

SHOULD GPs BE TREATING PATIENTS WITH HIV INFECTION?

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My immediate response to this question would be to reply, "Of course, who else?" and dismiss it as a non-question in the first instance. However, it appears that there is a perception that general practitioners are reluctant to become involved with the care of patients infected with the HIV virus.

If this is so, and it definitely is not so amongst the generalists that I know, we need to examine a few of the issues and potential reasons why this might be.

Gawie Pistorius has defined a family physician as someone who will manage any problem that any patient has at any time and at any place. This is not "superdoc" but merely reiterating a basic principal of family medicine that we are prepared to take on any patient from cradle to grave and manage their problem whatever it may be.

The hallmark of a doctor who believes in family medicine principles is that he sees the patient in the undifferentiated state and is prepared to help the patient with whatever problem this is. If he is able to treat the condition, he will do so and if the patient requires help from a specialist colleague he will refer him to the most appropriate practitioner. However he will still treat the patient while using all the resources available to treat the disease. Family practitioners believe that "It is not possible to treat diseases, it is only possible to try to treat patients".

Thus appropriate use will be made of specialist colleagues when their specialist knowledge is required to help manage a problematical situation. Family practitioners have long ago abandoned the impractical specialist clinic idea as the most appropriate for run-of-the-mill day-to-day management of a person's medical problems. The female patient with HIV infection, tuberculosis, diabetes mellitus, hypertension who develops an ingrowing toenail has difficulty deciding which clinic to go to with her problem and even more difficulty deciding when to have it attended to when she also has to take one child to an immunisation clinic and another to a general paediatric clinic for a painful ear.

Yes, these clinics should be in place for the problematical situations that require in-depth investigation and super-specialised knowledge of the latest and greatest advances. Here the consultant should be used for his specialised knowledge of disease when appropriately referred by the family practitioner with his specialised knowledge of that particular patient. Then each doctor will be used appropriately and the patient managed to optimum benefit.

With ten percent of the population believed to be HIV positive, the number of these

patients developing illness as a result of their compromised immunity will increase. They also do not present with a ready-made diagnosis at the HIV clinic but present to their usual care-giver. This person then has to treat the patient in the context of the patient's presentation, i.e. where the person presents, what facilities are available to both patient and practitioner alike and what modalities of investigation and treatment are available. In other words, the family practitioner does what he does with every patient.

The argument that practitioners do not want to treat these patients because of fear of infection is also a flimsy one. The chances of infection with a needle-stick injury are minimal and testing for the virus is unhelpful as the test may be negative when the patient is most infective. Also, doctors never stopped practising when no protection was available for Hepatitis B, and surgeons had to operate in the face of gas gangrene when antibiotics were not available.

"Even if we do all the fancy CD4 counts and our patients need the antiviral drugs, they cost too much and are not available to the patients I treat." In the days before antibiotics doctors still treated pneumonia and we still care for patients with terminal disease even when the chemotherapy no longer works. Even without HIV infection, life still remains a fatal disease.

Family practitioners know this and know that their role is to treat and help patients to the best of their ability with what is available. Part of that contract is to find out what is available and if it is available for their particular patient. If the modality of treatment is not available due to cost or other implication the practitioner does not ever say, "There is nothing I can do for you."

Family practitioners treat people and not diseases, and therefore will also treat people with HIV infection as they do any other person. South Africa is in the phase of this disease where more people are presenting with clinical manifestations or the results of their compromised immunity.

Hence it may be the fear of not being up-to-date with this disease — as it was not seen in the wards of the medical schools at the time we were training — that could give rise to generalists not wanting to become involved in treating these patients. Many disease protocols have changed radically since our medical school days and family practitioners have adjusted to these by appropriate continuing medical education. This will also be the same for this disease and we are starting a regular column which will address practical problems generalists have in managing patients with HIV infection. ●