



**When doctors oppose change they are protecting their own vested interests, and they hide behind corrupt professionalism**  
Des Spence, p 57

PERSONAL VIEW Philip Mortimer

# Earlier identification and treatment is the way to tackle HIV

**A**fter 30 years and thousands of scientific papers published on AIDS and its virus, can we see the wood for the trees? Would earlier diagnosis and treatment, by interrupting HIV transmission and limiting its rising incidence, better control its spread and ultimately reduce costs?

Analogies sometimes help. Even before HIV had been discovered AIDS was being compared with chronic hepatitis B. The groups at risk and the routes of transmission were similar, and in both infections a carrier state eventually led to the exhaustion of the target tissue. HIV has, however, proved itself unlike hepatitis B virus—it has continued to resist attempts to develop a vaccine against it, but is much more susceptible to antiviral treatment.

With the drug treatment of HIV now offering such promise, a better analogy lies in the conquest of tuberculosis by combined drug treatment in the 1950s. The stigma that attached to tuberculosis might have allowed case finding and contact tracing to be deemed too difficult, but it was generally accepted that intensified measures to find cases of active tuberculosis were justified to get the full benefit from streptomycin based treatments. On evidence or suspicion of an exposure, and even without, mobile mass x ray units were dispatched to factories and schools. At recruitment centres and in nurses' homes young people were skin tested. If reactive they were referred for a chest radiograph. Self referral was also made possible.

The possibility of exposure to tuberculosis was less easily recognised than for HIV, so case finding was not cheap. In 1950 it cost as much as £632 (at least £17 000 (€20 800; \$27 300) in 2011 terms) to identify an active case of tuberculosis by mass radiography.<sup>1</sup> But once a case was found treatment was started and steps were taken to ensure compliance and as far as possible detect and deal with relapses. Counts of acid fast bacilli and culture of sputum smears were used to estimate infectivity and check for drug resistance. To delay treatment until a case deteriorated or became open was not an option.

With the introduction of combined drug treatment, notifications of respiratory tuberculosis in England and Wales fell, from 42 435 in 1950 to 20 799 in 1960, and to a low of 3942 in 1990.<sup>2</sup> Dispensaries and sanatoriums, immobilisations and sunlight exposures, surgical pneumothoraces and pneumonectomies: these treatments were all abandoned. Effective case detection and combined drug therapy made tuberculosis an uncommon disease.

The prevalence of HIV infection in the UK may by now have exceeded that of active tuberculosis in the era immediately before antibiotics, and this prompts the question: might earlier diagnosis and antiviral treatment do for epidemic HIV what the introduction of streptomycin did for tuberculosis? Antiviral drug combinations are already restoring normal life to those whose immune function is faltering, but they could offer all those found to be infected the suppression of HIV replication, the possibility of longer preservation of immune function,<sup>3</sup> and the likely elimination of infectivity other than in the special circumstances of blood, tissue, or organ donation.<sup>4</sup> The extent to which transmissions during the early hyperinfectious phase would continue would depend on the level of antiretroviral coverage.

Before antituberculous drugs were available, chest physicians who were concerned with the threat to families and workmates from open but recoverable cases consigned many patients to sanatoriums. To minimise HIV infectivity simply by prompt drug treatment seems, by comparison, an opportunity not to be missed, though the concomitant problems of adherence, resistance, and cumulative toxicity will, as with tuberculosis therapy, have to be borne in mind.

A recent House of Lords report has identified some weaknesses in present clinical practice.<sup>5</sup> It suggests that reluctance to test for HIV in general practice means that some symptomatic infections are not being diagnosed, and it calls for people at highest risk to be empowered to monitor their own HIV status. Self testing—freely available for pregnancy diagnosis, for example—is feasible for HIV, but is illegal. The report recommends that this regulation be scrapped. A person who becomes HIV infected is now better off knowing as soon as possible, and self testing would facilitate this. It would encourage behavioural change even in the absence of treatment, and the decision to treat might be taken earlier based on viral load rather than depleted CD4 count; that is, on cause not effect.

Strategically, early treatment should be seen as the first step in controlling incident HIV, and not just as leading to further drug expenditure (though for the medium term it will inevitably do this). The analogy with tuberculosis cannot be stretched as far as to claim that it will conquer HIV in a generation, but within that time span real clinical and public health benefits would have accrued. Delays in diagnosis and drug treatment are currently contributing to the rising HIV incidence in the UK.

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References are in the version on bmj.com.

