ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

1. What is the incidence and prevalence of HIV in the UK and how does this compare to other European countries?

The prevalence of HIV in the UK in 2015 has been estimated at 1.6 per 1000 population. This represented 101,200 people, of which 13,500 were unaware of their infection status. It was higher among men at 2.3 per 1000, than women at 0.98 per 1000. (1) Gay/bisexual men accounted for 47,000 of this total giving a prevalence of 58.7 per 1000 in this population.

In 2015 there were 6095 people diagnosed with HIV in the UK, giving a rate of 11.4 per 100,000 people. This comprised 1018 adults over the age of 50, 5012 adults aged 15-49 and 65 children. (1) In comparison to the average in most other western European countries (6.3 per 100,000 people), this is substantially higher. This is thought to be due to a combination of high testing rates and ongoing transmission. The highest rates of new HIV diagnoses in 2015 were Estonia, Latvia and Malta. (2)

The number of UK people diagnosed with an AIDS-defining illness has dramatically reduced over the past decade. In 2015 this constituted 305 people, down from 714 in 2006. In the European Union as a whole, this totalled 3754 people. (2) The most common AIDS-defining illness was Pneumocystis pneumonia. All-cause mortality among HIV sufferers aged 15-59 years has also improved, with a reduction from 10.2 per 1000 in 2006 to 5.7 per 1000 in 2015. (1)

2. Compare the provision of HIV services in East London to the rest of the UK.

The HIV service for Barts NHS Trust is spread over three sites: The Royal London, Newham and Whipps Cross hospitals. The Grahame Hayton Unit is housed within the Ambrose King sexual health centre at The Royal London site and is dedicated to HIV care. Once diagnosed, patients are usually referred to the service by sexual health clinics, other hospital specialties and GPs.

There are a range of Consultant-led specialist and review clinics, along with emergency drop-in sessions. Inpatient facilities are provided on a shared infectious diseases/infection and immunity ward, which comprises a multidisciplinary team. Patients often present acutely unwell with uncontrolled or advanced disease therefore this level of expertise is essential. This set up is similar in units across the rest of London, with a total of 18 providers spead over 30 specialist clinics.

Large teaching hospitals across the country follow the same model however the difference is in the number of patients with HIV residing in their catchment area. From the 2015 data, it is estimated that two in five people living with HIV actually reside in London. (1) This poses a particular problem when designing services to meet the local population need.

The commissioning of HIV services throughout the country is a complex system, mainly comprising a mixture of local authorities, CCGs and NHS England. Each is responsible for a different facet, be it prevention, specialist treatment, antenatal screening etc. This can lead to disparity in services, disjointed provision and inefficient care. A recent study by The King's Fund highlighted those issues and reinforced the need for further cooperation and joint-working in order to ameliorate the situation. (3)

London has attempted to partly address this issue with local authorities having jointly commissioned a pan-London HIV prevention programme, focussing on HIV testing. There are however further improvements still to be made.

3. Gain a better understanding of the psychosocial impact of living with HIV.

Even with the progress around HIV education, advances in treatment and general shift in public perception, HIV can still be a major stigma for many people. This stigma is often due to lack of knowledge, fear and perceived stereotypes. (4) The sequelae can be serious, i.e. avoidance of HIV testing or non-compliance with treatment. Harrassment, bullying and mental health issues have all been well documented. Although I was of course aware HIV-related stigma and discrimination are still in existence, I did not realise to what extent.

An interesting case I encountered on my elective really helped to highlight this. A gentleman of African origin who had been admitted acutely with an AIDS-defining illness, was ready for discharge to a specialist HIV rehabilitation centre. However the only person aware of his diagnosis was his wife, even though he'd been receiving daily visitors on the ward. They were concerned that if he were to move to a HIV rehab unit then people would become aware of his diagnosis and he would be ostracised from his community.

This made me acutely aware that not only does a HIV diagnosis carry a health implication, but the psychosocial aspects are wide ranging and in some cases more debilitating. In comparison to medical management, which is continuing to improve year on year, the holistic approach to life and wellbeing perhaps hasn't quite caught up.

4. Explore HIV medicine as a possible future career

Although I thoroughly enjoyed my sexual health module in 4th year, it was very lecture-based and felt I needed to gain clinical exposure to the specialty. I therefore decided to focus my elective in this area, with particular emphasis on HIV medicine. Over the course of my elective I have been exposed to multiple facets of the speciality, from general genitourinary medicine clinics to specialist inpatient HIV care. From seeing the complex HIV patients on the ward, I now realise how much general medicine training is not only helpful but essential. It has shown that every day is different and brings new challenges. Not knowing what will turn up to walk-in clinics is also very exciting.

I have been lucky enough to shadow and talk to different professionals within the sexual health team including physicians, nurses, health advisors and many more. They have given me an honest insight into the demands, pitfalls and highlights of a career in GU/HIV medicine. Most useful has been the conversations with the GU/HIV trainees, who have provided real insight into the ST3 application process and subsequent training pathway. I feel overall I have gained a real flavour for life as physician in GU/HIV medicine, which will hopefully go some way in focussing my applications post-foundation training. I have enjoyed my time on placement with sexual health and would encourage others, if interested, to do the same.

References

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2. European Centre for Disease Prevention and Control. WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2015. Stockholm: ECDC; 2016. Accessed May 2017.

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3. Baylis A, Buck D, Andeson J, Jabbal J, Ross S. The Future of HIV services in England. Shaping the response to changing needs. April 2017. The Kings Fund. Accessed May 2017.

https://www.kingsfund.org.uk/publications/future-hiv-services-england

4. Terrence Higgins Trust. Stigma and HIV. Accessed May 2017.

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