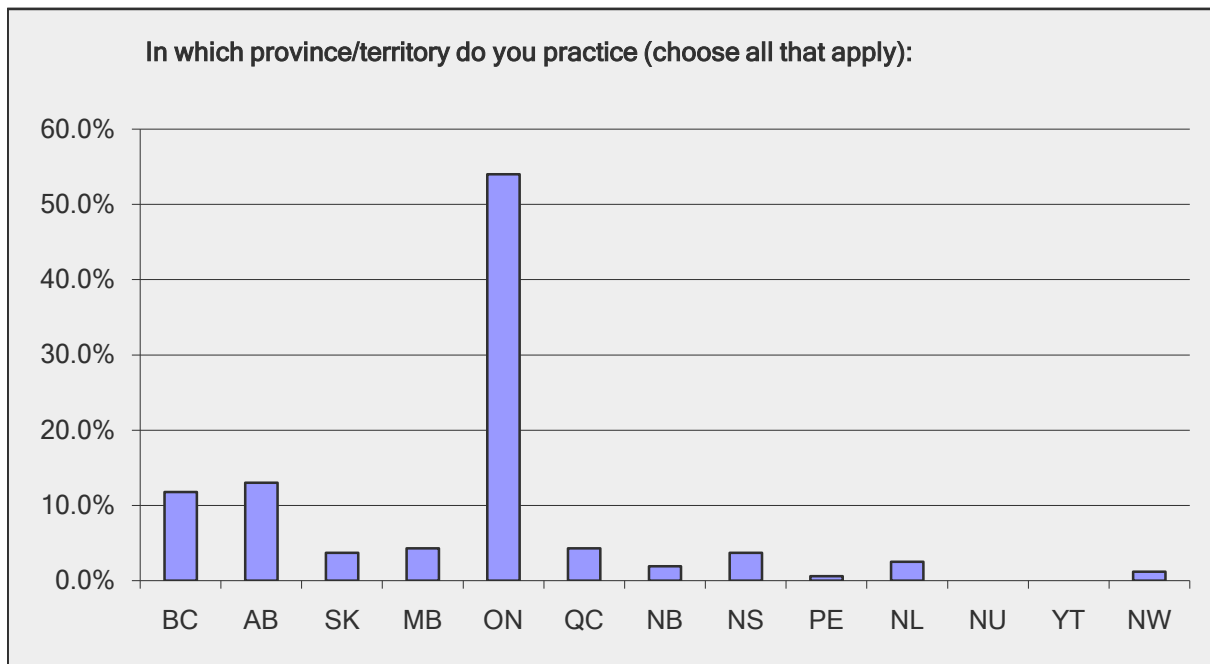


Question 1

COA Survey on Blood Borne Pathogens

In which province/territory do you practice (choose all that apply):

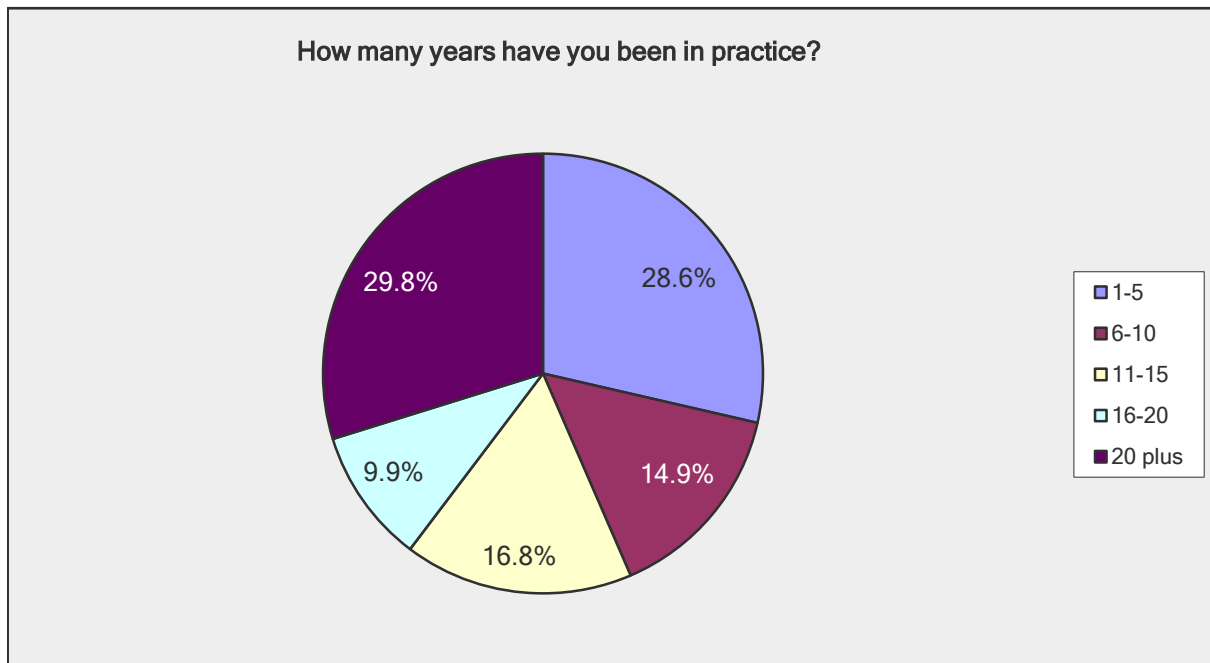
Answer Options	Response Percent	Response Count
BC	11.8%	19
AB	13.0%	21
SK	3.7%	6
MB	4.3%	7
ON	54.0%	87
QC	4.3%	7
NB	1.9%	3
NS	3.7%	6
PE	0.6%	1
NL	2.5%	4
NU	0.0%	0
YT	0.0%	0
NW	1.2%	2
<i>answered question</i>		161
<i>skipped question</i>		0



Question 2

COA Survey on Blood Borne Pathogens

How many years have you been in practice?		
Answer Options	Response Percent	Response Count
1-5	28.6%	46
6-10	14.9%	24
11-15	16.8%	27
16-20	9.9%	16
20 plus	29.8%	48
<i>answered question</i>		161
<i>skipped question</i>		0