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**The analogy with tuberculosis cannot be stretched as far as to claim that it will conquer HIV in a generation, but in that time real clinical and public health benefits would have accrued**



A Glasgow tram encourages testing for tuberculosis in 1957

**The current guidance sends out the wrong signals to the public about the risk of infection from infected healthcare workers and perpetuates lawful discrimination of people with HIV behind a smokescreen of “patient safety”**

PERSONAL VIEW **Richard Ma**

## Discrimination against doctors with HIV must end

The English Department of Health has consulted on its proposals to change the management of healthcare workers who are infected with HIV. It recommends relaxing the restriction on such workers performing “exposure prone procedures,” provided that they are taking combination antiretroviral therapy, they are regularly reviewed by HIV and occupational health doctors, and their plasma viral load is consistently suppressed to undetectable levels.

This recommendation follows the initial suggestion by the health departments’ expert advisory group on AIDS (EAGA) in 2007 that restrictions on dentists with HIV be reviewed. A working group that included EAGA, the Health Protection Agency’s advisory panel for healthcare workers infected with bloodborne viruses, and the health departments’ advisory group on hepatitis was established to review national guidance on the management of healthcare workers infected with HIV, hepatitis B, or hepatitis C.

The UK has one of the strictest regulations in the world; only Australia, Ireland, Italy, and Malta take a similar stance. The proposed change allows healthcare workers to perform all types of exposure prone procedure, such as hysterectomy and open heart surgery.

The new guidance takes into account the small number of reported incidences of HIV transmission from healthcare workers to patients worldwide: four reports involve four healthcare workers and nine infected patients. Despite over 30 years of review between 1988 and 2008 and over 10 000 patients tested, there have been no cases of HIV transmission from healthcare workers to patients in the UK. The risk of HIV transmission is low for exposure prone procedures and even lower for less invasive procedures; current risk estimates are between 1 in 1 672 000 and 1 in 4 680 000—the second estimate being similar to the risk of being killed by lightning. This risk would be reduced further with treatment with combination antiretroviral therapy.

The Department of Health uses current evidence to balance patient safety with the rights of HIV infected healthcare workers. However, this recommendation is long overdue. HIV is covered by the Equality Act 2010 and is classed



**Doctors with well managed HIV may be allowed to perform open heart surgery**

as a disability. Because of the demographics of risk groups, people with HIV already have to deal with prejudice and discrimination. The current guidance dates from 2005 and is unnecessarily risk averse: it sends out the wrong signals to the public about the risk of infection from infected healthcare workers and perpetuates lawful discrimination of people with HIV behind a smokescreen of “patient safety.”

Despite the low risks, public perception of this proposal must not be underestimated. The comments on the websites of the *Daily Telegraph* and *Daily Mail* in response to this proposal suggested much public hysteria and fear about the risks of HIV transmission. Some people did not want the risk no matter how small; some preferred to exercise informed choice by having healthcare workers declare their serostatus before a procedure; others went further to suggest that HIV positive healthcare workers should wear badges so that they could be “identified”; and one even suggested the UK should have a “list” of HIV positive healthcare workers like a “sex offenders’ register” so that “their activities could be monitored.” Views regarding healthcare workers infected with HIV as “irresponsible” were common; one even compared an HIV positive worker doing an operation with Typhoid Mary doing the cooking. Some justify that current restrictions must be working because no cases have been detected in the UK; if that were true, there would be many more than four reports of transmission of HIV from infected and untreated healthcare workers

from countries without such restrictions.

The General Medical Council advice on the responsibilities of healthcare workers infected with a bloodborne virus such as HIV. Workers must seek advice and treatment, in this case jointly between an HIV physician and occupational health physician. The new recommendations would make this process more robust. Infected healthcare workers who do not adhere to these recommendations would put their careers at risk. There are no reliable data on the prevalence of HIV infected healthcare workers, but by extrapolating the prevalence of HIV in the general population to healthcare workers, the tripartite working group estimated there could be 110 people affected. This could be an underestimate: the Health Protection Agency says that one in four people in the UK with HIV have not had it diagnosed.

The objective of policy is to reduce the undiagnosed prevalence of HIV, including among healthcare workers. This new recommendation might help previously undiagnosed healthcare workers to come forward to be tested and managed appropriately and may help to improve society’s attitudes to people with HIV.

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BETWEEN THE LINES Theodore Dalrymple

# The comforts of spiritualism

Poor Sir Oliver Lodge! An eminent physicist, pioneer of radio, competitor with Marconi, he is remembered today, if at all, mainly for having been a propagandist for spiritualism. His best known book, *Raymond or Life and Death*, first published in 1916 and subsequently reprinted many times, recounts his efforts to get in posthumous touch with his son, Raymond, who was killed at Ypres in 1915.

Sir Oliver's pain at losing his son clearly was assuaged by what he thought was evidence of Raymond's continued existence on "the other side," and his book, which came with all the authority of a celebrated fellow of the Royal Society, was just what tens of thousands of bereaved parents, for obvious reasons, wanted to read and believe. The book was ridiculed in some circles because Raymond revealed, among other things, that there were still cigars and whiskies and soda in the ethereal realm. In fact, life there continued much as before.

