HIV testing in medical admissions is a missed opportunity

Editor – We read with great interest the article by Ellis *et al* (*Clin Med* October 2012 pp 430–4). The authors suggest that there are probably low levels of testing in hospital medical admissions, representing a missed opportunity for testing.

We completed an audit to determine if guidelines for HIV testing among medical admissions were being followed. 200 case notes for patients admitted to an acute trust in 2011 were reviewed. Our patient population includes several areas of high HIV prevalence (>2/1,000). BHIVA guidelines recommend widespread testing in patients from areas of high HIV prevalence.

Of the patients presenting from areas of high HIV prevalence, only 1% were appropriately tested for HIV. 3% of patients from lower prevalence areas were tested. An additional 14% of patients from lower prevalence areas should have been offered an HIV test. 2% of patients had a history of intravenous drug use and 12% had a clinical indicator condition. Alarmingly, there was no evidence that any patients had been questioned about HIV risk factors.

We were concerned as to why medical admission was not seen as an opportunity for HIV testing. We devised a questionnaire based on the guidelines to assess doctors' knowledge and attitudes towards HIV testing. The survey was completed by 50 medical doctors (14 foundation year 1 doctors, 20 senior house officers, 8 specialist registrars and 8 consultants).

The survey showed that knowledge was poor. On average doctors could name 3.48 clinical indicator conditions out of a possible 38 (Table 1).[1] A 5-point Likert scale was used to assess attitudes towards HIV medicine. 68% of doctors questioned felt confident asking about HIV risk factors and 74% felt confident offering patients an HIV test. In contrast, however, 88% felt they would like further training in HIV medicine.

Implications of testing form part of the Core Medical Training Curriculum (2009) and the importance of offering screening is highlighted in the Specialty Training Curriculum for General Internal Medicine (2009). Despite this, our survey might suggest that doctors' lack of knowledge may be one reason why HIV testing in medical admissions is indeed a missed opportunity.

CLAIRE ALSTON
SpR, Surrey and Sussex NHS Trust

DAISY MOFFATT
FY2, Surrey and Sussex NHS Trust

ANDREW ASHERSON
SpR, Surrey and Sussex NHS Trust

NATALIE POWELL
Acute medicine consultant, Surrey and Sussex NHS Trust

NOSHI NAROUZ
Consultant in GU/HIV medicine, Sexual and Reproductive Health Centre, Crawley Hospital

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1 The British HIV Association, the British Association for Sexual Health and HIV and the British infection Society. *UK National Guidelines for HIV Testing 2008*. London: BHIVA, 2008. www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf [Accessed 7 December 2012].

The RCP should support the statutory regulation of herbal practitioners

Editor – Your editorial (*Clin Med* October 2012 pp 403–4) suggests that when statutory regulation of herbalists takes place via the Health and Care Professions Council (HCPC), herbalists should be required to report on the adverse effects of herbal preparations. However, the leading herbal professional bodies have operated for years within the UK Yellow Card Scheme (YCS), advocating that all practitioners should be party to this when statutorily regulated by the HCPC.

In the light of your call for participation in the YCS, it is odd that you should characterise the HCPC as 'an unusual home' for herbal practitioners. The only way that all herbal practitioners can be required to participate in the YCS is through statutory regulation; voluntary regulation will not suffice. The government white paper, *Trust, Assurance and Safety*[1] specifically ruled that 'emerging professions should be managed by the existing statutory regulatory bodies' to use existing expertise to promote common regulatory standards as well as multidisciplinary working. The HCPC is surely the most suitable regulator for herbal practitioners precisely because of its wide ranging portfolio. Significantly the HCPC has expressed its backing for the statutory regulation of herbal practitioners.[2]

