WHAT CAN WE LEARN FROM THE H₁N₁ FLU EPIDEMIC?

The recent global epidemic of the swine influenza virus known as H₁N₁ has brought to light some interesting personal observations and may in fact produce some positive consequences, despite its potentially lethal effects for those who unfortunately become infected. Despite the fact that like most other strains of the flu, it attacks infants, those who are medically compromised, and aged populations, it also has a predilection for infecting and killing young adults, even those without preexisting medical conditions. The shortage of vaccine to protect all age groups initially led to the severe rationing of vaccine doses only for those in high-risk categories, who could benefit most from the protection it provides. To tightly control administration of the limited amount of vaccine, it was made available only in government-run community health clinics staffed by properly informed health care workers, rather than through local doctors' offices, so that only the highest-risk populations who met strict criteria were inoculated first until more vaccine became available for everyone. Pregnant women and small children with certain medical conditions often stood in long lines for hours to get the chance to be vaccinated.

Eventually grade schools began to get the vaccine as more was made available by the manufacturers. Health care workers in hospital emergency rooms and intensive care units who had the greatest potential for exposure to the virus from their infected patients, and who could pass it on to numerous compromised patients if they themselves were infected, also were high on the list for early vaccination. A few weeks later, other health care workers who had direct patient contact were inoculated to prevent the spread of the H₁N₁ virus and to keep hospitals fully staffed with healthy workers to treat the sick. As a health care worker who provides anesthesia for some extremely medically compromised dental patients in the hospital operating room, your editor understood the necessity to be included in this high-priority group, but felt a little uneasy about receiving the vaccine before his grandchildren.

Although pregnant women, children, and ambulatory medically compromised high-risk groups were able to get to community clinics to receive their flu shots, one high-risk group was almost totally forgotten. Few public health officials considered patients with special needs who were homebound, or whose physical or mental impairments made it essentially impossible for them to wait in long lines for the vaccine, even though many would have qualified as priority recipients for the vaccine. These are the same overlooked popula-

tions that have difficulty receiving dental care because dentists have minimal exposure to managing their care when they are in dental school. Although the actual dental procedures performed for these patients are no different from those used for others, it is dentists' lack of appropriate patient management tools that serves as the barrier to treatment for them.

The inequities within the health care delivery system, as demonstrated by the community for this group of patients with special needs regarding the H₁N₁ vaccination process, provide us with a reminder that the dental needs of this same population have been either forgotten by most of the dental profession, or discounted because dentists do not know how to deal with their special needs in the dental office. Unfortunately, many of these same dentists don't realize that the advanced general anesthesia training that dentist anesthesiologists receive in their 24-month (or longer) Commission on Dental Accreditation (CODA)-accredited anesthesia training programs requires that dentists have extensive experience in providing ambulatory general anesthesia for patients with special needs. Thus they could easily provide high-quality dental treatment for many if not most of these patients with special needs who cannot otherwise cooperate with any treating dentist unless they are safely rendered unconscious in their own dentist's office by a dentist anesthesiologist. This can be accomplished with the addition of a highly skilled mobile ambulatory general anesthesia practitioner who can transform essentially any dentist's office into a fully monitored mini-operating room. In fact, it takes extra time to induce general anesthesia for these patients compared with using local anesthesia alone; however, the dentist can more than make up that time with the enhanced speed and efficiency that result from rendering dental treatment while the patient is totally unresponsive. With new ultra-short acting general anesthetic drugs such as propofol and remifentanyl, the extremely rapid recovery process enhances office efficiency and cost-savings for patients or their sponsors.

Advanced anesthesia certainly facilitates access to care for many diverse groups of dental patients, including those with special needs. We need more highly qualified dentist anesthesiologists to improve access to high-quality restorative dental care for this group, as well as for other groups of patients, including dental phobics who may have the funds or insurance coverage for treatment but do not have the ability to fully cooperate with the operating dentist without sedation or general anesthesia. If advanced anesthesia services were available in every dental school, all dentists

would have exposure to the ease with which many patients with special needs can be comprehensively treated with their use. Although these special patients might still remain on the “outside” of the medical establishment, our profession could at least meet its responsibility to provide proper dental care for them.

Using our model, perhaps the government and medical communities would be more responsible in making certain that they no longer overlook the nondental needs of this group. Another potential benefit of the H₁N₁ epidemic is that members of the population in general, including dentists and physicians, are being even more cautious with their own personal hygiene, to prevent infecting others as well as themselves. They are more often washing their hands with soap or alcohol-based hand sanitizer, and they are sneezing into their elbow or shirt sleeve rather than into their hands. They now more completely understand the importance of keeping their hands away from their eyes, nose, and mouth, particularly after touching objects that may have been contaminated. My hospital has installed alcohol-based hand sanitizer dispensers at every elevator area and in patients' rooms to make it very convenient for everyone to clean their hands before seeing a patient and after they leave the room. These mea-

sures not only will help reduce the spread of the H₁N₁ virus, they also may reduce the infection rates of surgical patients, as well as the number of sick days taken by employees with the H₁N₁ flu, the seasonal flu, the common cold, and other similar illnesses.

Just as the discovery of the HIV-AIDS virus several decades ago prompted dentists to begin wearing personal protective equipment, including gloves, the H₁N₁ virus may very well teach health care workers to be more cognizant of the necessity of more frequent hand washing. Ultimately, the postoperative bacterial infection rates of our patients may be significantly reduced, and we as health care professionals may reap the benefits of better personal health and the need for fewer sick days. During the current economic downturn, the need for fewer sick days and a reduction in the subsequent loss of productivity are more important than ever.

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