discharge SSI risk was not observed. If a detection bias were present in our surveillance procedure, it would mean that the relationship of postdischarge SSI with clean and low-risk surgical procedures was even greater than observed. Reimer et al also reported that 70% of all postdischarge SSIs were detected in clean wounds[4]; Law et al[5] found a similar figure, 65%. Other authors, however, found otherwise.[2,3]

Regarding the risk factors for postdischarge SSI, our results on body mass index agree with the higher frequency of postdischarge SSI in obese patients found by Weigelt et al.[7] Nevertheless, we did not observe their significant inverse trends with length of operation and wound class, and the relationship with alcoholism. Weigelt et al[7] justified in part their results on duration of operation and wound class by a shorter postoperative stay. We could not confirm their observations, as our results did not change after adjustment for postoperative stay. In another study, cancer and surgeon were suggested as predictors for postdischarge SSI.[10] The results of this latter study were based on a rather small number of postdischarge SSIs, and the surveillance procedure used to identify postdischarge SSI was different.

In summary, our results suggest that most classic risk factors for SSI are not determinants for postdischarge SSI (apart from body mass index); patients developing SSI after discharge are more similar to patients not developing any infection.

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OSHA Issues Final Ergonomic Standard

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OSHA published its final ergonomic standard in the November 14 *Federal Register* (65 FR 68261). While OSHA and the Clinton Administration herald the new standard, major groups, including a coalition headed by the US Chamber of Commerce and the American Hospital Association (AHA), have filed petitions challenging implementation of the standard.

"There's no underlying science to support these standards," said Steve Bokat, general counsel for the US Chamber of Commerce, in reference to OSHA's new standard. OSHA predicts that 460,000 fewer workers will suffer work-related injuries each year. Industry leaders have disputed the agency's cost estimate of $4.2 billion a year to employers, saying the figure would be considerably higher. The standard will go into effect January 16, 2001.

The final rule is significantly changed from the proposed rule issued by the agency in November 1999. Major changes include (1) a shortened period for invoking work-restriction provisions; (2) a "simple screening tool" for employers to use to determine job relatedness when musculoskeletal disorders (MSD) or "signs or symptoms" are reported; (3) a provision for resolving differences in medical opinion over work removal or temporary work restriction; and (4) a grandfather clause with fewer specific obligations and a 1-year delay in the requirement to have MSD management, which includes work-restriction protection, in place. The new standard is available from the home page of the OSHA web site, at http://www.osha.gov.