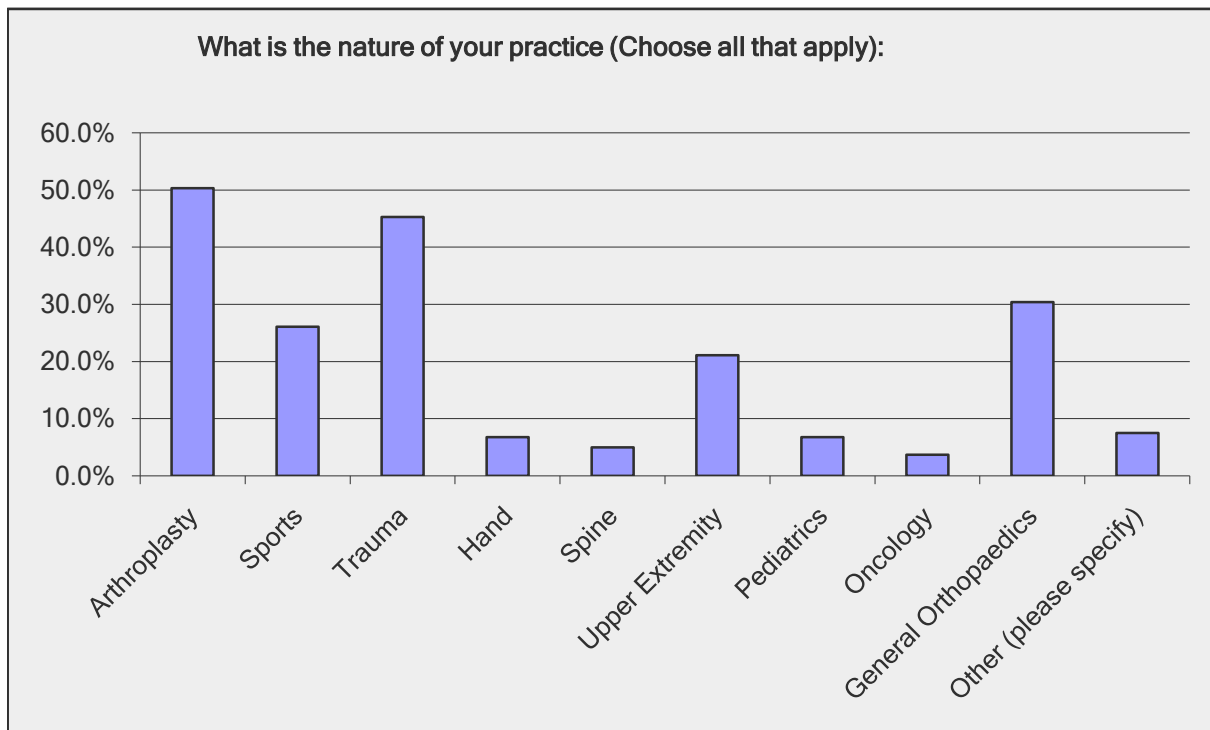


Question 3

COA Survey on Blood Borne Pathogens

What is the nature of your practice (Choose all that apply):

Answer Options	Response Percent	Response Count
Arthroplasty	50.3%	81
Sports	26.1%	42
Trauma	45.3%	73
Hand	6.8%	11
Spine	5.0%	8
Upper Extremity	21.1%	34
Pediatrics	6.8%	11
Oncology	3.7%	6
General Orthopaedics	30.4%	49
Other (please specify)	7.5%	12
<i>answered question</i>		161
<i>skipped question</i>		0



Question 3

Other (please specify)

locum

Administrative

Spine

foot and ankle

admin

Foot and Ankle - why is this not a choice?????????????

foot and ankle

foot and ankle

foot/ankle

shoulder and elbow

consultant work only---no surgery

foot and ankle

Question 4

COA Survey on Blood Borne Pathogens

What is the setting of your practice? (choose all that apply)		
Answer Options	Response Percent	Response Count
Urban	28.0%	45
Teaching/Academic	57.8%	93
Community	32.9%	53
Rural	7.5%	12
<i>answered question</i>		161
<i>skipped question</i>		0

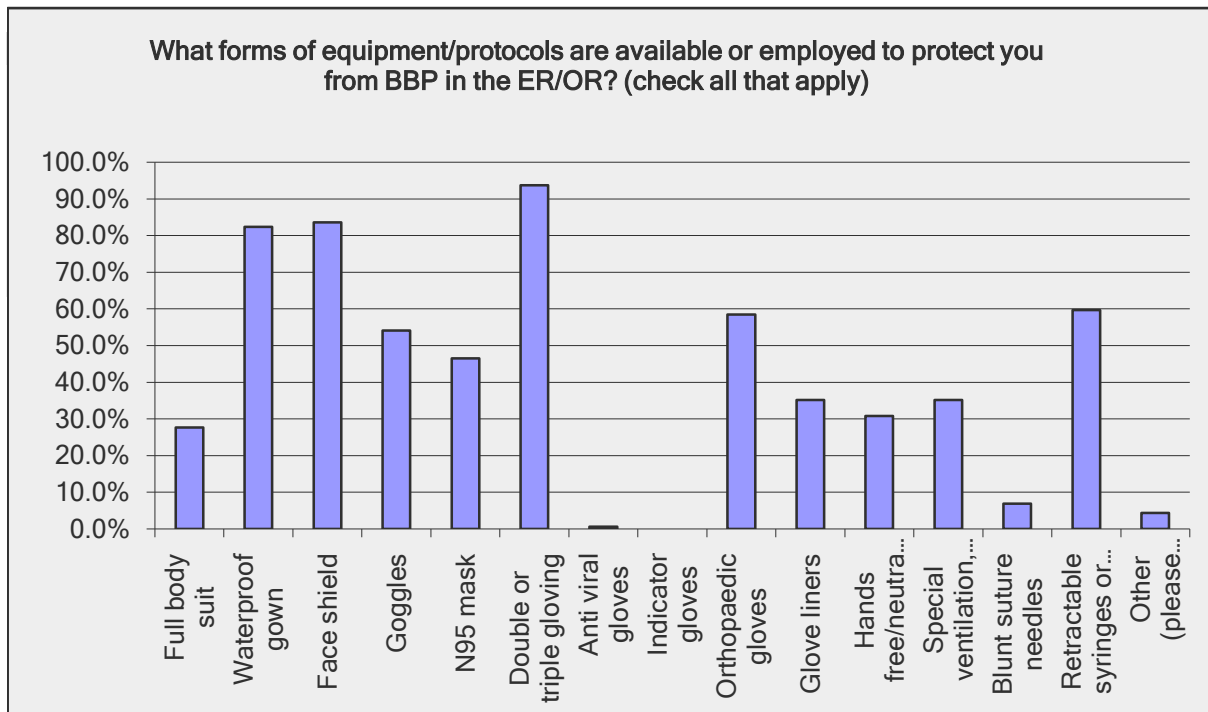


Question 5

COA Survey on Blood Borne Pathogens

What forms of equipment/protocols are available or employed to protect you from BBP in the ER/OR? (check all that apply)

Answer Options	Response Percent	Response Count
Full body suit	27.7%	44
Waterproof gown	82.4%	131
Face shield	83.6%	133
Goggles	54.1%	86
N95 mask	46.5%	74
Double or triple gloving	93.7%	149
Anti viral gloves	0.6%	1
Indicator gloves	0.0%	0
Orthopaedic gloves	58.5%	93
Glove liners	35.2%	56
Hands free/neutral sharps zones	30.8%	49
Special ventilation, eg. laminar flow	35.2%	56
Blunt suture needles	6.9%	11
Retractable syringes or similar product	59.7%	95
Other (please specify)	4.4%	7
answered question		159
skipped question		2



