

GUEST EDITORIAL

Thirty years on, and still there is much to accomplish

Sexually transmitted disease does not recognize national boundaries.

World AIDS Day falls on Dec. 1 and makes this a particularly good moment to reflect on the implications of the disease for the dental profession in the United States and elsewhere in the world. Even more momentous, next year will make it 30 years since the first case study detailing an unusual cluster of pneumonia cases among gay men alerted the world to AIDS as a new sexually transmitted disease.¹

In the decades since, this dreadful disease has created some extraordinary challenges that have been met with equally extraordinary responses. The response of the medical, dental and pharmaceutical professions is of particular interest, because coming to grips with the processes of disease is their stock in trade. It's what they do best when acting in the best interests of the patient.

The professionalism of the medical teams around the world who continue to care for increasing numbers of human immunodeficiency virus (HIV)-infected patients is really something to celebrate—even when their efforts may be limited by different governments and budgets around the world.

The disease created a specific role for the dental professionals who were asked to identify and classify new and unique oral lesions, as well as to treat and relieve symptoms. It also forced the profession to take a critical look at ethical and professional standards. Even today, oral health care professionals are challenged by being asked to screen patients for HIV.² In light of the latest data reported by the U.S. Centers for Disease Control and Prevention³ indicating that an estimated 44 percent of HIV-infected gay men are unaware of their infection, it is not unreasonable that oral health care professionals should be involved in the identification of infected people.

Once HIV was identified, the value in sharing data was recognized by the pharmaceutical industry. A number of manufacturers, who otherwise were competitors, agreed to share data from the many research projects and clinical trials that then were being undertaken. The recent expansion of the Internet made it possible to evaluate this research 24/7. In this way, the development of many of the drugs that

David Croser, BDS, LDSRCS, MFGDP(UK)

are the basis of today's highly active antiretroviral therapy (HAART) proceeded at a much faster rate than might have been possible otherwise. The benefits of that sharing continue to pay dividends in human terms around the world as the generic versions of those drugs become available.

While HAART reduced the infectivity of HIV disease and the morbidity for those infected, the dental profession achieved something that was to benefit every patient, by upgrading standards of infection control and applying them universally. The continuous upward revision of those standards, together with a process of regular audit, is an obvious benefit in eliminating the transmission of all blood-borne diseases—not only HIV.

The international response of health care workers who have risen to the challenge of HIV contrasts dramatically with the response of many governments around the world. Governments generally are mandated to protect their populations, and so precautionary measures frequently are introduced as a knee-jerk reaction to any potential threat.

It remained an anomaly until January 2010 that patients with HIV or AIDS could be refused entry at the U.S. border. It had taken 22 years before the United States joined the rest of the world in accepting that sexually transmitted disease does not recognize national boundaries.

At the same time, health care workers infected with HIV were excluded from performing

exposure-prone procedures, as a precautionary measure. Dentistry around the world was subjected to elevated levels of scrutiny and precaution following the Acer case, in which six patients of the same dentist apparently developed HIV after receiving treatment from him. The route of transmission was never satisfactorily explained.⁴

Clear and regularly updated guidance from government and its various agencies is expected to eliminate ambiguity. Yet, courts asked to assess the risk to the public treated by HIV-infected health care workers, as occurred in the case of an HIV-positive hygienist in Georgia who was removed from practice in 2001, have acted on the perception of risk rather than on actual scientific information about transmission.⁵

The world currently is divided in its opinion on the need to stop HIV-positive oral health care professionals from working with patients. With the introduction of HAART (which can make the viral load undetectable in patients with HIV disease) and the universal application of high levels of infection control in dentistry, there is no documented evidence anywhere in the world of transmission of HIV from a dentist to a patient, apart from the mysterious case of Dr. Acer and his six patients.

Dentists and hygienists in the United States who are HIV-positive now are able to continue in their chosen professions, provided they comply with certain parameters. Those parameters

can be found in the international consensus statement contained in the Beijing Declaration of 2009.⁶

Meanwhile, in the United Kingdom and in some other countries of Europe, this enlightened view has yet to be accepted. Although the precautionary actions adopted some 20 years ago are still in place, the infected dentist or hygienist who has just been diagnosed must stop practicing immediately.⁷ Such people are left to deal with the obvious financial consequences of losing their careers just as they face up to a lifetime of managing their newly diagnosed condition.

This unnecessary act of discrimination is to be the subject of a legal challenge. This may give the dental profession something else to celebrate on Dec. 1. ■

Dr. Croser is the communications manager, Dental Protection, 33 Cavendish Square, London, England, W1G 0PS, e-mail "david.croser@mps.org.uk". Address reprint requests to Dr. Croser.

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