



Letters and comments

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COMMENT ON

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Needle-stick reporting among surgeons

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All practising surgeons, trainees and consultants, should pay attention to the warning signs in this research as it could have far reaching consequences for not only their career but also their health and that of their families. I wanted to comment on a number of issues raised in the discussion.

Thomas and Murray limited the retrospective study to one centre having no reason to believe that its findings were not representative of the wider problem. To expand on that, a study I co-wrote, looked at the barriers to needle-stick injury (NSI) reporting by a sample of all grade of surgeons, in various specialities, in three UK hospitals representing a rural, district and tertiary hospital.¹ Seventy questionnaires were hand delivered and the number of injuries and reporting practice was identified. Surgeons were asked to identify from a list the reasons why they did not report their injuries and record importance on a 5-point Likert scale (1–5). There was also a free-text section for additional comments. A total of 52 surgeons and trainees replied (75%). Of these, 42 (81%) had at least 1 NSI with four (8%) reporting more than 20 in their surgical career. Eight (19%)

had reported all their injuries to occupational health and only 24 (46%) were aware of the NSI hospital policy. These findings reflect those of Thomas and Murray and emphasise the problem of under-reporting of NSI among surgeons in UK hospitals.

Thomas and Murray also postulated that surgeons make a risk assessment at the time of injury. This is supported by our results that showed the two main reasons for failure to report an NSI was ‘low transmission risk’ (Likert 3.617) and ‘too time consuming’ (Likert 3.708).¹ It is potentially dangerous for surgeons to self-assess in these circumstances as we usually have multiple conflicting interests culminating, usually, in the most time-efficient solution. Bearing in mind the prevalence of HIV, hepatitis B and C is steadily increasing, the surgeon ‘judging a book by its cover’ in a quick assessment could lead to disaster. Making our own risk assessment comes largely from many hospital policies in the UK having the lead clinician as the risk assessor and main protagonist in managing the NSI. Surely, to break this attitude of self risk assessment, independent staff from occupational health or infection control should lead the management of these situations thereby standardising the response for all NSI incidents. My current institution simplified their NSI policy in 2006 to include a hotline telephone number and a dedicated infection control clinical nurse who would come to theatre during normal working hours. They obtain a detailed report of the incident, take blood samples as necessary and arrange prompt follow-up thus saving time and anxiety on the part of the victim.

As the main barrier to NSI reporting seems to be the time it takes and its complexity, we tried to identify areas where the process could be improved. One of the problem areas was obtaining blood from the source for blood-borne disease testing. Taking a blood sample from the anaesthetised patient at the time of the injury seems like the simplest proactive step but is loaded with ethical challenges regarding autonomy of the source patient versus the well-being of the surgeon.² A simple solution may be to include in all consent forms, a section explaining that blood may be taken for testing while you are anaesthetised if a member of staff experiences a NSI. The patient could have the option to opt out of this if they so wish. This gives the patient autonomy while protecting the well-being of theatre staff.

NSI reporting should be encouraged by surgeons and as role models for other members of staff, we should set an example as we are at the front line of potential injury and

almost guaranteed to get NSI.⁵ We can no longer gamble with our careers, our finance or our health by failing to report needle-stick injury.

References

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AUTHOR'S RESPONSE

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We would like to thank Stephen Kelly for his helpful comments and were particularly pleased to see that our findings from a single, busy district hospital are indeed reflected by his own very similar study across the surgical specialties in three quite diverse centres.¹ This certainly reinforces the message that current practices are leaving surgeons exposed; although transmission rates are currently small, they are generally increasing. We agree that it is the on-the-spot decision making undertaken by the operating surgeon that is the most risk-prone event and are particularly interested in his efforts at reducing this. Management of these incidents by independent occupational health staff should be encouraged but the emphasis of their involvement must be to make the process more straightforward, taking the perceived inconvenience out of the process that deters so many.² I would be interested to see if the structures put in place by the Kelly and McCann group have made a difference in reducing the barriers to reporting in their hospitals.

We acknowledge that the testing of anaesthetised patients for blood-borne viruses is an area of unresolved ethical debate. In principle, we support the idea of patients giving pre-operative consent to a blood test in the event of a needle stick injury.

The 'take-home' message from both of these pieces of work is that needle stick injuries are common in surgeons and are associated with a small, but significant, risk to our career, health, families and not least our patients.

Thankfully, to date, we have not seen a transmission of a blood-borne virus to a surgeon but note that other theatre staff have been inoculated. It is our responsibility as surgeons to protect our working environment by ensuring structures are in place to allow the consistent, safe and responsible management of these incidents.

References

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2. Wallis GC, Kim WY, Chaudhary BR, Henderson JJ. Perceptions of orthopaedic surgeons regarding hepatitis C viral transmission: a questionnaire survey. *Ann R Coll Surg Engl* 2007; **89**: 276–80.

LETTER

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Transfer of a pre-operative surgical site mark to the opposite side increases the risk of wrong site surgery

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Surgery performed at the incorrect anatomical site can be devastating for both patients and surgeons.¹ We wish to highlight the case of a patient who had been correctly



Figure 1 Left forearm correctly marked with an arrow.