Time to deliver

Reflections on the XVI International AIDS Conference

It is twenty-five years since the human immunodeficiency virus was first detected. Twenty five years ago I was just starting medical school and even by the time I finished HIV was barely mentioned. Twenty-five years later the pandemic has gathered frightening momentum and an international conference can attract 31,000 delegates. The theme of the conference was *Time To Deliver*, because after years of doubt, debate and rhetoric the medical community now has a number of proven strategies to both prevent and treat the virus.

While the South African government's approach to HIV was severely criticized at the conference, South African researchers, activists and health workers made significant contributions. In South Africa the frontline of HIV treatment, care and prevention is the district health system. The family physician is one of the key figures in organizing and delivering these district health services and therefore in answering the call of the *XVI International AIDS Conference.*

In this editorial I would like to pose the question 'What does the challenge *Time To Deliver* mean for South African family medicine and how can family physicians contribute to this goal?' In answering this question I would like to reflect on the contribution of the family physician to the district health system as defined by WONCA.[1]

Care-provider

South Africa currently provides HAART to only 13% of those in need [2] and therefore family physicians in all districts must actively support the provision of treatment, including within PMTCT programmes.

While family physicians may provide care directly through consultations the scale of the pandemic and availability of family physicians necessitates that they work in teams particularly with clinical nurse practitioners. Thus, continuity may be with the team more than the individual. Within this team the family physician should be skilled in appreciating, mentoring and supporting nurse and other practitioners and see this as part of their role.

In addition they should be at the forefront of clinical governance and quality improvement activities. For example a recent audit performed by a family medicine registrar in a clinic in the Eastern Cape revealed that 100% of CD4 counts took more than a month to return to the patient. This audit led to critical reflection and plans for improvement.

It is also clear that caring for people with HIV and AIDS demands a holistic approach to the myriad of inter-related biological, psychological and social aspects of the illness. This is an approach that is fundamental to the philosophy of family medicine.

Medical decision maker

Most family physicians who qualified before 1990 will have gained only a sketchy understanding of HIV and its related virology and immunology during their training. Anti-retroviral medication has likewise introduced completely new classes of drugs with complex interactions and adverse reactions. Family physicians need to go beyond familiarity with clinical guidelines on HIV and ARVs to a deeper appreciation of the underlying rationale and science. As they are the most qualified practitioner in the district health system they should be able to make appropriate decisions when individual patients go beyond the parameters of the guidelines. For example, last week a patient, with a CD4 count of 42, presented for initiation of ARVs while taking TB treatment and warfarin for a recent deep vein thrombosis. Another patient presented with peripheral neuropathy while taking ARVs and also being treated for multi-drug resistant TB. All family physicians therefore should ensure that their knowledge of HIV medicine is brought up to date and in sufficient depth, to not only follow guidelines, but when necessary to make their own scientifically sound judgments.

Communicator

The diagnosis of HIV has profound implications in terms of lifestyle and family. The family physician should be able to counsel a patient faced with decisions regarding testing, disclosure, negotiating safer sex, infant feeding and medication use to name but a few. In our PMTCT system it is frequently the pregnant mothers who are seen as bringing the disease into the home and who are seen as the "victims, vessels and vectors" [3] of this disease. Didactic lifestyle messages of abstinence, being faithful and using condoms are often unrealistic for these women who are dependent on their male partners to help fulfill these messages.[3] Motivational interviewing with its emphasis on a collaborative, evocative and respectful approach to counseling lifestyle change may be a useful model that engages with the complexity of individual situations and allows the development of more relevant solutions.[4]

Community leader

The family physician should be familiar with the local drivers of the epidemic and health needs of their practice population and be able to initiate or support appropriate community-based interventions designed to either prevent the spread of HIV, offer care or support treatment. Community-orientated primary care might involve home-based care, local hospices, orphanages, foster-care, pre-schools, nutrition projects, support groups or buddy systems for ARV adherence. These may all require initiative or clinical support from the family physician.

Manager

Although opportunistic infections in HIV often present acutely, the advent of ARVs and the long natural history of HIV supports a model of chronic care: continuity of care, collaboration between health workers and patients in setting goals and working as a team, achieving adequate comprehension of the illness and its treatment amongst patients, dealing with lifestyle change, use of evidence-based guidelines and capturing of information in problem-orientated records and flow charts. The family physician should be competent to initiate and sustain systems for chronic care.

In many ways the role of the family physician in the HIV pandemic is no different to other important and common chronic diseases and yet the scale of the epidemic and urgency of response necessitates an energetic, tenacious and visionary approach. In another twenty five years time we should be able to say as a discipline that we answered the call *Time To Deliver.*

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Letters to the Editor

The Emergency Medicine Consultation: Revisited

To the Editor: Emergency Medicine is a broad discipline. “It may be regarded as a multidisciplinary ‘resuscitation, stabilization and appropriate disposition’ speciality.”[1]

Emergency units are often characterized by large amounts of patients and few medical staff; leading to the health care professional not being able to spend enough time with a patient. Many consultations are rushed, simply to clear the queue. Patients tend to be dissatisfied with the quality of service received, often not knowing how to use medication and present with frequent exacerbations of many common chronic conditions. One such comment follows: “I’d rather be treated at the SPCA than come to hospital.”[2]

This letter addresses the holistic management of patients presenting to Emergency units. The proposal is that the word “prevention” be added to the above definition of Emergency Medicine and that patients be managed using the “Educate – Bio – Psychosocial” approach that is often taught in Family Medicine and Psychiatry.

For Example, a 55 year old male presents with polyuria and polydipsia. He is a known diabetic on oral hypoglycaemics. His glucose is 24.

Bio: Resuscitate, correct glucose and electrolyte abnormalities.
Educate: Spend some time educating him about his illness, medications, diet and dangers of poorly controlled diabetes. Book him for follow up at OPD.
Psychosocial: His wife just died. He is at high risk for depression. Book him to see the psychologist. This need not be done immediately but should be part of a holistic approach to patient care.

Hospitals have allied health professionals that are enthusiastic and willing to assist. The dieticians, social worker, OT, Physiotherapist, and Psychologist are just a few to name and all have a role in Emergency Medicine.

It seems futile to see 40 patients, claim to have cleared a queue, doing no justice to the medical profession and patients alike. Maybe, by following the “Educate – Bio – Psychosocial” approach; we will have fewer patients visiting the SPCA.

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