

Many burns were a result of an epileptic patient having a fit next to a petroleum lamp due to shortage of anti-epileptic medication. This kind of case was fairly typical and I saw many other similar ones.

3. My experience

My experience in Malawi has changed the way I view the world, and made me acutely aware of the advantages I have at home in our medical training and resources. I have seen people in real need of medical assistance on a scale so large that even when I was resting I felt that my time should be spent helping them. This elective also taught me about the value of sharing. Having things meant so much more when I was able to share them with others. The fact that people here had so little in terms of material possessions compared to people back home and did not in any way reduce their zest for life. One could find pleasure in simple things here without the need to spend much. I left Malawi feeling richer for the wealth of medical knowledge that I had accumulated, but also for the countless lessons in life that made me grow internally. I learnt that less really can be more.

Acknowledgements

The author would like to thank all the staff at the various hospitals visited for their time and encouragement.

Conflict of interests statement

The author would like to declare that there are no conflicts of interest in this work, financial or otherwise.

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G. Virich
 Department of Plastic Surgery,
 West Suffolk Hospital,
 Hardwick Lane, Bury St. Edmund's,
 Suffolk IP33 2QZ, UK
 Tel.: +44 7980467613; fax: +44 2078341085.
 E-mail address: george.virich@hotmail.com

Published online 23 December 2006

1743-9191/\$ – see front matter
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 doi:10.1016/j.ijssu.2006.12.002

“SCALPEL SAFETY”: How safe (or dangerous) are safety scalpels?

“Scalpel Safety” is a new term coined to inform users that there are two choices currently available to them to ensure their protection from this common sharps injury – (1) a combination of a single-handed scalpel blade remover and a passing tray or (2) a safety scalpel.¹ Although safety scalpels have been promoted as the safer method, the medical literature contradicts this assumption.

Firstly a study by Fuentes et al.¹ found that combining a single handed scalpel blade remover with a passing tray was as safe and up to five times safer than a safety scalpel. His research paper reviewed the circumstances associated with a 137 scalpel blade injuries sustained over a 16-year period in a tertiary referral hospital in Brisbane, Australia. Also CDC sponsored research, published by Alverdo-Ramy² found that “active” safety devices (where the safety mechanism needs to be activated by the user, in contrast to “passive” safety devices where the safety mechanism is activated automatically) were inconsistently activated. The activation rates in their study ranged from a low of 17%. (Activation rates recorded in this study were 17%, 27%, 67% and 90%.)

Secondly and more worryingly is the EPINet (Exposure Prevention Information Network) data published in 2003 by Perry et al.³ In Fig. 1 of their article they noted in the year 2000–2001 91 injuries caused by reusable scalpels and 42 injuries caused by disposable scalpels (described elsewhere in the text as safety scalpels). This was incorrectly interpreted as evidence to support use of safety scalpels.

However, according to Dr. Sheila Dunn,⁴ president and CEO of the consulting firm Quality America (personal communication) in 2000–2001 90% of scalpels in use in America were reusable handles and only 10% were safety scalpels. This would mean a relative incidence of injuries four times higher for safety scalpels than for reusable scalpel handles.

In an article by Hogan,⁵ the use of safety scalpels in the year 2002 was 22%. This equates to a relative incidence of nearly twice as many injuries for safety scalpels compared to the injury rate sustained by staff using reusable handles.

We believe the term “Scalpel Safety” should be adopted universally and that OSHA guidelines should recommend use of a combination of a single-handed scalpel blade remover and a passing tray as the first line injury prevention strategy.

Conflicts of interest

Dr. Michael Sinnott is a co-inventor and co-owner of the Qlicksmart patents.

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Michael Sinnott*
Daryl Wall
Princess Alexandra Hospital, Ipswich Road,
Woolloongabba, Brisbane, Queensland 4101, Australia

*Corresponding author. Tel.: +61 07 3240 7513;
fax: +61 07 3240 7583.
E-mail address: michael_sinnott@health.qld.gov.au
(M. Sinnott)

Published online 21 February 2007

1743-9191/\$ – see front matter
© 2007 Surgical Associates Ltd. Published by Elsevier Ltd.
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doi:10.1016/j.ijssu.2007.01.010