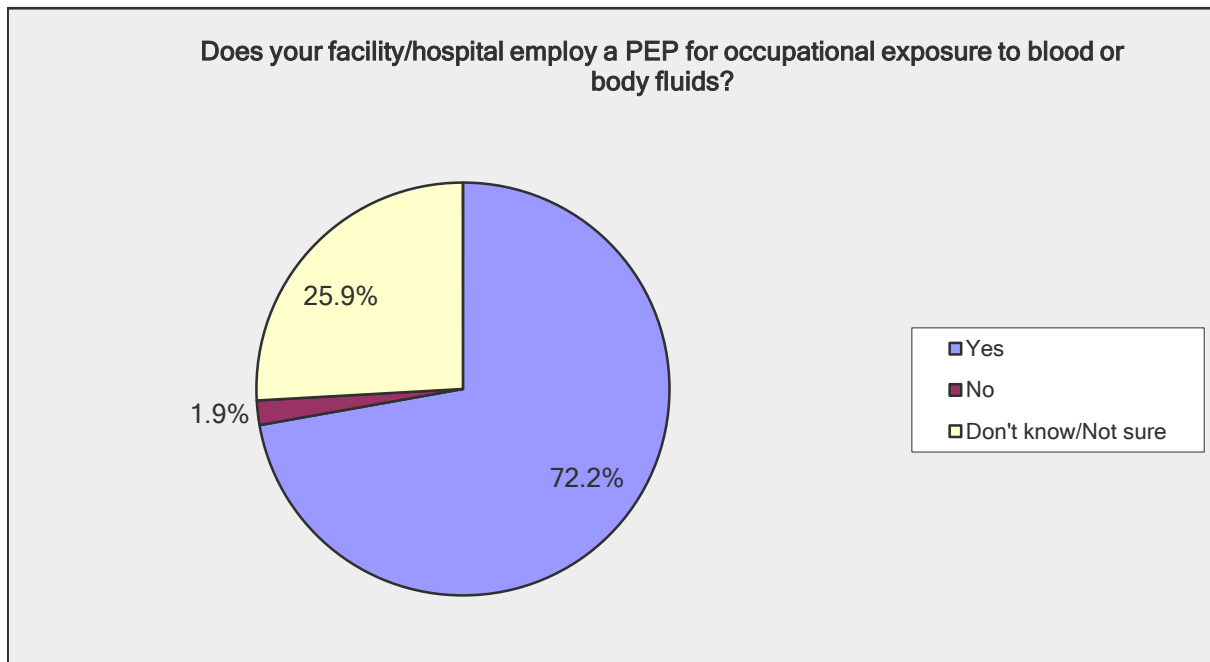
Question 5

Number	Other (please specify)
1	helmets for tja
2	Stryker hoods
3	All of these are available- in a limited manner
	We usually operate on the highest risk patients (trauma) with double gloves as our only defence
4	Protective hoods
5	no longer in or
6	We are only allowed to wear body suits during arthroplasty cases
7	Our Orthopaedic group have forced our hospital to provide for us cut resistant autoclavable outer glove material gloves, we have also informed our hospital that drill bits and limited re-use items will be consumed at an increased rate because of our concerns over BBP and the CPSO threat of licence restriction for "high risk Practitioners"

Question 6

COA Survey on Blood Borne Pathogens

Does your facility/hospital employ a PEP for occupational exposure to blood or body fluids?		
Answer Options	Response Percent	Response Count
Yes	72.2%	114
No	1.9%	3
Don't know/Not sure	25.9%	41
<i>answered question</i>		158
<i>skipped question</i>		3

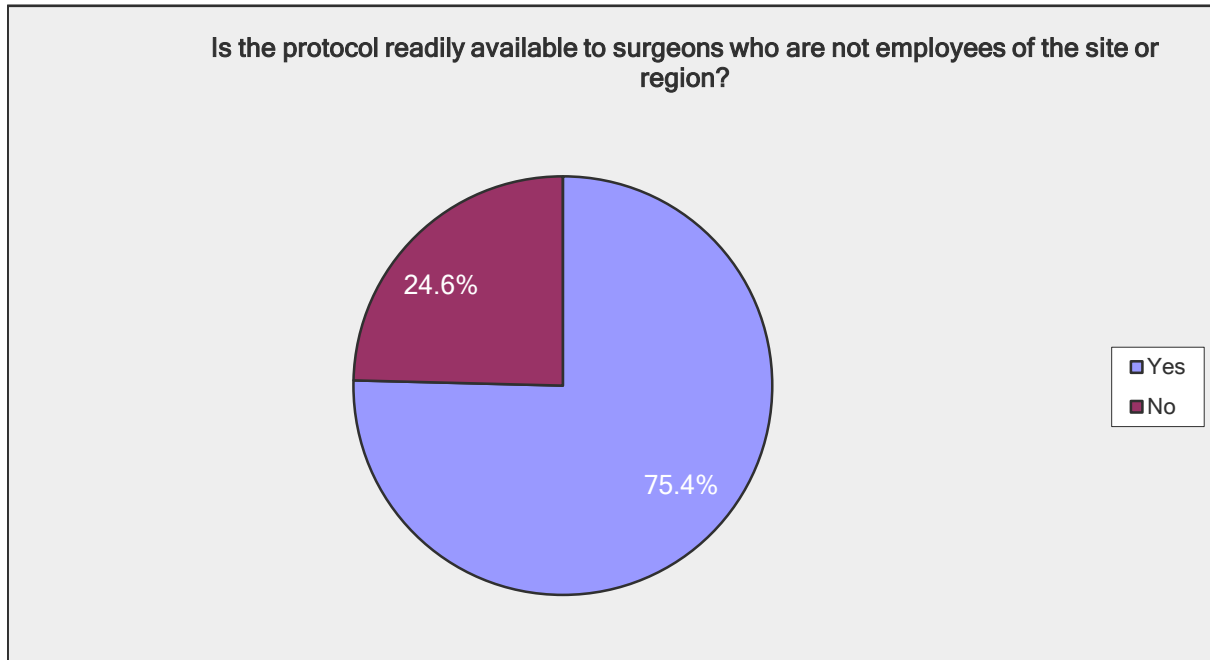


Question 7

COA Survey on Blood Borne Pathogens

Is the protocol readily available to surgeons who are not employees of the site or region?

Answer Options	Response Percent	Response Count
Yes	75.4%	104
No	24.6%	34
If no, why not?		26
<i>answered question</i>		138
<i>skipped question</i>		23



Question 7

If no, why not?

I don't know if it is or not

Given to all staff, but physicians need to request

unknown

don't know

They would have to contact Occ Health to obtain it.

We don't have surgeons from outside the site working in our institution

Don't know if available

have never read this though

i don't know if it is

?

not sure

Not employees

dont know

unknown

Don't know

i do not know if it is available

not sure

Never been provided with this info.

Physicians aren't employees of the hospital

no follow up available

i have never bothered to check

Not sure

unknown

We are not considered employees of the corporation so the responsibility is ours

I do not understand this question

not sure

Question 8

COA Survey on Blood Borne Pathogens

Please describe any issues you have experienced with regard to post exposure protocols:		
Answer Options		Response Count
		24
	<i>answered question</i>	24
	<i>skipped question</i>	137

Response Text

none
 none
 none known
 -
 seems to work well as needle sticks are common with our young learners.

i was exposed once in a private surgical center during my training (BC). there was no protocol in place 4 years ago, not sure what the status of this is now

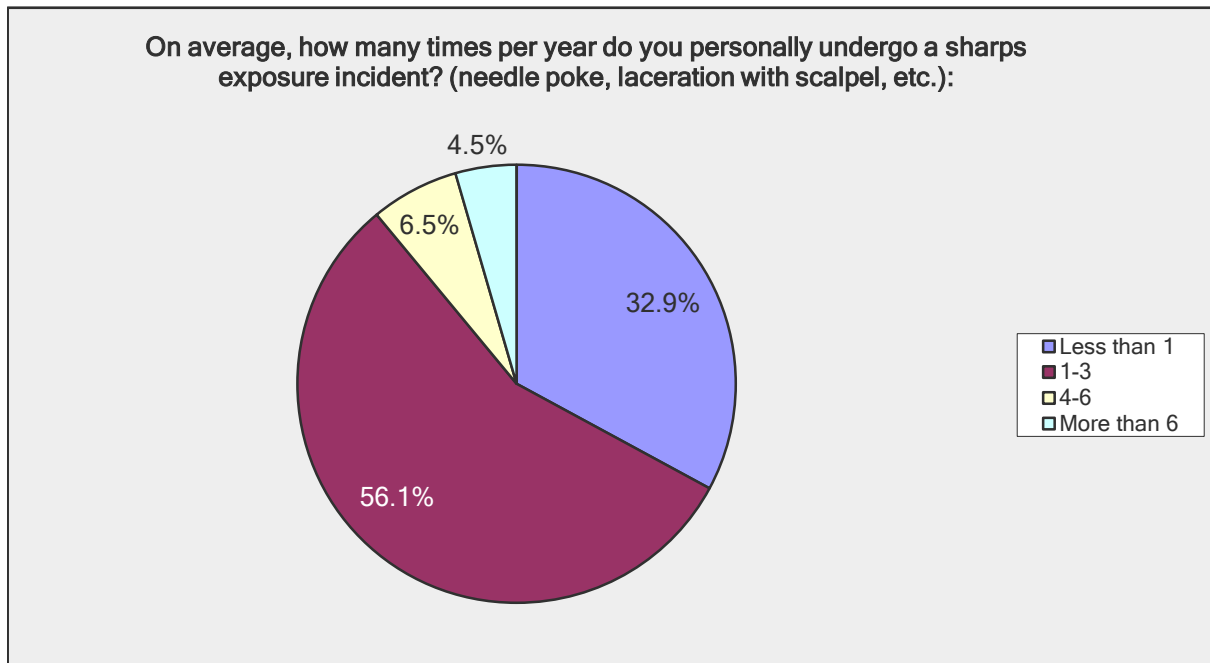
Health Nurse is located in another city 2.5 hours away
 not had to be used/employed
 more accessible and convenient for nurses
 recently had needlestick exposure by resident from HCV patient. post exposure occupational visit vague and not veery helpful
 works well, surgeons often don't follow for fear of career ending
 documentation of positive BBP status
 have been denied request for whole body suits twice now for Hep pos patients (due to cost)
 occurred about 10 yrs ago, seemed well managed at the time
 no testing of sergeon
 none
 none
 very lengthy reporting process with onus on surgeon to gather info on patient, thereby creating conflict of interest
 None
 Wcb
 None
 no t well publized
 Was cut by bone from a femoral neck fracture from a known HIV Hep C patient after the hospital removed our orthopaedic gloves due to cost concerns. I was left to my own to go to the ER and follow up in 3 months. The ER doctor on at the time subjected me to the same corporation guidelines but it was not done throught the employee health unit.
 If I am to invoke post exposure protocols I am concerned that the CPSO will restrict my licence without any evidence of sero-conversion
 complex so ignore or not report exosure

