

Blood-borne virus-related discrimination in dental services

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Abstract

While the risk of infection through occupational exposure to blood-borne viruses is a major concern of dental health care workers, the National HIV/AIDS Strategy and many health, AIDS and discrimination-related agencies have identified discrimination related to HIV/AIDS as a priority area for action. In 1995 the Commonwealth Department of Health and Family Services selected the School of Medical Education at the University of New South Wales to conduct a national project to reduce discrimination related to blood-borne viruses within dental services (Godwin, Meihubers & Rotem 1997). This paper provides an overview of the study and its major findings.

The study focused on quality of care issues which may cause or manifest discrimination. Key stakeholders were invited to review policies, procedures, organisational arrangements and other systemic issues which influence the quality of oral health services to populations within selected geographical regions.

Introduction

The risk of infection through occupational exposure to blood-borne viruses is still a major concern of dental health care workers. The effectiveness of standard precautions in infection control in health care services requires awareness of patient rights as well as the implementation of standards and guidelines (National Health and Medical Research Council 1996).

The presence of blood-borne viruses within the Australian community, particularly HIV/AIDS and the increasing incidence of hepatitis C, has highlighted the challenges faced by dental health care workers in delivering oral

health care services. Some of these challenges include containing the risk of infection of dental health care workers; containing the risk of patient to patient infection; and containing discrimination within oral health care services against people living with blood-borne virus infections (Epstein 1990; *Journal of the Canadian Dental Association* 1990; Foltyn 1991; Gooch et al. 1993; Schulman 1993; Pugliese 1995; Puplick 1996). Hepatitis B immunisation is available for health care workers, and has reduced the risk of infection with this virus.

According to Feacham (1995), 'discriminatory attitudes and ignorance of the role of dental health in the management of HIV are reported to be a significant continuing problem'. Several government reports and articles have highlighted the degree of this discrimination and the consequences for people living with blood-borne virus infections and for the wider community. Public health consequences of discrimination include the increased risk of the spread of blood-borne virus infection through the community by discouraging potentially infected persons from seeking diagnosis and so gaining both education in preventing the spread of the virus and treatment of the disease (Bray et al. 1990; Kass et al. 1992; NSW Anti-Discrimination Board 1992; Snyder 1993; Lenehan et al. 1994).

The National HIV/AIDS Strategy and many health, AIDS and discrimination-related agencies identified HIV/AIDS-related discrimination as a priority area for action. In particular, the Commonwealth Department of Health and Family Services established a national research and education program to address HIV/AIDS-related discrimination. It commissioned work undertaken by Kippax and colleagues (1992) and market research which guided program strategies, including a national media campaign directed at the general community. A further strategy was to address HIV/AIDS-related discrimination in health care settings and selected health professions.

In 1995 the Commonwealth Department of Health and Family Services selected the School of Medical Education at the University of New South Wales to conduct a national project to reduce discrimination related to blood-borne viruses within dental services (Godwin, Meihubers & Rotem 1997). The viruses of particular relevance to the project were HIV, hepatitis B and hepatitis C. Creutzfeldt Jakob Disease, while not caused by a virus, was also initially considered, but was not included in the project beyond the consultative stage. This paper provides an overview of the study and its major findings.

The dental services project was developed from the earlier HIV/AIDS Related Discrimination: Health Care Worker Project (School of Medical Education, University of New South Wales 1994).

Method

The study focused on quality of care issues which may cause or manifest discrimination. Key stakeholders were invited to review policies, procedures, organisational arrangements and other systemic issues which influence the quality of oral health services to populations within selected geographical regions.

The key stakeholders included:

- dentists (both private and public)
- dental therapists
- assistants
- hygienists
- prosthetists and technicians
- the AIDS Council
- people living with HIV/AIDS
- the Hepatitis C Council and hepatitis C support groups
- organisations representing injecting drug users
- State and Territory health authorities.

