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Infection prevention support for general practitioners in the Netherlands

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Considering high-risk activities and the presence of infection prevention in physician offices

To the Editor:

We read the article titled “Current practice of infection control in Dutch primary care: Results of an online survey”¹ with great interest. This study illustrates the need for infection prevention specialists in the outpatient setting, particularly physician offices. Physician offices can have a deceptively benign appearance in terms of infection prevention; however, history demonstrates differently.² With physician offices, there are high-risk activities to consider, including reprocessing, injections, infusions, and procedures. A portion of this study looks at the reprocessing methods employed at general practitioner offices. Unfortunately, the authors found that the offices do not always follow reprocessing standards, placing patients at risk for health care–acquired infections. Following national standards and instrument manufacturer’s guidelines in a physician office can be challenging, as the recent article on reprocessing has clearly spelled out.³

We also observed the absence of injection safety in the survey, which may be a reflection of the current national infection prevention and control guidelines for general practitioners that the survey was based on. In the United States, serious outbreaks have occurred in the outpatient setting due to improperly preparing and administering injections.⁴ Examples of such improper processes include the reuse of single-dose vials, batch preparation, syringe reuse, and preparing injections in a contaminated environment. In the United States between 2001 and 2011, thousands of patients were notified of possible disease transmission due to unsafe injection practices.⁴ Often times these findings were only made after viral hepatitis transmission. Infection prevention specialists are necessary to prevent potential outbreaks via unsafe injection practices and to promote safe practices. We did note through our research that the transmission of bloodborne pathogens is extremely low in the Netherlands.⁵ Injection safety has gone beyond health care with the establishment of supervised injection centers for intravenous drug users. We can learn some critical lessons on eliminating unsafe injection practices from the Netherlands.

Having an infection prevention specialist on staff or as a consultant can be of great advantage to clinics who perform any of these high-risk activities. Most staff and physicians receive only a minimal amount of infection prevention education during school and training; therefore, they may not recognize a potential infectious disease transmission issue. By standardizing practices with policies, procedures, trainings, and competencies, infection prevention specialists can create an environment free of disease transmission.

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Infection prevention support for general practitioners in the Netherlands

To the Editor:

We agree with Harris et al with respect to their comments about unsafe injection practices in general practitioner (GP) offices. In our study, this particular area of infection prevention was only a minor part of the investigation.¹ We looked, for example, at the cleaning of nondisposable instruments; practices concerning needles and other sharp disposables were not covered.

It is true that transmission of bloodborne pathogens in the Netherlands is low. This is mostly due to the country’s needle and syringe exchange program, which is aimed at reducing harm due to injections and has been in place since 1984.² The low prevalence of hepatitis C virus (HCV) and hepatitis B virus (HBV) may, however, result in low awareness of the risks surrounding injection practices in GP offices. Needle stick accidents very rarely lead to the transmission of HBV and HCV, due to a low background prevalence; however, the

risks of unsafe injection practices are sufficiently high to warrant more research into this subject.

We also agree that the presence of infection prevention (IP) consultants in GP offices could be a very important tool in reducing potentially dangerous complications following high-risk activities. In the future, we hope to repeat this study in GP offices that do utilize the help of such consultants and compare the results with GP offices that do not.

Common practice shows that GPs in the Netherlands currently do not hire IP experts or consultants. Support for GPs is in place, however, in the form of a national IP guideline for GPs³ and continuing medical education on IP subjects. GPs usually maintain close contact with the clinical microbiologists to whom they send patient samples, or they can seek advice on IP from experts at regional hospitals or from the municipal health service. There are also various initiatives in the Netherlands such as that of the Ministry of Health, Welfare and Sport, which launched a regional program to address antibiotic resistance in 2016. An important part of this program was the establishment of 10 antibiotic resistance regional care networks with the aim of preventing antibiotic resistance and combating its spread at the regional level by focusing on all health care institutions and health care professionals in a particular region (including GPs).⁴ So, we are hoping that GP offices in the Netherlands will hire consultants specialized in infection prevention, acquire IP skills themselves, or work with IP teammates.

The 2017 Geneva Think Tank on infection prevention and control and antimicrobial stewardship confirmed the importance of fostering the skills necessary for effective infection prevention and control and antimicrobial stewardship, as well as how little attention these areas have been given in the past.⁵ Together with Harris et al, we believe that improvement of infection prevention practices is the best way forward.

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