Question 9

COA Survey on Blood Borne Pathogens

On average, how many times per year do you personally undergo a sharps exposure incident? (needle poke, laceration with scalpel, etc.):

Answer Options	Response Percent	Response Count
Less than 1	32.9%	51
1-3	56.1%	87
4-6	6.5%	10
More than 6	4.5%	7
If you answered Less than 1, please indicate the approx. frequency of		20
	<i>answered question</i>	155
	<i>skipped question</i>	6



Question 9

If you answered Less than 1, please indicate the approx. frequency of sharps exposure that applies to you per year in the box below.

I have had one sharp exposure since starting my practice

0.5

1 per 3 years

once in 3 or 4 years

1 per 3 years

1 per 3 years

0.5

once every two years

4 times in 15 years

one very other year

0

Not one in the last 4 years, 2 during residency and 1 in my fellowship

once every 5 years

01/03/2010

1 every two years

1 in 2 years

once per 3 years

0.5

1

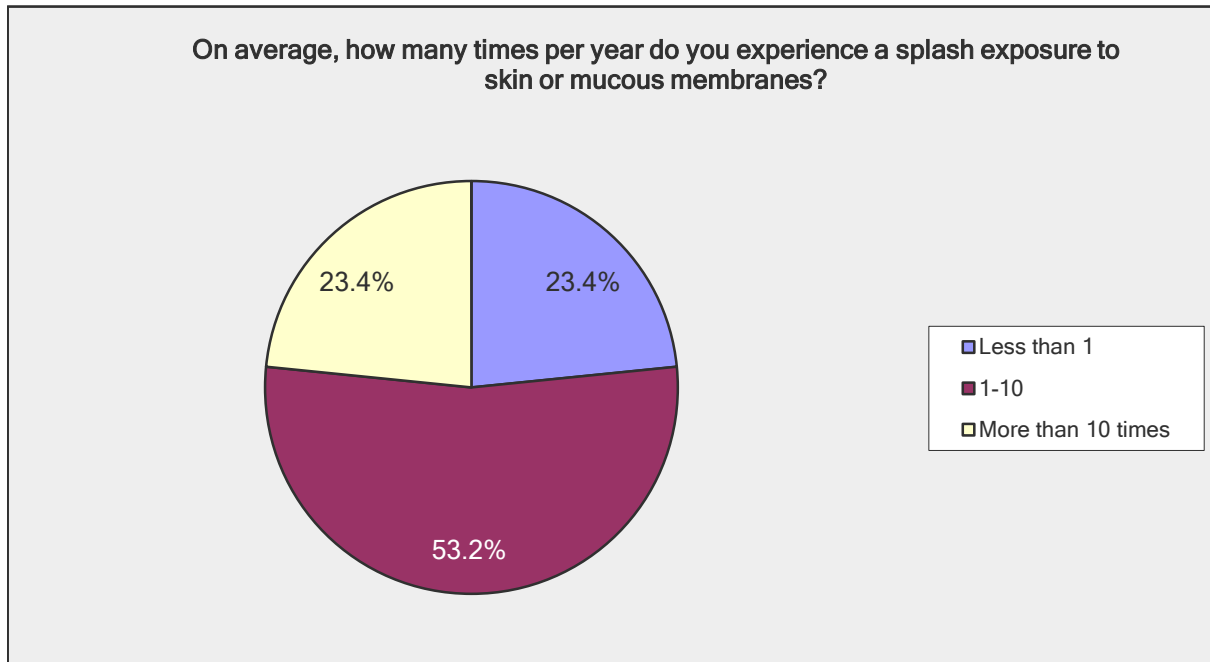
one every 3 years

Question 10

COA Survey on Blood Borne Pathogens

On average, how many times per year do you experience a splash exposure to skin or mucous membranes?

Answer Options	Response Percent	Response Count
Less than 1	23.4%	36
1-10	53.2%	82
More than 10 times	23.4%	36
Comment?		11
<i>answered question</i>		154
<i>skipped question</i>		7



Question 10

Comment?

Large shield always

never in eyes or on damaged skin, and this is always wiped with alcohol containing disinfectant within 30-60 minutes if not immediately

mostly blood on forehead

commonly around the neck during arthroplasty cases

Cannot wear face guard due to fogging of glasses. Please correct this

Due to inadequate protection during total joint replacement surgery. our hospital refuses to provide body protective suits for total joint replacement. I insist on their use in any patients with known Hep B, Hep C, or HIV.

