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.

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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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