Selection of sites

In selecting sites, efforts were made to represent metropolitan and regional areas. Following consultation at federal, State, Territory and regional levels, the following sites consented to participate in the study: Australian Capital Territory, Hobart, Melbourne, Sydney, Lismore, Adelaide, Perth, North Brisbane and Cairns. The criteria for selection included agreement of the local Australian Dental Association representative to help organise and participate in the study and the willingness of most other local stakeholders to take part.

Review of key issues

Following an extensive literature review and consideration of the findings of the HIV/AIDS-related discrimination survey of health workers (School of Medical Education, University of New South Wales 1993), key areas of concern were identified. Consultation undertaken through this project focused on five major areas which impinge on the quality of oral health care services and which may lead to or manifest discrimination against people living with blood-borne viruses.

These five areas are as follows.

- **Access**
The access of people living with blood-borne viruses to dental services might prove life-saving and is considered by many to be a basic right.
- **Confidentiality**
A breach of confidentiality puts people living with blood-borne viruses at risk of discrimination in all aspects of their daily lives. Lack of confidence in maintaining confidentiality is a major reason for failing to disclose blood-borne virus status.
- **Infection control**
The implementation of standard infection control procedures is a prerequisite of quality dental care and is essential to reducing discrimination related to blood-borne viruses in the dental setting.
- **Occupational health and safety**
Dental health care workers have indicated that refusal of treatment of people living with blood-borne viruses is closely allied with fear of occupational exposure to blood-borne viruses.
- **Clinical care**
The provision of clinical dental care to people living with blood-borne viruses brings with it the need to attend to wide-ranging psychosocial and medical implications of blood-borne virus infection.

The consultation process

Modules were developed to facilitate reflection on the five main areas of concern and to trigger discussion with colleagues in the respective regions. One hundred and thirty modules were sent to 70 locations within the nine selected regions. Ninety modules were returned, representing a 69% response rate. Completed and returned modules then formed the basis for planning and preparing the regional workshops.

Workshops

Full-day and half-day workshops (depending on the availability of participants) were conducted in each of the nine regions. Each workshop was facilitated by at least one member of the project team.

Discussions focused on the issues which were rated highly and on areas where significant differences in the ratings were evident. Participants were requested to

identify activities they intended to carry out after the workshop and to complete a workshop evaluation form.

Workshop reports and feedback evaluations

A modified Delphi survey was used to obtain additional input from the participants by correspondence. Participants in each setting were provided with two opportunities to respond to a list of issues and suggestions raised in the workshops. A final report was prepared for each region, detailing the priority issues in each major area of concern, as determined by the group for that region, along with suggestions for addressing the issues and allocating responsibilities for the implementation of the suggestions. The reports were carefully edited to ensure that concerns and suggestions were not attributed to participating individuals and organisations.

Preparation of final report and guidelines for review of dental health services

The final stage of the project was the preparation of a report on the whole project, incorporating the detailed accounts from each region, modified to retain confidentiality.

The workplace review module contained guidelines for individuals or regional managers who wish to conduct a similar review process in their practice/region. It outlined steps taken to identify aspects of practices or behaviour which would contribute to discrimination against people living with blood-borne viruses in the dental workplace, with guidance for the review process and assistance in developing sustainable outcomes. The module has been designed principally for the dental workplace, but could be adapted to other health care settings.

Results

Workshops were well attended, with a total of 108 representatives from dental health care workers and community-based groups. It should be noted, however, that the private sector was under-represented especially by dentists, due to the loss of earnings incurred by absence from practice.

The priority issues for each region varied across the five main areas of concern. Following is a summary of the issues raised during the regional workshops and subsequent Delphi responses.

Access

The access of people living with blood-borne viruses varies within regions of Australia, with some areas providing a dedicated unit for the dental treatment and management of this group. The relative importance of medical and financial criteria in determining the eligibility of people for public dental services varies considerably: in some regions people with HIV/AIDS and other specific medical conditions are immediately eligible for public dental treatment; in other regions eligibility is based solely on financial criteria. The importance of triage and fast-tracking people living with blood-borne viruses was commonly raised.

Access to private dental services was also identified as a major concern, with anecdotal evidence indicating refusal of treatment by some dental practitioners when patients disclosed their viral status.

