THE EDITOR'S CORNER

Lessons from AIDS and SARS

Anyone who has not been stranded on a desert island for the last six months is well acquainted with the outbreak of severe acute respiratory syndrome. It has been a lead item on the evening news practically every day since SARS was first described as a public health threat. Even during the height of the combat in Iraq, SARS made the headlines.

A recent article in the *New York Times* highlighted the effect that the SARS outbreak has had on doctor/patient relationships in Toronto. In this city, identified by the World Health Organization as a SARS hot spot, it seems that many patients are staying away from their physicians' offices—in effect denying themselves adequate care—out of fear of contracting the virus from other patients. It has been recommended by local hospitals that doctors wash their hands with alcohol after each patient and that they always wear surgical masks when meeting patients face-to-face. At least one Toronto physician has expressed the concern that these measures dehumanize the doctor/patient relationship. In this case, I would definitely tend to err on the safe side. But perhaps some lessons can be learned from the public and governmental reactions to the AIDS epidemic.

More than a decade ago, we all implemented the "Universal Precautions" mandated by OSHA in response to the incident in which one dentist allegedly infected several of his patients with the HIV virus. Everybody assumed that this transmission was due to inadequate infection-control measures. It was later shown that the dentist in question passed the virus to his patients via intentional injection, as a deliberate criminal act. Under those circumstances, no governmental restrictions could ever have prevented the tragedy. Still, the regulations (now called "Standard Precautions") remain in effect.

Zealous protection of patients, staff, and self alike from infectious diseases is of critical importance to each and every orthodontist. None of us would deny or even debate that point. What is debatable is the need for government regulatory intervention in the matter. As a group,

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orthodontists are among the most intelligent, the most highly educated, and the most conscientious of all professionals. We are entirely capable of choosing appropriate measures for the protection of our patients and ourselves. It is our duty to keep ourselves abreast of the latest developments in infectious-disease control and to implement sterilization measures at the highest level, and I personally do not know of any clinicians who do not do just that. Past government regulations have not even distinguished between orthodontic offices, where the possibility of cross-contamination with patient bodily fluids is minimal, and other types of dental practices, where such contamination is much more likely. Most government regulators simply do not know the very real differences between orthodontic practice and general dental practice. The reasoning seems to be that what is good for one type of dental practice is good for all.

Many of the restrictions and regulations imposed in the wake of the AIDS scare can now be judged as overkill. And in this age of evidence-based health care, there is little evidence to support the need for new government-imposed measures to control the spread of SARS. The Toronto doctor's concern about feeling less human and less humane in his interactions with his patients certainly applies to orthodontists and dentists as well as to physicians. Increased government regulation without sound scientific backing not only detracts from the doctor/patient relationship, but adds significantly to the cost of health care, further degrading that relationship.

The SARS outbreak will likely be contained in due time. As this is being written, in fact, WHO has already eased its travel advisory for Toronto, and has announced that Vietnam has contained the spread of the disease in that country. The numbers coming out of Beijing continue to climb, but to date there have been no SARS-related fatalities reported in the United States. This may well be at least partly due to the more sophisticated infection-control practices already in place in U.S. health-care providers' offices.

Until SARS is contained in its entirety, however, we would do well to take it seriously. Even if no cases have been passed from patient to patient in any type of dental office, orthodontic or otherwise, it is our responsibility to make the chances of that occurrence as infinitesimal as possible. By keeping abreast of the latest recommendations regarding disease prevention and infection-control procedures, and by putting those recommendations into effect immediately on a voluntary basis, we will not only be providing a duty-bound service to our patients (and ourselves)—but we may also be avoiding the ever-present menace of further government regulation.

RGK