One of the strongest pieces of evidence for Raymond's survival was that his father learnt, through a medium, of the existence of a group photograph taken of Raymond in Belgium just before he died, in which someone leant on his shoulder. Sir Oliver had known nothing of this photograph before, and by coincidence a few days later the mother of a medical officer in Raymond's battalion, who had had it in his possession, sent it to Sir Oliver. The medical officer was Dr Alexander Bruce Cheves, who qualified in Edinburgh in 1911, joined the Royal Army Medical



Conan Doyle: medical spiritualist

**Hell... "should perhaps rather be looked upon as a hospital for weakly souls than as a penal community"**

Corps in 1914, and died in 1935. In the photograph, Raymond was sitting in the first row of the group, and the man behind him was leaning on his shoulder.

To us, no doubt, it is surprising that so many brilliant people took spiritualism seriously. Sir William Crookes, the inventor of the cathode tube, and winner of the Nobel prize for physics, was a firm believer. Charles Richet, who won the Nobel prize for medicine in 1913 for his elucidation of anaphylaxis, spent most of the last part of his life writing books with titles such as *The Great Hope*.

But the most famous medical believer in spiritualism was Sir Arthur Conan Doyle. He had hoped that he would be remembered more for his spiritualist work than for Sherlock Holmes, but it was not to be. In 1918, he wrote a short book called *The New Revelation*, a prelude to his two volume history of spiritualism. Sir Arthur relates the kind of evidence that impressed him:

*A lady in whom I was interested had died in a provincial town. She was a chronic invalid, and morphia was found by her bedside. There was an inquest with an open verdict. Eight days later I went to have a sitting with Mr Vout Peters [a favourite medium, incidentally, of Sir Oliver Lodge]. After giving a good deal which was vague and irrelevant, he suddenly said, "There is a lady here. She is leaning upon an older woman. She keeps saying 'Morphia.' Three times she has said it. Her mind was clouded. She did not mean it. Morphia!" Those were almost his exact words.*

Sir Arthur, being a very nice man, could not bring himself to believe in hell, but he did believe in what he called "probationary spheres," for those who had not done well (morally) in life. These, he said, "should perhaps rather be looked upon as a hospital for weakly souls than as a penal community": a kind of celestial unit for personality disorders, I suppose.

Theodore Dalrymple is a retired doctor

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## MEDICAL CLASSICS

### Euthanasia: or, Medical Treatment in Aid of an Easy Death

A book by William Munk; first published 1887

I bought a Victorian medical monograph in a second hand bookshop in Sydney during a brief incarnation as ship's surgeon in the mid 1960s. Its eye catching title was *Euthanasia*, but the word was used in its original Greek sense of dying pleasantly, rather than in the modern medical sense (crucially preceded by the qualifier "voluntary") of actually choosing the time and mode of your own death. "There is little to be found in medical writings," says the author, Dr William Munk, "on the management of the dying... The subject is not specially taught in any of our medical schools [and] needs a systemic treatment that has not hitherto been accorded to it."

Though liberally scattered with entire paragraphs in Latin and Greek and the names of drugs long forgotten, it nevertheless describes a crucial principle of modern pain management. Opium, "our one trustworthy remedy," he writes, "must be administered in such doses as will appease suffering and disorder, and in this respect we are to be governed solely by the effect and relief afforded... [Its effects] continue for about eight hours, and if its action is to be maintained it should be repeated at intervals of that duration or somewhat less." It took a century before that common sense advice became routine practice in palliative care. Perhaps we should submit some of his other suggestions to modern controlled trials? Hiccup, for example, may be "somewhat alleviated by a sinapism to the epigastrium, and a spoonful of aniseed water swallowed slowly." No need to involve big pharma then.

Another section that surely still has clinical relevance concerns choosing the right wine for the dying. "Madeira from its slight acidity is specially agreeable to the palate, and is besides the most sustaining and cordial of wines. But [Hungarian] tokay is often more acceptable than any other wine... It is best given with cream." Brandy goes better "with yolk of egg and sugar." If the situation arose, I would certainly welcome some Tokay at the end of my own last supper, perhaps to wash down a favourite dessert with *sauce barbiturique*.

Some of Munk's other observations are more of historical interest. Though he strongly opposes deliberate attempts to shorten the dying process, Victorian nursing attendants, it seems, might hold different views. He deplores the practice ("very prevalent in France and Germany and... not unknown in this country") of deliberately removing pillows to make terminal dyspnoea even more terminal.

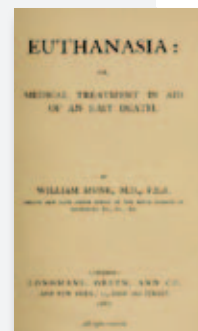
Given the amount of time Munk had clearly spent at death beds, it is disappointing that he recalls no memorable dying words. However, if you want to know how to write an extempore prescription for "ether punch" or find out what the wonderfully named "strabismus patheticus orantium of Boerhaave" is, then the British Library has two copies.