Public and private dental sectors regarded access issues quite differently. Lengthy waiting lists and triage and fast-tracking processes experienced in public dental services are not features seen in the private sector. It was difficult to gauge the differences in access issues between the public and private sector because of the under-representation of private dentists in this process.

Confidentiality

The issue of confidentiality was of major concern to many groups. Some community group representatives expressed unwillingness to disclose their viral status to dental health care workers, fearing that confidentiality would not be maintained, or that they would experience difficulties in accessing dental care. They asserted that a dental practitioner had no need to know of a patient's viral status if their infection control standards were satisfactory. The dental profession, however, felt that knowledge of a patient's viral status allowed them to provide optimal quality of clinical care, including increased prevention of oral disease, early detection of lesions, prophylactic treatment, and management of periodontal conditions.

Related issues concerned the number of dental practice staff who were made aware of a patient's viral status, lack of confidentiality policies and the lack of understanding of the importance of maintaining confidentiality, and legal implications of breaches of confidentiality.

The methods of dealing with breaches of confidentiality were generally poorly understood. Policy for dealing with breaches of confidentiality is mandatory in light of various State and Territory anti-discrimination laws. It was regarded as much more important to prevent breaches of confidentiality than to address the consequences. It was also noted that confidentiality has to be viewed in the light

of freedom of information legislation throughout Australia. It was stated that issues surrounding confidentiality were just as threatening to dental health care workers as they were to patients.

Infection control

Infection control legislation, protocols and monitoring procedures vary considerably among the regions. Infection control legislation is in place in Victoria, and has recently been introduced into New South Wales under the Dentists Act. South Australia has been very active in developing infection control protocol and practices, with the AMADA Quality Management Infection Control Certification Programme (a program conducted by the South Australian branches of the Australian Medical Association and the Australian Dental Association). This program manages voluntary and independent audits of infection control and occupational health and safety procedures in medical and dental practices.

Consultations highlighted the importance of continuing education concerning infection control practice and procedures as being fundamental to reducing discrimination in dental services. Monitoring infection control procedures was regarded as critical, and many participants agreed that it should be linked to accreditation of dental workplaces.

Occupational health and safety

It was acknowledged in all regions that occupational health and safety should have a higher priority. Many dental health care workers reported that they were not adequately informed concerning occupational health and safety and, consequently, that they often did not protect themselves appropriately against perceived risk. Allied dental health care worker groups emphasised the importance of knowledge of occupational health and safety issues in the dental workplace, with the need for pre-vocational training for dental assistants within private dental services.

Clinical care

Participants generally agreed that, overall, the dental profession lacks knowledge and understanding of the clinical care involved in managing people living with blood-borne viruses, and that, while there are a few specialist dentists able to provide more expert care for people living with blood-borne viruses in the major Australian cities, this care does not exist for many patients living in rural or remote areas.

The importance of effective liaison between the medical and dental professions was stressed as critical to achieving quality clinical care for people living with blood-borne viruses. It was suggested in all regions that dentists should be receiving regular continuing education in the clinical treatment and management of people living with blood-borne viruses, and that there is a lack of printed material available on the importance of oral health care for this group.

Various organisations and associations were seen to be responsible for implementing the suggestions to address the issues of concern, including the associations representing the different dental health care worker groups, State, Territory and federal departments of health, public dental institutions and community organisations.

Discussion

This project enabled dental health care workers and community representatives to review the dental health services in their respective communities. For many of these practitioners, representatives and consumers, this has been the first opportunity to identify concerns and negotiate ways and means to improve services.

The approach used serves to raise awareness and improve understanding of policies and procedures. At the same time, it provided an opportunity for the people who know the most about the situation in a particular context to offer their practical knowledge and to attempt to anticipate and solve problems as a team.

The process enabled clarification of misconceptions and has led to concrete decisions concerning improvement of the system. The structured discussion encouraged creation of more effective channels of communication for further review and improvement.