blood droplets on skin, no mucous membrane exposure

Usually wearing a face shield if I know this is likely

Mainly debris from saw blades

All during trauma or arthroplasty cases

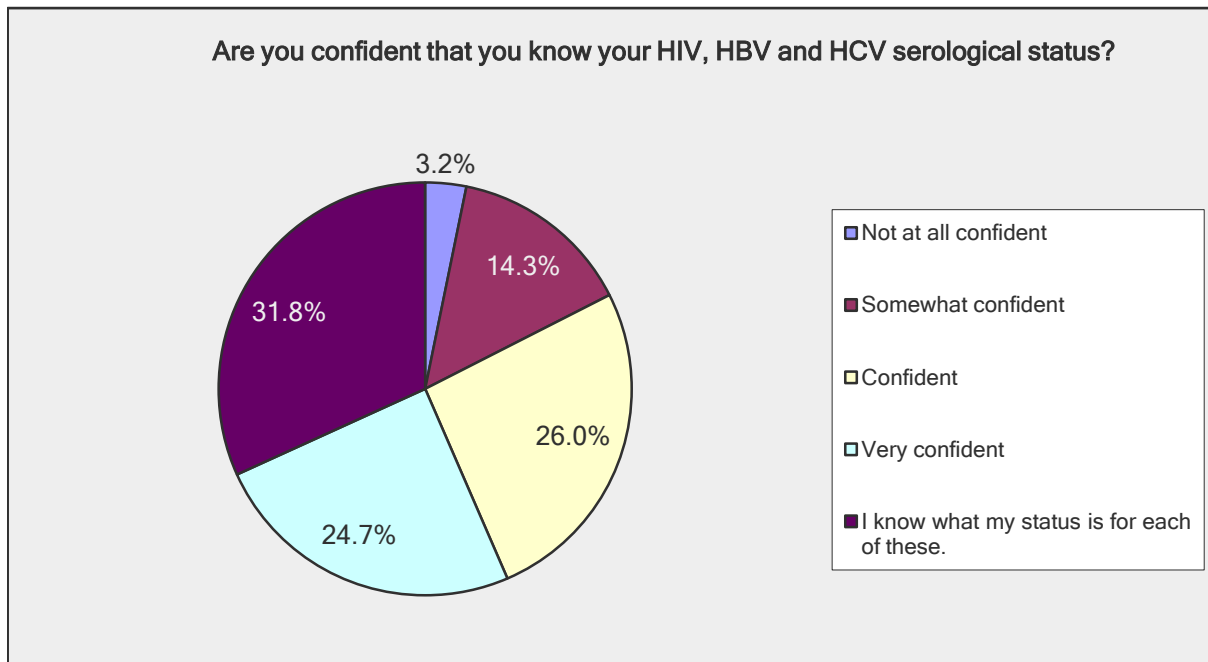
usually skin exposure

COA Survey on Blood Borne Pathogens

Are you confident that you know your HIV, HBV and HCV serological status?		
Answer Options	Response Percent	Response Count
Not at all confident	3.2%	5
Somewhat confident	14.3%	22
Confident	26.0%	40
Very confident	24.7%	38
I know what my status is for each of these.	31.8%	49
Comment?		7
answered question		154
skipped question		7

Comment?

what happens if I am positive? Do I loose my job? Is it better to not know?
 insurance application testing recently
 Tested after last exposure and continue to be negative, and HBV immune
 as of 1 yr ago
 recent insurance blood work
 Only because of the College in Ontario demanding this
 From previous testing related to sharps "incident"

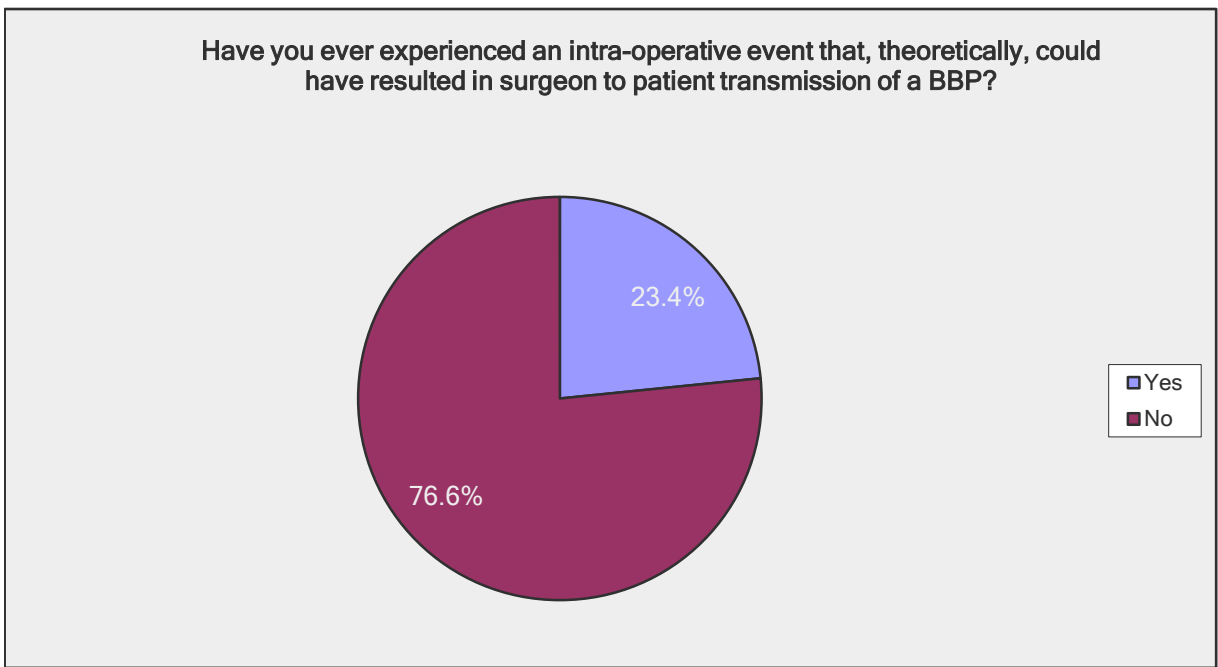


Question 12

COA Survey on Blood Borne Pathogens

Have you ever experienced an intra-operative event that, theoretically, could have resulted in surgeon to patient transmission of a BBP?

Answer Options	Response Percent	Response Count
Yes	23.4%	36
No	76.6%	118
If "Yes", please describe here:		19
	<i>answered question</i>	154
	<i>skipped question</i>	7



Question 12

If "Yes", please describe here:

splashes and pokes are part of the job. Theoretically possible to contract disease.

Needle stick

needle prick

Glove puncture with unrecognized bleeding

Needle injury Hep C positive patient

needle stick

needlestick

needle stick, patient status unknown, medium risk demographic

needle poke

finger cut on sharp bone

Operated on HIV, HB and HC patients.

non-hollow needle stick event as a resident

Needle scratch (skin only) in a patient with known Hep C

suture needle puncture, tension band wire puncture, sharp bone end puncture, blood / fluid splash

laceration

A metal spur from HEP B patient poked my hand during hip revision surgery.

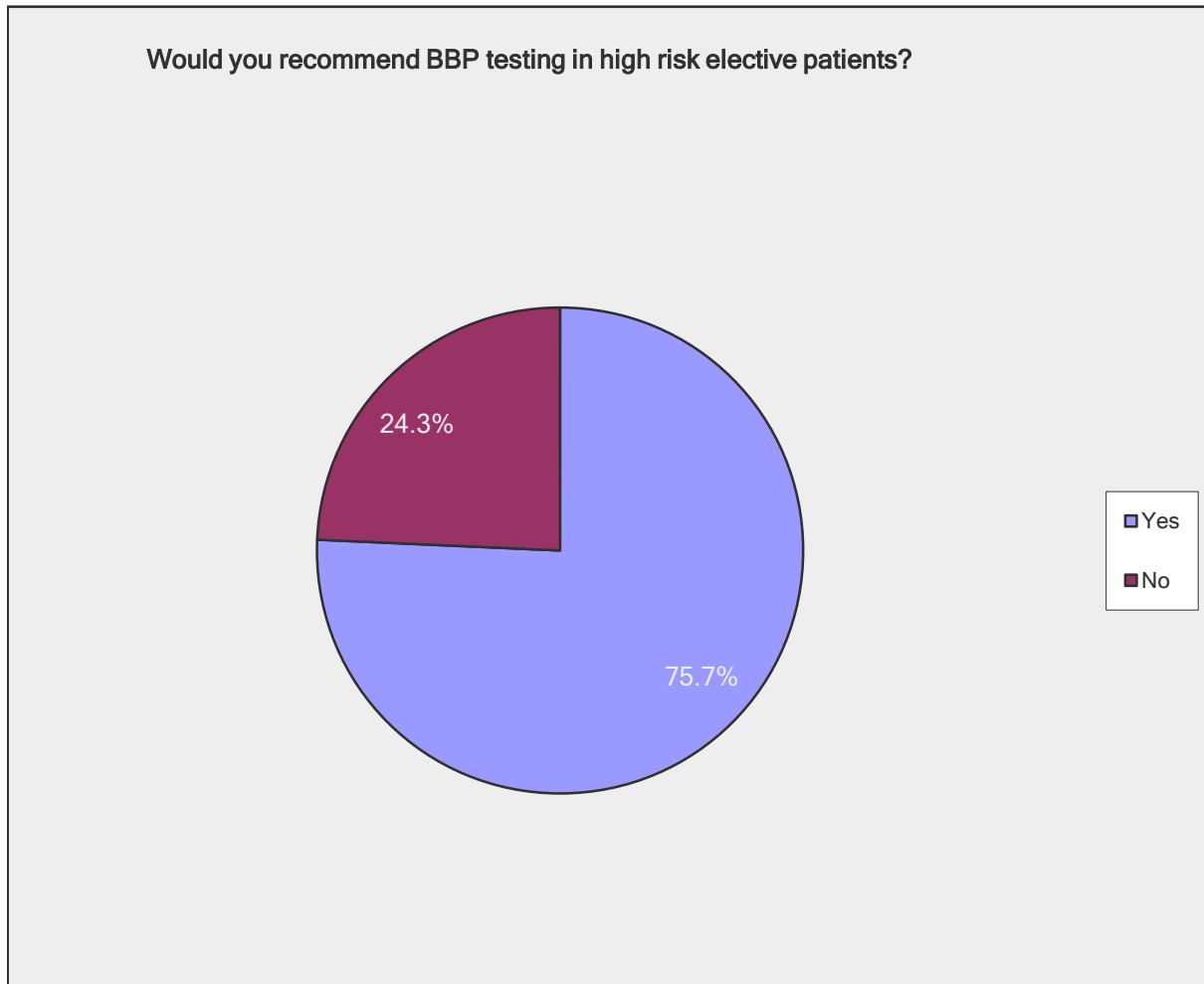
Needle poke to self while suturing.

