Commentary on:
Knowledge, attitude and practice of Iranian medical specialists regarding hepatitis B and C virus infection

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Dear Editor,

We have read with interest the article on “Knowledge, Attitude and Practice of Iranian Medical Specialists regarding Hepatitis B and C” by Kabir and colleagues (1). Although the authors have previously published several papers on the same issue, this recent survey has revealed several important findings we wish to emphasize (2). In this study the overall knowledge of physicians regarding preventive measures of viral hepatitis is shown to be relatively low. Interestingly, physicians' knowledge of viral hepatitis C was significantly lower than viral hepatitis B. Despite the growing epidemic of viral hepatitis C and the decreasing burden of viral hepatitis B, it seems that the medical community and health-care workers (HCWs), are not familiar with this changing epidemiology of viral hepatitis (3-5). Because preventive measures for viral hepatitis C are based more on the behavior of both patients and health-care workers it is crucial to include and highlight this information in the academic education and continuous professional development (CPD) of HCWs (3). Health-care workers and especially physicians should be empowered to not only protect themselves and their patients but also to promote knowledge of diseases within the community. A point of concern in studies like this is their focus on HCWs' knowledge of protecting themselves against viral hepatitis rather than the responsibilities of medical specialists on patient safety (6, 7). The good news in Kabir et al.'s report is the improved coverage of hepatitis B vaccination in the target population with higher rates of postvaccination testing of anti-

HBs antibody compared to previous studies (6, 8). There seems to be increasing alertness toward protection against hepatitis B as well as improved implementation of preventive measures, at least at the individual level (7, 9). On the other hand, Kabir et al.'s findings revealed that approximately 8.1% of the medical professionals in their survey had not received a complete vaccination series (three doses at 0, 1, and 6 months). Interestingly medical professionals who did not receive a hepatitis B vaccination overestimated the prevalence of viral hepatitis in the general population. As was correctly pointed out by the authors, this finding indicates that relying on medical professionals' increasing fear of the disease to promote vaccination coverage is not sufficient and may have even detrimental effects. Another important area of research concerns the reasons why some medical specialists do not receive the hepatitis B vaccination. Possible factors may include concerns about the safety and effectiveness of the vaccine or barriers to accessing the vaccine (8). One solution being used in some countries is that all medical professionals must present a certificate of vaccination before beginning to practice, although some authors have raised ethical debates about this (10). Because the use of preventive measures such as double gloves, masks, and eye protection are mainly associated with particular specialties, the use of these measures could not be generalized to all family physicians and specialists. The same is true for testing patients for hepatitis B and C infection. With respect to testing for hepatitis C, there are also ethical and financial considerations that preclude their universal use. Additionally, the underreporting of needle stick injuries is a major problem worldwide (11). The importance of improving this situation is not just related to legal issues because it also would help in health management, finding hot topics for further inter-

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vention, and implementing necessary measures to prevent its occurrence. Kabir et al.'s study, along with others, has properly established the underreporting of needle-prick injuries among HCWs; however, the application of proper strategies to enhance reporting of needle-prick injuries is still a matter of debate (11). In Kabir et al.'s survey all participants with needle-prick injuries had received the HBV vaccine and immunoglobulin, but the prevention practices for viral hepatitis C infection were not clearly reported. As mentioned above, although the risk of acute infection with hepatitis C virus is much lower than hepatitis B virus after a needle prick, the problem is growing, and providing a transparent picture of the real situation could establish the implications of promoting preventive measures for HCV infection. One best practice for the prevention of needle pricks is avoiding the recapping of syringes, and this precaution needs to be promoted more actively among medical professionals (11). An important shortcoming and bias of Kabir et al.'s study is that the study population did not represent all medical specialties in Iran. Furthermore, some of the enrollees were attending postgraduate courses on viral hepatitis and thus were probably familiar with the growing epidemic of HCV despite the matter Lankarani stated in his letter.

I believe that similar studies focus on building healthcare workers' knowledge for the purpose of protecting themselves against viral hepatitis rather than the medical responsibility of protecting patient safety (6,7). However, we had a question from dentists that asked, "Which probability will increase due to not sticking to preventive rules: transmission of the infection from (a) patient to patient, (b) patient to dentist, or (c) dentist to patient?" Dentists were able to choose more than one option. This question shows our concern about patients' safety. To compare our results with similar previous studies requires attention to the differences in our tools (questionnaires), which have different validity and reliability scores. Of the mentioned studies on Iranian medical and dental practitioners' knowledge, attitude and practice of their fields, only one of them has assessed the practice of dentists (6), two are only letters (8,9) and one is a review article that does not focus exclusively on Iran (7). In addi-