thyroid stimulator blocking antibody could be species specific and therefore not show up in the mouse test yet still have stimulating properties on the human thyroid.

"Ivan Roitt was behind this brilliant interpretation," writes Adams, who soon afterwards found that "long acting thyroid stimu-

lator protector" disappeared when he used mouse thyroid extracts. He then rounded up half a dozen Dunedin academics as bioassay subjects and proved that the new antibody really did stimulate the human thyroid. Backed by the finding of long acting thyroid stimulator protector in 90% of cases of

untreated Graves' disease, this work soon established that the condition was indeed a true autoimmune disease, caused by thyroid stimulating antibodies. Had Burnet's book come out a mere six years later there would have been no need for a single cautionary word.

PERSONAL VIEW

A different slant on surgery and HIV

Anne Stotter

At St Mary's Hospital, London, and increasingly at other centres, facilities have been developed to provide for the needs of the growing numbers of patients who are becoming positive for HIV antibody, some of whom currently have AIDS. The typical patient is young, educated, with a short life expectancy. Many are male homosexuals, and some are heterosexual or intravenous drug users, or both. Confidentiality and discretion have been recognised from the outset to be important in their health care, and full discussion of management options is now the norm.

Great efforts are made to provide investigation and treatment in the way most acceptable to the individual patient. Out-patient appointments are made to suit personal needs, and open access is provided for investigating and managing intercurrent events. The clinic is quiet, unhurried, and friendly. Cups of coffee and magazines are at hand to occupy waiting patients, and anything and everything is discussed (both in the waiting and the consulting rooms), from drug trials through support stockings to the cinema. Formal or informal counselling is available at all times and at every stage. Even for the most mundane procedure in a fit person the personal basis of care makes placement on to a waiting list inappropriate. Time spent as an inpatient continues to be in a warm, supportive, community-like environment, in so far as is compatible with medical care.

At St Mary's, AIDS related admissions are mostly concentrated in a few wards where the staff are appropriately trained and sympathetic. It is when HIV positive patients attend the general outpatient clinics or are admitted to other wards, such as a general surgical ward, that the high quality of care that they receive elsewhere becomes most apparent. Those who have been concerned with establishing the systems for providing medical services to HIV positive people have aimed at optimal care and have established a pattern of care that is of substantially higher quality than that available to the community generally.

For example, consider a woman with a breast lump admitted for surgery, who is comparable in many ways to an HIV positive

man having a lymph node biopsy whose cytology suggests a lymphoma. The woman has probably been seen in a busy general clinic, been told she probably has breast cancer (based on the results of cytological testing and mammography), perhaps with a nurse and a couple of medical students present, but certainly without a counsellor to hand. Although she does not have to wait for the operation, there would have been no readily available organised community back up to help with her children, or aging parent,

... the patient is the most important member of the team.

or distraught relatives. Though those who care for cancer patients do their best to provide the kindness, time, and information that is needed, the facilities and staff available do not compare with the scale of those provided for AIDS patients.

Much discussion continues about consent for HIV testing, and it has been established that among other things such testing should not take place without counselling, both before the event and after a positive test result has been obtained. Moreover, such counselling should generally be performed by those who know about the virus and about AIDS and are competent counsellors. Contrast this with the routine arrangements for explaining the nature and possible complications of a major operation and obtaining written consent. This is ordinarily the responsibility of the most inexperienced doctor in a surgical team, who does not generally know all that the patient may need to know, is often not good at explaining, and may well be rushed off his or her feet.

The AIDS epidemic is new, and new structures and approaches have been developed to deal with it. These were established before funding was available, and funding for the long term had to be fought for. AIDS has attracted political attention only in part because young, educated,

vocal men have been affected; those health carers who could anticipate the scale of the epidemic recognised the necessity for communicating with the general population, the media, and politicians. AIDS services currently are well funded through the far sight and commitment of those clinicians, with the support of educated and empathetic politicians.

Rather than adapting the existing imperfect models of conventional medical care, new models have been developed which have emphasised the value of honest and straightforward communication, the role of the patient in decisions about management options, and the benefit of care by a multidisciplinary team (including disciplines from outside as well as within medicine). The traditional paternalism has been left behind. The patient is the most important member of the team, which exists to provide for his needs and wants. The medical professionals concerned have developed a service of which they can be proud.

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I find myself asking why I shouldn't provide comparable time, personal support, and flexibility in my management of other patients. The answer seems to be simple: I should. Long waits for outpatient appointments, crowded clinics, inexperienced staff working with inadequate back up, scrappy explanations of medical problems and the options for management, poor communication with others concerned with health care, hospital admissions scheduled with little or no consideration of the patient's needs and preferences, and last minute cancellations of admissions for operations are all unacceptable. Moreover, the idea that talking to those who might help to change the status quo might be demeaning or unprofessional is a poor excuse for continuing with a second rate system. If we chose to do so, the rest of us could improve our service just as those who care for AIDS patients have done. If nothing else is achieved from this devastating virus the example set by the response to it could help to raise the standards of medical care generally.

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