cut during operative case

K-wire use with a drill that was not in best working order

COA Survey on Blood Borne Pathogens

Would you recommend BBP testing in high risk elective patients?		
Answer Options	Response Percent	Response Count
Yes	75.7%	115
No	24.3%	37
Why or why not?		58
	<i>answered question</i>	152
	<i>skipped question</i>	9



Question 13

Why or why not?

Is that ethical. We need to protect ourselves from everyone.

I would like to know.

Good technique should always be performed, and I feel it would be an invasion of privacy. If we follow good technique, risk is minimal. Would be poor to say "oh I will be more careful"

important information to know to minimize risk - in particular to residents and med student who would be assisting

why does the surgeon need to know their status and divulge this to the college and the patient, yet the patient is not required to divulge his or her status. This violates basic human rights.

Precautions should always be the same

We assume all high risk patients are positive

In spite of universal precautions - it is best to know the risk.

Most cases should probably be treated as high risk anyway. It would not change my decision to operate.

although with universal precautions, it technically shouldn't matter, the fact is that it does. when we know someone is +, we take extra precautions, its human nature.

Inordinate cost/benefit

more knowledge leads to more awareness

If we pick up a BBP then pt can receive Rx to decrease viral load and improve their outcome AND decrease our risk of exposure

If I am concerned enough I simply take extra precautions

pt can receive anti-virals to decrease infectivity risk, and it may justify use of space suits

all should be considered positive..."universal precautions"

assume everyone has a communicable disease.[]

Hospitals should provide the necessary/requested/proven means to protect the surgeon (and patient)

could be construed as a reason to refuse treatment, which has precedents for medicolegal and human rights action

to protect team in case of exposure

Either patients and physicians both get tested or neither group gets routinely tested

Universal precautions should always be used

their status doesn't matter to me, i still have to operate on them, we already take precautions, so

nothing would change if i knew their status.

Patient is part of the team not only for informed consent but to make sure all members are in an optimal state of preparedness; this is 'sold' to patient as being part of overall safety precautions. I had one patient refuse, and polled the OR team if they accepted; the one nurse who was not comfortable was assigned elsewhere. Don't remember why patient refused.[]

Main issue is to decrease need for prophylaxis to personnel if exposure occurs.

I assume they are infected.

risk to staff exposure

universal precautions better approach

should make no difference as the tests, early on, may be negative in an infected patient

I assume that everyone is an ineffective risk

Peace of mind for all involved, including the patient

If I can identify the high risk patient, the whole team is extra vigilant.[]

The risky situation is the patient who appears to be low risk but a carrier who is asymptomatic such as with Hep c

Question 13

If exposure occurs, BBP testing should be easily available and accessible, otherwise, medical need vs patient privacy balance should prevail

we are always a little more careful when the risk is defined

we should take universal precautions and assume all are contaminated.

all patients should be treated with universal precautions

It increases alertness among staff if these are known in advance

To protect staff and urge precautions.

Why not? If patients are identified as high risk by history then they should be tested.

surgeon has a right to know if elective patient is positive,

part of general health screening -- if patient's are high risk, they should be counselled to have appropriate testing.

To ensure they've been treated adequately to lower their risk of post-operative infection

Proper advice to patient requires complete medical information of all current and past illnesses of the patient. Informed consent for surgery requires full disclosure of all risks, including risks associated with BBP status.

Universal precautions

patients right to privacy and volunteer testing

To protect the surgeon or team, a higher index of intraop protection may be considered.

Appropriate treatment can decr viral loads and lessen risk to OR team

Safety of the operating team. We are routinely cautious, but can be more cautious in a confirmed case, Human nature

Personal protection

If I have to undergo testing and possibly lose my job despite the fact that the surgeon is much more likely to get something from the pt than the converse and the College :a: won't allow me not to treat any patient!

b: won't compensate me if I sero-convert!

then I think I have a right to know if I have been exposed

Definitely!

universal precautions for all. the last thing you want to do is change your usual routine for high risk patients; therefore, develop a safe routine for all

It's a public health issue. Not only does the patient have to be protected but health care professionals deserve and require the same protection and assurances

all patients treated with universal precautions, no safe patients

the assumption is they're all positive

All patients should be treated as high risk.

Safety for health workers

would still use universal precautions and would not refuse to treat them anyway

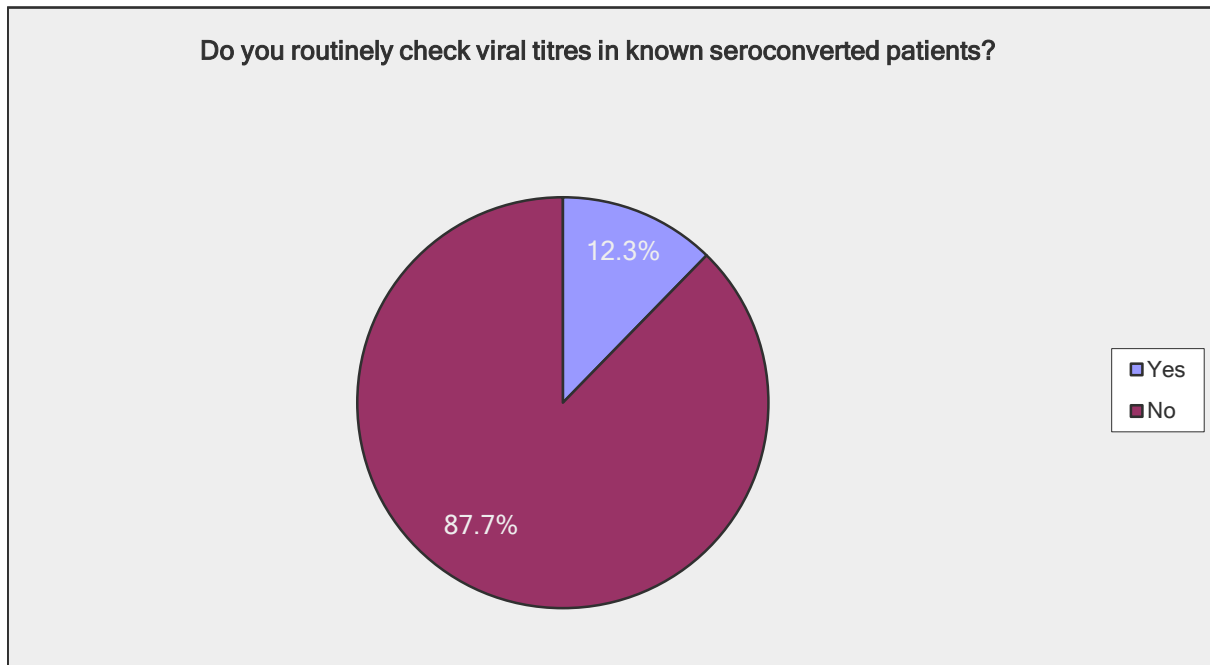
Surgeons have no 'rights' Political correctness has impaired logic. I remember when VDRL was standard for all patients admitted to hospital. There are large red stickers on patients charts warning they all allergic to "environment" but there is no available documentation to state the patient is HIV positive. Surgeons are not privileged to this information. Those who advocate universal precautions push pencils not Knives.

