore. If you would like to present a poster, please complete the attached abstract form. For further information regarding this program or registration material, please write to:

Hospital Epidemiology:
New Challenges and Controversies
6900 Grove Road
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Hospital Epidemiology: New Challenges and Controversies
March 10-12, 1989 Hyatt Regency Baltimore Hotel

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If, in the conduct of these studies. human subjects were exposed to risks not required by their medical needs, the author affirms that the study was approved by an appropriate committee, or, if no such committee was available and informed consent was needed, it was obtained in accordance with the principles set forth in "The Institutional Guide to DHEW Policy on Protection of Human Subjects."

First Author's Name, Address and Work Telephone number

Name _____

Address _____

_____

_____

Telephone _____

Co-authors' Names, Addresses, and Status in the College, if Applicable

Name _____

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_____

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EXAMPLE

RISK FACTORS FOR INFECTION FOLLOWING RENAL TRANSPLANTATION: PROSPECTIVE STUDY. D.G. *Maki*, *B. Fox and B. Storer.* University of Wisconsin, Madison, WI.

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employee health to assist in counseling staff about appropriate follow-up. However, it seems far better to offer mandatory counseling, routinely offering voluntary, coded testing with documentation of acceptance or refusal. Anonymous testing sites can also be recommended for this special subgroup of the "worried well." This approach supports the individual and protects the institution.

Additionally, if the employee is going to be told the result -- positive or negative -- in the absence of patient consent (how else does one relieve the anxiety?), how can the physician not tell the patient or family the results as well?

Our particular facility has used this approach very effectively for the past year and we have found that it indeed prevents setting up a "no win" situation. The key to its success is the mandatory counseling and sensitivity to the anxiety level of the staff person. At the same time there is no undue pressure for testing the patient when such decisions are least likely to be made without stress or complications, as noted by Dr. Dixon.

Enrollment into the Burroughs-Wellcome study of prophylactic AZT for needle puncture exposures to HIV requires knowledge of serology status of patient and HCW alike. Eligibility almost of necessity requires exposure to a known HIV patient because of the timing of the first dose. Thus, the approach outlined above remains useful. If the study outcome determines that prophylactic AZT is indeed efficacious, the principle on which testing is determined can be modified. In the meantime, this approach is submitted as a workable and effective alternative.

Judene Bartley, MS, MPH, CIC
Epidemiology Coordinator
Harper Hospital, DMC
Detroit, Michigan

Letters to the Editor should be addressed to INFECTION CONTROL AND HOSPITAL EPIDEMIOLOGY Editorial Offices, C41 General Hospital, University of Iowa Hospitals and Clinics, Iowa City, IA 52242. All letters must be typed, double spaced, and may not exceed four pages nor include more than one figure or table. The editors reserve the right to edit for purposes of clarity or brevity.

Corrections

Table 2 of the editorial "Pseudomeningitis -- Another Nosocomial Headache" by Burke A. Cunha, MD (September 1988, p 392) should include the following figures in the line beginning "Goldstein & Abrutyn/1985": The number of "Patients Involved" should be 17, and the number of "Patients Treated" should be 0. The editors at SLACK apologize for any inconvenience this may have caused the reader.

Table 3 was inadvertently omitted from the article "Safe and Cost-Effective Cleaning of Pressure-Monitoring Transducers" by Richard Platt, MD et al (September 1988, pp 409-416). The editors apologize for the error.

TABLE 3
OUTCOME OF PATIENT COURSES

	Ethylene oxide sterilized	Alcohol wiped
Organisms recovered from flush solution		
None	589 (84%)	684 (84%)
1-9 CFU/mL recovered from any specimen	67 (10%)	73 (9%)
⩾ 10 CFU/mL from any specimen	1 (0%)	4 (0%)
None obtained	43 (6%)	48 (6%)
Organisms recovered from cannula tips		
None	282 (40%)	311 (38%)
1-9 CFU	15 (2%)	13 (2%)
⩾ 10 CFU	10 (1%)	17 (2%)
None obtained	393 (56%)	468 (58%)
Blood cultures obtained during course		
None	583 (83%)	666 (82%)
1	31 (4%)	26 (3%)
2	39 (6%)	55 (7%)
⩾3	47 (7%)	62 (8%)
Positive blood culture during course		
No	87 (12%)	115 (14%)
Yes	30 (4%)	28 (3%)
None obtained	583 (83%)	666 (82%)
Antibiotic after first day		
None	429 (61%)	512 (63%)
Any	271 (39%)	297 (37%)
Aminoglycoside (included in "any")	57 (8%)	63 (8%)
Any temperature >101°F		
No	622 (89%)	732 (90%)
Yes	78 (1 1%)	77 (10%)
Blood cultures obtained during 2 weeks after course		
None	592 (85%)	695 (86%)
1	26 (4%)	26 (3%)
2	43 (6%)	48 (6%)
>2	39 (6%)	40 (5%)
Positive blood culture during 2 weeks after course		
No	93 (13%)	102 (13%)
Yes	15 (2%)	12 (1%)
None obtained	592 (85%)	695 (86%)

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