It is a matter of regret that the RCP appears to be having second thoughts about backing statutory regulation of herbal practitioners. In an address on traditional medicine, Dr Margaret Chan, Director-General of the World Health Organisation (WHO), said 'The two systems of traditional and western medicine need not clash. Within the context of primary health care they can blend together in a beneficial harmony, using the best features of each system and compensating for certain weaknesses in each... The time has never been better, and the reasons never greater, for giving traditional medicine its proper place in addressing the many ills that face all our modern – and our traditional – societies.'[3]

In the interest of patients, we urge the RCP to support the statutory regulation of herbal practitioners as proposed by the Secretary of State for Health.[4]

MICHAEL MCINTYRE
Chair European Herbal and Traditional Medicine Practitioners Association, Chipping Norton, UK

ANDREW FLOWER
NIHR Research Fellow, Primary Care, University of Southampton

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1 The Stationery Office. *Trust assurance and safety, the regulation of health professionals in the 21st century*. London: TSO, 2007. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_065947.pdf [Accessed 7 December 2012].

2 Health and Care Professionals Council. *HPC's response to the joint consultation on the report to Ministers from the Department of Health Steering Group on the statutory regulation of practitioners of acupuncture, herbal medicine, traditional Chinese medicine and other traditional medicine systms practiced in the UK*. London: HCPC, 2009. www.hpc-uk.org/assets/documents/10002B

Table 1. HIV risk factors. Reproduced with permission of the British HIV Association.[1]

	AIDS-defining condition	Other conditions where HIV testing should be offered
Respiratory	Tuberculosis	Bacterial pneumonia
	Pneumocystis	Aspergillosis
Neurology	Cerebral toxoplasmosis	Aseptic meningitis/encephalitis
	Primary cerebral lymphoma	Cerebral abscess
	Cryptococcal meningitis	Space occupying lesion of unknown cause
	Progressive multifocal leucoencephalopathy	Guillian-Barré syndrome
		Transverse myelitits
		Peripheral neuropathy
		Dementia
		Leucoencephalopathy
Dermatology	Kaposi's sarcoma	Severe or recalcitrant seborrhoeic dermatitis
		Severe or recalcitrant psoriasis
		Multidermatomal or recurrent herpes zoster
Gastroenterology	Persistent cryptosporidiosis	Oral candidiasis
		Oral hairy leukoplakia
		Chronic diarrhoea of unknown cause
		Weight loss of unknown cause
		Salmonella, shigella or campylobacter
		Hepatitis B infection
		Hepatitis C infection
Oncology	Non-Hodgkin's lymphoma	Anal cancer or anal intraepithelial dysplasia
		Lung cancer
		Seminoma
		Head and neck cancer
		Hodgkin's lymphoma
		Castleman's disease
Gynaecology	Cervical cancer	Vaginal intraepithelial neoplasia
		Cervical intraepithelial neoplasia Grade 2 or above
Haematology		Any unexplained blood dyscrasia including: • neutropenia • thrombocytopenia • lymphopenia
Opthalmology	Cytomegalovirus retinitis	Infective retinal diseases including herpes viruses and toxoplasma
		Any unexplained retinopathy
Ear, nose and throat		Lymphadenopathy of unknown cause
		Chronic parotitis
		Lymphoepithelial parotid cysts
Other		Pyrexia of unknown origin
		Any lymphadenopathy of unknown cause
		Mononucleosis-like syndromw (primary HIV infection)
		Any sexually transmitted infection

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3 Chan M. Address at the WHO congress on traditional medicine, 2008. www.who.int/dg/speeches/2008/20081107/en/index.html [Accessed 7 December 2012].
4 Department of Health. *Practitioners of acupuncture, herbal medicine and traditional Chinese medicine.* Written ministerial statement. London: DH, 2011.

Those receiving disability benefits have suffered disproportionately from the austerity measures

Editor – There has been much debate about the causes, precipitating factors and management of the financial crisis. However, it is clear that a major factor has been the spending by governments and individuals of money that they do not have. Therefore the solution must include a return to financial probity. A major contributor to the fiscal deficit is social expenditure and this must be reduced to balance the budget. Many of those receiving benefit have suffered disproportionately from the austerity measures that many feel are necessary. So it is not only just, but also essential, that claimants, new and old, be treated both compassionately and realistically during reduction of the benefits budget.