In the event that there is an incident I believe that testing of the patient and the surgeon should be performed. So why duplicate?

Question 14

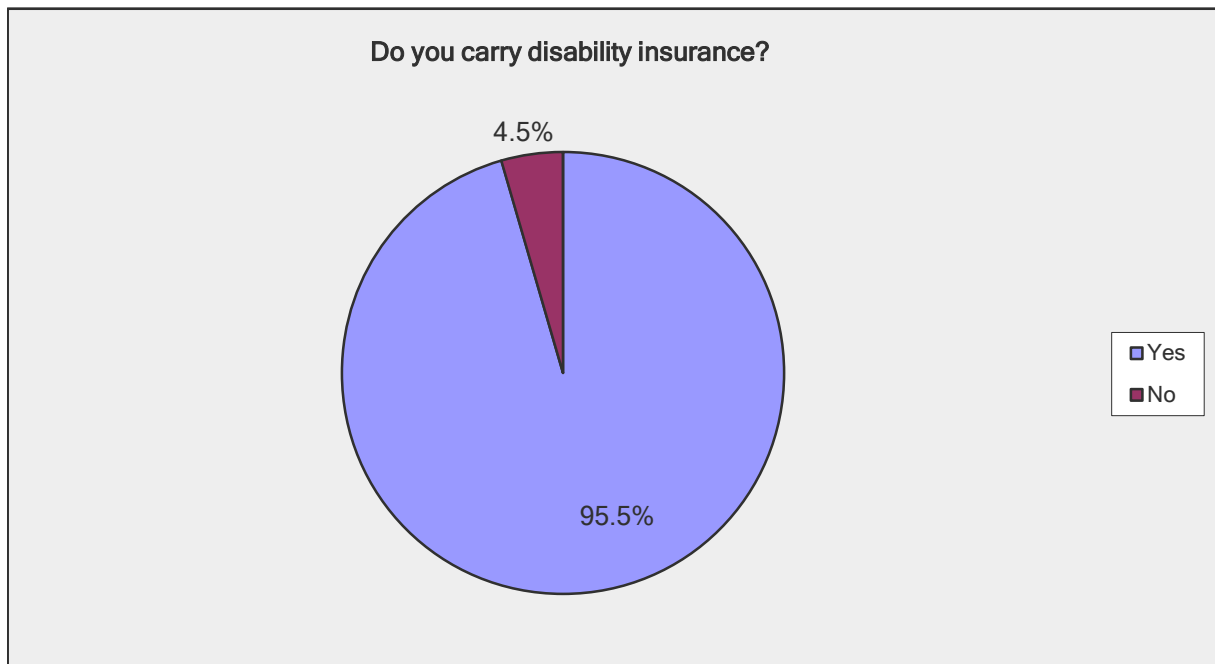
COA Survey on Blood Borne Pathogens

Do you routinely check viral titres in known seroconverted patients?		
Answer Options	Response Percent	Response Count
Yes	12.3%	19
No	87.7%	135
<i>answered question</i>		154
<i>skipped question</i>		7



COA Survey on Blood Borne Pathogens

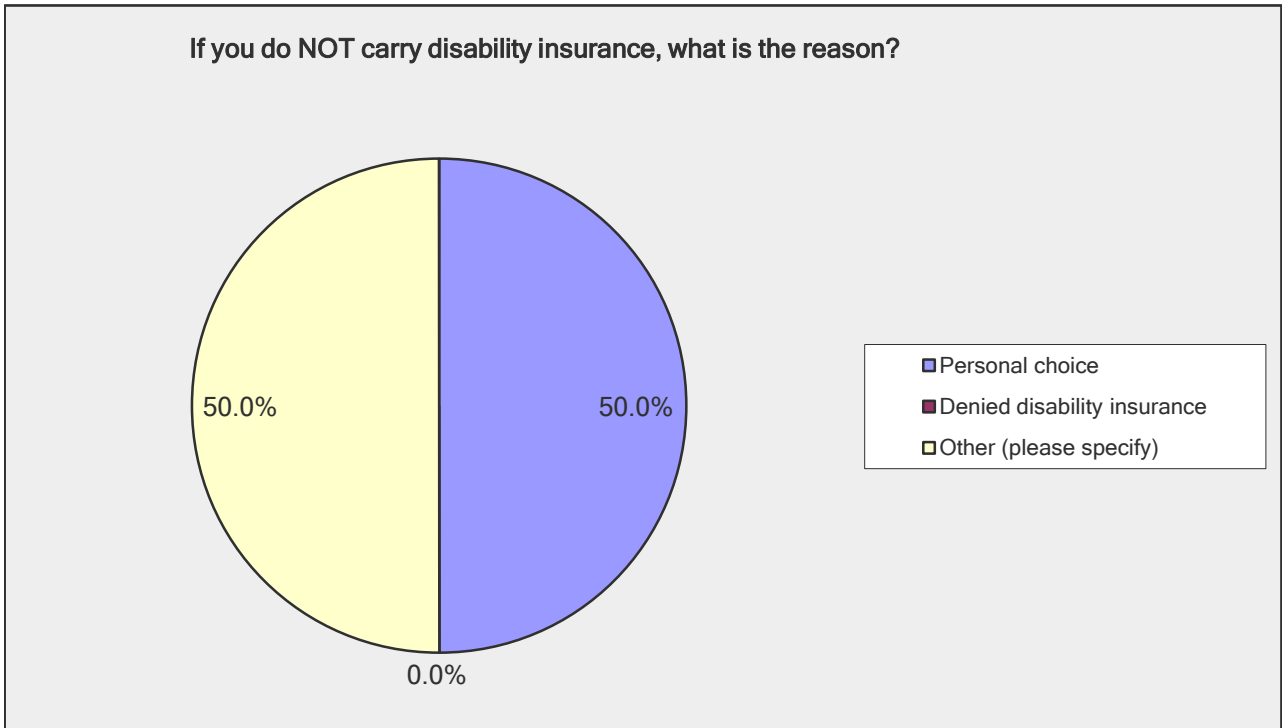
Do you carry disability insurance?		
Answer Options	Response Percent	Response Count
Yes	95.5%	147
No	4.5%	7
<i>answered question</i>		154
<i>skipped question</i>		7



COA Survey on Blood Borne Pathogens

If you do NOT carry disability insurance, what is the reason?		
Answer Options	Response Percent	Response Count
Personal choice	50.0%	3
Denied disability insurance	0.0%	0
Other (please specify)	50.0%	3
<i>answered question</i>		6
<i>skipped question</i>		155

