Public at Risk: Addressing the syringe reuse problem in healthcare

by Wanda Wilson

On behalf of the millions of patients who receive injections for anesthesia, pain management, and other health reasons each year, the American Association of Nurse Anesthetists (AANA) applauds the efforts of the Centers for Disease Control (CDC), Nevada State Department of Health, lawmakers, and the media to finally expose and correct the frightening infection control problem caused by contaminated syringes,needles, and medication vials that was brought into the light by the recent hepatitis C outbreak in Nevada. As the professional association representing more than 37,000 nurse anesthetists who administer 30 million anesthetics each year, the AANA looks forward to working closely with these organizations and other healthcare associations and societies to ensure patient safety across the nation.It is important for the public to know that most healthcare professionals have their patients' best interests-rather than the bottom line-at heart, and to that end adhere to accepted infection control standards and guidelines when injecting anesthetic drugs or medications.

Unfortunately, and for reasons yet to be determined, there are still some healthcare professionals, including nurse anesthetists and physician anesthesiologists, who put their patients in harm's way through poor infection control practices when applying this most basic of medical/nursing skills. As has been reported in the media, this issue goes beyond provider specialty, title, and credentials. In anesthesia alone, there have been several high-profile cases of improper use of needles/syringes/medication vials over the last six months that put many patients at risk: *In October 2007, Dr. Kamal Tiwari, an anesthesiologist, was accused of reusing syringes on an unspecified number of patients at a surgery center in Bloomington, Ind. At least two tested positive for hepatitis C.*In November 2007, reports surfaced out of Long Island, N.Y., that anesthesiologist Harvey Finkelstein, MD, was under investigation by the New York State Department of Health for allegedly reusing syringes to draw up medicine from multi-dose vials and exposing thousands of patients to blood-borne pathogen infection. *In February 2008, Nevada health officials closed an endoscopy center in Las Vegas after six patients were diagnosed with hepatitis C. The outbreak was traced back to nurse anesthetists allegedly reusing syringes to draw up medicine from single-use vials, thereby contaminating the vials which were then used for multiple patients. *Also in February 2008, Dr. Scott Young, an anesthesiologist working at a gastrointestinal clinic in Las Vegas, was observed by Nevada health inspectors reusing syringes and potentially contaminated vials of medication on multiple patients. According to the investigation report, "The anesthesiologist was asked what the process was when he went from a used Propofol vial to a new patient. The anesthesiologist stated that he would change the needle and reuse the same syringe." Simply stated, reusing needles and syringes, and using medication vials in an unsafe and inappropriate manner, is inexcusable and cannot be tolerated. If there are any gray areas with regard to proper usage of needles, syringes and medication vials, then those gray areas must be identified and made black and white. The AANA is committed to working with the CDC and other groups to put an end to such needless, tragic situations as those in Nevada, New York, and Indiana.It is disappointing that some of our physician colleagues have weighed in on the Nevada situation involving nurse anesthetists by suggesting on websites and talk shows that doctors never reuse syringes or improperly use medication vials and that only nurses and other healthcare providers do. While the evidence in state health department reports and the media clearly indicates that reuse of syringes and improper use of vials are not uncommon practices among anesthesiologists, the AANA believes the focus of our efforts should be on fixing the problem rather than fixing blame.If we are to solve this problem and regain the public trust, then denial and finger pointing need to stop and healthcare professionals must work together for the public good.Patients should never have to fear that the injection they received for the purpose of supporting their health or promoting their healing might actually make them sicker due to a dirty needle/syringe or tainted vial of medication. The AANA will work tirelessly with the CDC and other interested organizations to achieve this outcome.Wanda Wilson, CRNA, PhD

President, American Association of Nurse Anesthetists

Park Ridge, Illinois.