explained by confounding. They couldn't all have the same bias." The American College of Surgeons' Manual on Control of Infection in Surgical Patients has recommended the practice since its first edition in 1976, the CDC *Guideline for the Prevention of Surgical Wound Infections* has recommended it since 1982 (category II), and the Joint Commission's "Agenda for Change" has recently targeted surgical wound infections as one of its hospitalwide "clinical indicators."

Why the reluctance among hospital epidemiologists to determine these rates? I suspect several problems. First, in the 1970s we all learned to produce the old reports of "infection rates by site, service, and pathogen" from line-listing infections and dividing by hand-counted denominators. This precomputer technology is too tedious to produce rates stratified by surgeon and risk class. How many SHEA members are facile at managing data and producing epidemiologic reports of stratified rates by computer?

Second, it is simply human nature to look for all the reasons why we can't or shouldn't do whatever is new, difficult, time-consuming, and on the cutting edge. Arguments for and against the value of surgeon-specific rates are readily available[2]; a two-hour videotape ("Surveillance by Objectives for Infection Control: Point/Counterpoint") is also available from the Medical Learning Center, St. Thomas Hospital (PO Box 380, Nashville, TN 37202; telephone: 615-386-2007).

While the argument rages, the fact remains that the surgeons have discovered the value of epidemiologic feedback for helping them improve the care of their patients. They want this service delivered to them accurately, and they want it managed in a responsible, confidential, and nonpunitive manner. In view of the pervasive movement to measure quality of care., to use quality measurements to effect change, and for hospitals to be held accountable for doing it well, some form of epidemiologic feedback to reduce wound infections to the irreducible minimum will not long be optional.

The only real question now is *who* is going to generate the rates? There are at least four serious contenders: the surgeons themselves, infection control, quality assurance (QA), and external authorities. While the surgeons may be seen to have a conflict of interest that could jeopardize the accuracy of the rates, they also have the most intense interest in improving the care of surgical patients and reducing malpractice risks. The new "standard" of the SIS is intended to put them in the driver's seat. Although infection control and hospital epidemiologists might appear to be more objective, it is not clear that they have the skills and resolve to take on the job. In fact, the percentage of hospital infection control programs providing specific rates to surgeons has been steadily declining, from 19% in the mid-1970s to a low of 6% in CDC's 1986 survey. At present, QA departments appear unlikely candidates because their creators, the Joint Commission and HCFA, have previously defined their role as numerator-counting line-listers, but the "Agenda for Change" may well create a demand for outcome measurement that could propel QA into the rate business. The threat that external authorities will take it over is real. given the HCFA mortality initiative and the directions of the "Agenda for Change." Continued reluctance within the hospitals will only hasten external control.

A famous aphorism among consulting statisticians goes, "If statisticians don't analyze data, others will." I might paraphrase it, "If epidemiologists don't generate accurate and specific rates, others will." I see SHEA at a critical crossroads. The health care world is desperately seeking energy and expertise to measure outcomes and improve quality. The rank and file of our organization must sort out the conflicting claims of efficacy from false enthusiasm, "Old Guard-ism," and inertia. We must decide whether ours is going to be a society *of hospital epidemiologists. To be epidemiologists we must generate the specific rates that will allow our colleagues to reduce adverse outcomes in their patients.*

The Surgical Infection Society has thrown down the gauntlet. You know someone is going to pick it up. Will it be SHEA?

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## SHEA Wit and Wisdom

**Dear *SHEA Newsletter:***

I was very taken by "Interested Reader's" advice in the last issue of the *Newsletter*. In my own experience dealing with authorship, I have learned an equally sobering lesson. This could best be summed up as, "*If the contributions claimed by each co-author in an investigation are summed, the total is always greater than 300%.*"

As a correlary to this lesson I would note the importance of acknowledging all co-investigators and colleagues, preferably in a public forum whenever possible. This type of activity (the so-called "good dog" approach) greatly facilitates future interactions with one's colleagues and subordinates. It always pays to oil the wheel before it squeaks.

Don "Company **Man" Regan, MD**

**Dear "Company Man,"**

Thank you for sharing those very wise observations with us. One can never be too effusive in praise of colleagues and subordinates. You are truly a man of tremendous insight and obvious talent and your letter has added a great deal to this month's *Newsletter*. Again, many thanks for your willingness to contribute. We hope that others among our extremely talented readership also will be willing to share their insights.

**The Editor**

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*Brief items of interest for the SHEA Newsletter may be sent to Robert A. Weinstein, MD, SHEA Newsletter Editor, Division of Infectious Diseases, Michael Reese Hospital, Lake Shore Drive at 31st St., Chicago, IL 60616. Copy must be typed, double-spaced, and may not exceed five pages.*