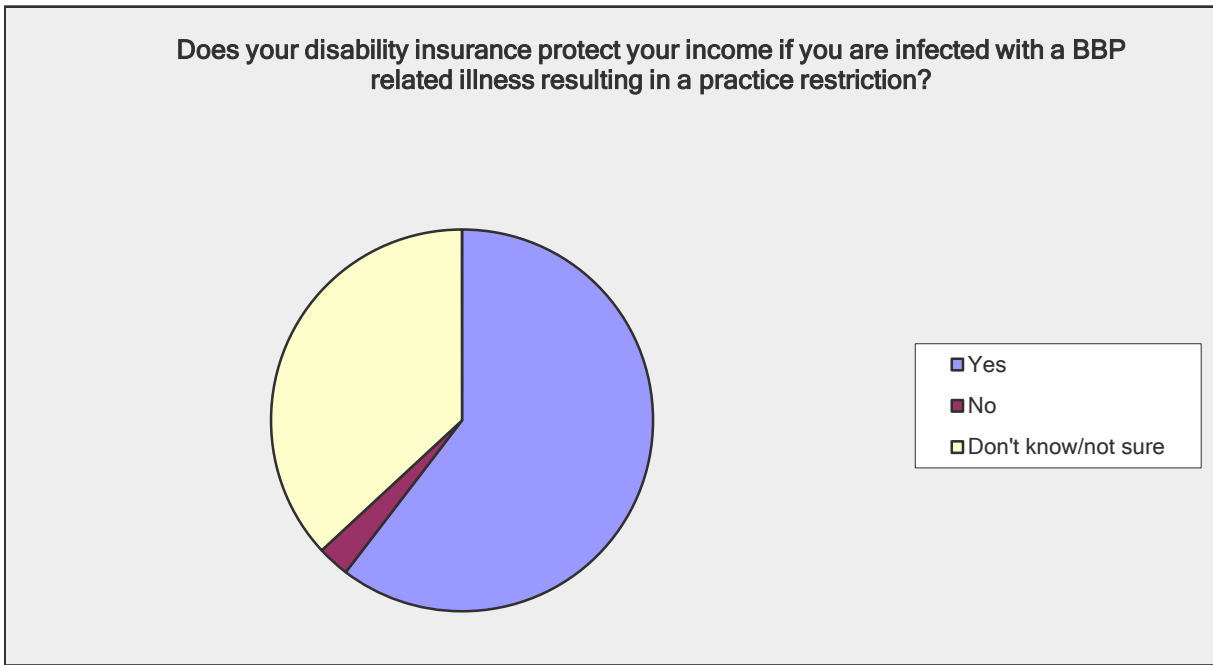
Other (please specify)
 too ld, too expensive
 expired
 near retirement age



COA Survey on Blood Borne Pathogens

Does your disability insurance protect your income if you are infected with a BBP related illness resulting in a practice restriction?

Answer Options	Response Percent	Response Count
Yes	60.4%	90
No	2.7%	4
Don't know/not sure	36.9%	55
Comment?		12
<i>answered question</i>		149
<i>skipped question</i>		12



Question 17

Comment?

Only some of it.

i obviously need to look into that

However, the wording is very loose. Most surgeons think that if they cannot perform surgery, then their disability insurance will cover them from an "own occupation" perspective. Not so, I've checked with my carrier and it all depends on how they define the essential tasks of an orthopaedic surgeon. I'm with a very well respected company and was flabbergasted to determine this.

not to level of present income

if occupationally related seroconversion

Its supposed to be own occupation clause but I am confident that they would try to weasel out of it possible

Pretty sure it does, I was tested before policy was signed

I assume "own occupation" protects me. If I convert the College states I can only do carpal tunnel releases or knee scopes where there is no chance of opening.

the problem with BBP insurance is that the college must take away your license to practice before you are considered disabled; therefore a surgeon who sero converts has worse of all worlds. first, the college won't take away your license to practice, but will make the surgeon disclose their serology status; thus effectively ending their practice, but disability payments won't be paid because the license has not been revoked.

protects part of my income

I believe that it does, I have researched it extensively with my broker and the underwriter, and both have indicated that it is likely that I am covered, however, after my extensive investigation I would caution all surgeons to review their policies as the answer to the coverage question is far more complex than anyone would anticipate. This should be appreciated by all surgeons

There was a precedent setting case with Dr Yabsley but not clear if disability would be accepted, Even if it is accepted is only good for 2 years at best so does not realistically help.

COA Survey on Blood Borne Pathogens

Any final comments?	
Answer Options	Response Count
	29
<i>answered question</i>	29
<i>skipped question</i>	132

Question 18

Question 18

Response Text

During residency there is a higher incidence of needle stick injuries as you're learning, I believe I had over 14 during 5 years. In practice now they are much less frequent.

no

No

in ontario this is really a draconian measure with very little data to suport physician to patient transmission. As orthopedic surgeon we accept this personal risk for the treatment of our patients. I am not sure we should also be putting at risk our junior trainees. I have had 3 residents report needlestick injuries over the last year. They do report to occupational health but in Ontario if they were to serconvert they would be unable to practice as orthopedic surgeons and would be living on resident disablitiy. If the legislation of mandatory reporting persists we should push as a society for manatory testing for all patients and have junior residents and med students excluded from the care of these patients

we should be routinely checking ourselves for seroconversion

CPSO must be challenged under both privacy act and human rights.

See previous comments

have major concern wrt potential development of HBV thru patient event and CPSO restriction of practice

COA could help by identifying an employment strategy for surgeons who are sero-positive

I am totally opposed to mandatory college testing of surgeon BBP status. It is unconstitutional. If that is allowed then mandatory testing of all patients for BBP should also be allowed to protect the surgeon.

If authorities want to test us all fine - but if we seroconvert because of OR exposure and they stop us operating , i.e. our career is finished because we got stuck with a needle, bone fragment etc from doing our duty for a patient, then a disability program should be in place for us. Period.

don't test unless you are ready to retire

no

Good idea, let us know.

there is not much actual data on surgeon intra-operative exposure leading to infection

As a rule surgeons do not take the measures to seriously.

BBP status of both the patient and surgeon should be known before any major surgical intervention to evaluate possible outcome adequately. Risks associated with the BBP status or any other medical condition of the patient ought to be discussed.

Semi-retired.[]

Assisting only

Body PROTECTION suits should be the standard of care IN PATIENTS WITH bbp (hiv, hEP b, hEP c) especially during procedures with a high risk for "splash" or "splatter" of b;lood, specifically total hip, knee, and revision total; hip and knee procedures. this should be a postion statement that the COA needs to adopt. this has been adopted as a standard of practice at UBC, but NOT other hospitals in BC.

NO

This is a media circus which ignores the welfare of the surgeon who is definitely at risk versus the more spectacular "possible" infxn of a pt by a surgeon. It's the pt usually bleeding NOT the surgeon.

Hope to see results soon and I hope a Canada wide policy comes out of it.

Question 18

I really feel that this issue has not been handled properly from the start. It is a very sensitive issue where unilateral decisions have been made. I feel that our rights as health care workers and human beings are being taken away from us

General recommendations and a position statement on this topic will be useful.

I personally feel that this issue is much overstated. We should employ Universal precautions, and with universal precautions, I am not aware of any surgeon seroconverting in the past 15 years. The last known and well publicized case was before we started being very careful.

The risk of transmission from a patient to me is much higher than from the surgeon to the patient. In my institution cost is more important than safety in my opinion.

This issue should be a concern to all surgeons and should be the largest unifying issue for COA members as the CPSO in Ontario has already acted to investigate serologic status which can potentially restrict surgeons practices based on no definitive scientific evidence. We have to demand better data and better accountability from provincial licensing authorities in regards to surgeon practice realignment and retraining in the event of a seroconversion. Surgeons have been very unfairly victimized in this process. We must do better.

The BBP policy of the CPSO was not achieved through collaboration, and is completely unfair to launch without protection for surgeons who might seroconvert. This is NOT a new issue, BBP have been around for decades. Why they chose to ram this through in the rushed and secretive manner they did is suspicious, and unprofessional

The exact risk of specific exposure is not clear. Airbourne exposure or plume from cautery is not clear. Risk of surgeon to patient exposure is not well documented.