Over the last few decades the disability expenditure has tripled at a time when the ability to treat disease has improved, so the increase cannot be due to failure of treatment. Change in the age profile of the working population might be partially responsible and the drift from physical to intellectual demands might work either way. Neither is likely to be a whole answer, but I believe the principle cause is deconditioning. In many chronic conditions the relationship between objective findings and performance is poor. To give an example from my own respiratory practice, I have seen patients with identical FEV1s whose sole complaint is an inability to carry guns across a heather moor or to run briskly playing tennis, while others are genuinely limited to 30 m walking on flat ground. The exercise limitation in the latter cannot be directly due to the respiratory impairment, but is due to a vicious circle of decreasing activity and increasing breathlessness – in other words deconditioning.

Deconditioned subjects are not malingerers, albeit often labelled as such, because by the time that they reach that stage they are actually disabled. The medical profession makes a major contribution by not recognising the need for aggressive rehabilitation at the earliest stages of chronic disease. Indeed habilitation is a better term, emphasising that attempts at rehabilitation during the late stages may be too late. The benefits system should recognise its contribution to the problem, which is a particular hazard during times of financial depression. It should facilitate and require attendance at (re)habilitation programmes, with frequent reassessment until the performance threshold is reached. It should also emphasise that Disability Living Allowance is not a long-term sickness pension, but, as its name implies, financial help for the disabled to reach full potential including employability. Similarly, benefits contribute to social deconditioning among the unemployed. In response to this the unemployed must be given the opportunity to experience work, but they in their turn should be under an obligation to accept it. One of the barriers to this is the perceived indignity of working for nothing. This would be mitigated if the benefit were presented as a state wage for the unemployed. Then like all wages it should be taxed or withdrawn fairly at no more than one pound for every three earned.

Both health and benefit sectors must recognise that deconditioning, and not impairment, is the determinant of limitation of performance in many subjects and they must act accordingly. If the immediate use of resources to reverse the latter for long-term benefit is to be acceptable to the tax-payer, the public must be educated to accept that the major toll on the disability budget is not fraud but deconditioning.

CK CONNOLLY
Retired physician, North Yorkshire

In patient care: should the general physician now take charge?

Editor – Kirthi *et al* (*Clin Med* August 2012 pp316–9) argue a case for the management of emergency-admitted medical patients by general physicians. There is, however, evidence that patients with a range of acute problems including coronary artery disease, stroke, asthma, acute upper gastrointestinal bleeding and ulcerative colitis all have better outcomes when looked after by relevant specialists.[1–4] Moreover it seems illogical that we might condone a system in which patients who are well enough to come to an outpatient clinic will be seen by a relevant specialist whereas those who are so ill that they require emergency admission will not. We have shown in Liverpool that changing the system for hospital medical admissions from care by general physicians (with a specialty interest) to one in which patients have their initial care on an acute medical unit followed by early transfer to the appropriate specialty team reduced mortality significantly for those aged under 65.[3] Kirthi points out that this did not improve mortality for those aged over 65, but nor did it worsen it. Older patients with multiple pathologies should surely be appropriately looked after by specialists in the care of the elderly medicine who are likely to be better able to deal effectively with the complexities of their medical and social care. We have more recently demonstrated, in a prospective assessment of medical admissions to our Acute Medical Unit (AMU) with a primary gastroenterology problem, that specialist gastroenterology consultant review within 24 hours of admission increased the proportion of patients who were discharged direct from the AMU from 3% to 23%.

A return to general internal medicine as a specialty to provide care for acutely admitted patients might be an appropriate solution for a small hospital serving an isolated rural community, but as a general model of care we think it would be a retrograde step. Seven-day cover by the acute medical specialties, which should include care of the elderly and acute medicine expanded appropriately, would, we feel, be a much better way forward. Moreover it will be very