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Competing interests: The author is a member of Dignity in Dying and was on the committee of its predecessor, the Voluntary Euthanasia Society.

*Euthanasia: or, Medical Treatment in Aid of an Easy Death* is available online at <http://openlibrary.org/books/OL14147238M/Euthanasia>.

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FROM THE FRONTLINE **Des Spence**

# Medicine is our vocation

Some commentators have a surgical knife out to stick into the National Health Service, and particularly into doctors. These newspapers tend to be on the political right, and their dogma runs that the NHS is a bureaucratic monolith akin to British Leyland, the car maker nationalised in the 1970s. It operates a closed shop, with restrictive working practices that benefit only NHS workers. Doctors are but jumped up, lazy, jobsworthy shop stewards. When doctors oppose change they are protecting their own vested interests, and they hide behind corrupt professionalism. And in these days of austerity, our fat cat public sector pay and pensions are used to beat us, along with unsubstantiated human interest stories that are caricatures of poor NHS care. The NHS would be better privatised and taken over by Richard Branson's Virgin Care: he would make the appointment system run on time. Doctors feel hurt, angry, vulnerable, and defensive. What to do?



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We should not defend the indefensible—sloppy, careless, and lazy care. The NHS is not perfect, and criticism is always legitimate, so long as it is legitimate criticism. The NHS should be kind and caring, and there can be no excuse if it isn't. We need to tackle poor communication, availability, and continuity. Pay is a concern, but pay freezes will continue and money will be clawed back through pensions reforms. The failings of doctors and the NHS, however, are mirrored in all large organisations, private corporations or public bodies, and by all professions.

But those on the right are ideologically blind and systematically fail to understand health economics. We are not building cars. The NHS is inexpensive and is very good at dealing with acute, serious, and chronic illness. The NHS has spared the UK population the distortions of free market medicine that tragically infect millions in the United States. And no health system should tol-

erate unreasonable, unrealistic, entitled, and ridiculously demanding patients—because the patient isn't always right, and medical consumerism is the ruination of healthcare.

And for doctors there is something more: we carry the burden of mistakes. Most doctors are genuinely sensitive people who seek to do their best. We make clinical decisions in good faith that in hindsight prove to be wrong. Doctors lie awake re-running these events and will always carry a burden of blame and guilt. Status and wealth offer no comfort for these feelings. Being a doctor is difficult, painful, and a vocation. We have been poor at expressing this and must reassert the notion of vocation. Vocation is something that professionalism will never be, something to believe in, and something we can defend in the papers.

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STARTING OUT **Kinesh Patel**

# Another doctor should investigate all hospital deaths

I'm going to get stick for saying this, but here goes. Surgeons are better at dealing with death than physicians, no matter how counterintuitive this generalisation might seem given the stereotypes involved. When a patient dies in hospital we physicians deal with the family sympathetically, express our sorrow, and move on. There's always another patient to see, another long letter to dictate.

Our surgical colleagues, however, take a different approach. They too express sympathy and sadness, but they also tend to take the death more personally. "Why did this happen?" they want to know. "What's to stop this happening again?" And then comes the inevitable "Who is responsible?" while the registrar dutifully stares at his or her shoes in contrition.

And after the harangue, the hunt for a cause begins. Notes are examined. People involved with the care are

interviewed. Ultimately, a judgment is made. Then all the findings are made public, with other consultants adding their thoughts.

The idea of that fills me with dread. Medics are just not used to having our failings aired in public, let alone facing thorough analyses of why bad things happen in hospital. Surgeons didn't like it either until it was foisted on them after the shenanigans over the safety of children's heart surgery at Bristol; now they wear their figures (when they're good) as a badge of pride.

I remember a 90 year old woman, in pretty good shape generally, waiting for a place in a residential home. She waited and waited for weeks. Then one weekend she died from pneumonia. Were there any consequences? Did things change? Did anyone raise an eyebrow? No. But if she had had an operation in the last month of her stay, things would likely have been different.



**We're so used to adverse outcomes among [elderly] patients, such as falling out of bed and pneumonia, that we don't even notice properly any more**

The usual explanations include that surgical patients are usually fitter and have had an active intentional treatment rather than being harmed by an omission of treatment, which is more common in medical patients. Reflective practice should be the norm, particularly with elderly patients. But we're so used to adverse outcomes among these patients, such as falling out of bed and pneumonia, that we don't even notice properly any more.

Mandatory inquiry into all deaths in hospital by a firm not involved in the patient's care might be a solution to this problem. Death is of course the ultimate hard outcome. We know that adverse events are common in hospitals and probably under-reported—what better first step to fix the problem than to look properly?

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