EDITORIAL

Current status of infection control

The survey on hygienic procedures in 6 regional dental clinics by Awadia and one year later in 1992 by Merchant in 9 additional regional dental clinics show unsatisfactory levels of infection control. Sterilization of instruments is not possible in most clinics since an autoclave or pressure cooker is not available or out of order. The practice regarding the boiling water bath is appalling, because the bath does not always contain boiling water and instruments are quickly picked for use which have not yet adequately been exposed to the heat disinfection. This problem could be solved by procurement of pressure cookers. However there is also a need for proper instruction of the dental personnel about heat sterilization and heat disinfection. It was observed that several intra-oral used instruments in many clinics were not exposed to heat at all. Is such practice purely negligence or unawareness of the hazard ?

The number of gloves is inadequate in most clinics. It is unacceptable to treat so many patients with the same gloves as has been observed in some clinics. Procurement of more gloves is a prerequisite for safe delivery of dental services.

Cleaning the surface of the bracket table or mobile cart top on which the instruments have been laid down with disinfectants between patients, flushing of the aspiration hose and handpiece tubes between patients and daily refreshing of the water in the dental unit and daily mopping of the floor of the surgery can easily be performed with hardly any extra costs. Why do so many clinics not practice such essential hygienic routine ?

Professional ethics

All members of the dental team who are involved in the treatment of patients have a moral obligation to treat the patients in a way they would like themselves to be treated. Moreover the medical ethics urged members of the dental team to treat patients at their level best. As a consequence they have to be scholars during their active lifetime to keep up with new developments and views in their profession. The dentist as the team leader is the first responsible person to guide, inform and instruct all members of the dental team in their respective tasks so as to ensure patient's well-being by rendering safe dental services in all aspects. This is even more true now with the emergence of the HIV pandemic. With no cure or vaccination for HIV infection the dental personnel owe it to themselves and their patients to keep up with adequate cross-infection control.

We intentionally elaborate and emphasize the professional responsibility, moral obligation and medical ethics since we have great concern about the current level of cross-infection control in dental practices in Tanzania. However this is only one part of our concern. There is another aspect that worries us.

Cross-infection control is a way of thinking

The area of infection control is changing with the introduction of new products and techniques and new views regarding cross-infection. The dentist, teamleader, as an university graduate can be expected to follow and evaluate the new information and make rational decisions upon encountering new situations. In many developing countries where extra costs of preventive hygienic measures can not easily be passed on to patients or insurance companies, and where the government lacks the funds to provide the dental team with adequate facilities and supplies, the dentist is faced with the additional problem of making (acceptable) compromises in the cross-infection control. In doing so the dentist must really understand and appreciate the problem of cross-infection and the risks involved during various treatment modalities. Adequate cross-infection control is not merely applying a series of standard measures but a way of thinking. Depending on the prevailing situation, thought has to be given to which measures should be taken and when and what is still acceptable to ensure patient's health. That makes the topic problematic since so many dental auxilliaries with inadequate education are rendering dental services without much supervision in this country. We have noticed that even among dentists, misconcepts regarding infection control prevail. Probably because in the past during their education, classroom and clinical teaching of infection control have been insufficient.

Call for action

The outcry from the dental clinics about the lack of sufficient supplies and instruments as a result of which appropriate infection control can not be carried out, should be taken seriously by the authorities. However the problem of procurement of supplies is not the only cause of inadequate infection control. Negligence and misconcepts do also play a role. This problem needs attention with the highest priority and calls for a concerted approach from the authorities to improve the situation. Any future support for the dental clinics which is not directed to improvements of the current appalling hygienic practice is to our opinion, mismanagement.

References

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