Among the principal issues that concerned community groups in all regions were those related to the need to disclose blood-borne virus status when giving a medical history, and how confidentiality was maintained. Representatives from the dental profession were able to discuss the importance of a full medical history in providing optimal clinical care, however, it was agreed that the issue of confidentiality is complex and at times poorly defined, with a need for review in many regions. Current medical history-taking procedures do not always ensure honest disclosure of medical status, and many respondents suggested that the reason for taking a detailed medical history should be explained and noted on the actual medical history form.

Most regions agreed that a directory of services would be useful in assisting people living with blood-borne viruses to gain information about available dental services and eligibility criteria. Access to many public dental services has become more difficult since the cessation of the Commonwealth Dental Health Program in November 1996, causing a diminution of both the number and type of dental services offered. Triage and fast-tracking were seen as essential for people living with blood-borne viruses, to overcome the issue of lengthy waiting lists. There was much discussion about establishing a dedicated unit for treating people living with blood-borne viruses, with many participants believing that general practitioners should develop the necessary skills and knowledge required to provide oral health care for this group. However, a dedicated unit is provided in some regions.

There was agreement that all dental health care workers should receive frequent information about control and occupational health and safety. This is an area that is still generally managed on a case-by-case basis. Accreditation of dental workplaces was seen as very important, with many participants regarding highly the AMADA Quality Management Infection Control Certification Programme in South Australia, a voluntary accreditation process.

Participants agreed that there should be more education for dental health care workers in the area of clinical care for people living with blood-borne viruses, and that people living with blood-borne viruses should be made more aware of the importance of good oral health care. Producing a treatment guidelines booklet was seen as useful for dental health care workers, as well as producing a booklet on oral health care for people living with blood-borne viruses.

Following the local reviews, some regions commenced improvements including:

- providing training developed by people living with blood-borne viruses and the AIDS Council for dental health care workers, administrative and technical staff
- inviting people living with blood-borne viruses to contribute to public and private dental policy-making committees
- in one region, investigating alternative methods of clinical waste collection and disposal
- having representatives from public dental services conduct a continuing education weekend workshop on the issues addressed in the project
- organising dental health care worker staff development seminars by a hepatitis C counsellor

- reviewing triage and fast-tracking mechanisms in a number of regions and, in two regions, implementing fast-tracking mechanisms for people living with blood-borne viruses
- in one region, covering confidentiality issues in more detail in the undergraduate dental curriculum
- in one region, posting notices in the reception and waiting areas of public dental services explaining standard infection control procedures in order to minimise perceived discrimination against people living with blood-borne viruses; and incorporating issues pertaining to confidentiality and sensitivity into the 'Dentistry and Law' component of the regional inservice training program
- some hepatitis C support groups using the review process as a focus to renew support group activity
- one dental technicians and dental prosthetists organisation presenting project material to the Social Development Committee of a State parliamentary inquiry into HIV/AIDS and hepatitis B.

Conclusion

The ability to replicate the findings of this study is affected by a number of limitations.

Firstly, the selection of sites was opportunistic rather than random. The productive review of services and consideration of ways to improve depended on the availability and commitment of local coordinators to undertake the review process. Secondly, private practitioners were under-represented in the workshops and subsequent survey. Thirdly, the shorter duration of some of the workshops due to competing time demands on the participants limited discussion of some of the issues raised.

Nevertheless, the project, while addressing discrimination issues which are often sensitive and confronting, highlighted major areas of concern and addressed areas of misunderstanding between dental health care workers and community groups. Communication channels were established and, in many cases, have been maintained. Some improvements in dental service delivery have occurred, and the dental profession has been made more aware of the needs of people living with blood-borne viruses. Future work is necessary to evaluate improvements and identify any other areas requiring change.

The review of dental health services requires continuity and active participation of key stakeholders. Providing guidelines to facilitate the process is important but not sufficient. In the absence of highly committed local coordinators able to convene and facilitate review meetings and follow up suggestions, the momentum for improvement is unlikely to be sustained. Professional bodies and local health authorities should make provision to encourage local practitioners and community members to continuously review the quality of services. Positive examples may be derived from the experiences of some divisions of general practice which are attempting similar objectives.

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