Letters to the Editor

Response to Surgeon-Specific Infection Rates

To the Editor:

Since 1987, the Epidemiology Program at Fort Sanders Regional Medical Center in Knoxville, Tennessee has analyzed and reported surgeon-specific wound infection rates for clean and clean-contaminated (class I and class II) operations done at our hospital. The denominator data is collected with the assistance of the operating room director. The numerator data is collected using our standard surveillance definition, which includes the microbiology laboratory, daily nursing condition sheets, data on readmission to the hospital, and reports from physicians and nurses. We include operations done in our day surgery program, and these are followed up by personnel in day surgery as part of a routine postoperative telephone questionnaire. The major deficiency, we believe, in our case finding, is in those cases of wound infection which present to and are handled by the surgeon in his or her private office without cultures being sent to our hospital's laboratory.

The response to this system by the surgeons at our institution has been gratifying. Although our infection rates are low (less than 1.5%), several of our surgeons have requested further information on each of the infections we reported to them. In one case, a surgeon had an infection rate significantly higher than that of the other members of his department. Reflecting the experience of others, further surveillance indicated that this physician brought his infection rate in line during the following quarter (three-month interval used in reporting).

Dr. Scheckler has pointed out that surgeon-specific wound infection rates are potentially misleading.[1] We certainly understand this argument, but we believe, based on our program, that the best analyses we can perform in a community hospital setting with a low infection rate are achieved and that our system is well received and probably effective.

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REFERENCE

1. Scheckler WE: Surgeon-specific wound infection rates—A potentially dangerous and misleading strategy. *Infect Control Hosp Epidemiol* 1988; 9:145-146.

How Simple Is Disease-Specific Isolation?

To the Editor:

I have some thoughts about the recent article titled "Searchin"' by Sue Crow, MSN, RN, CIC and curiously printed in the journal under the category of Product Commentary (1988; 9(7):328-329). In an effort to describe the evolution of isolation technique the reader is taken from biblical times to the present and advised that one way to address the ubiquitous "fear of contagion" is to isolate the patient. Further, the reader is advised that the simple and efficient way to do this is to practice a disease-specific isolation system. Issue must be taken with the description of this system as simple. Function of the system is dependent on reference material readily available at each nursing unit, specific signage outlining a variety of disease-specific steps required to provide patient care, special techniques for linen, waste and equipment reprocessing. and most important, clinical or diagnostic information to trigger initiation of the precautions. For the same reasons, efficiency of such a

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