

Transforming the delivery of health and social care: the case for fundamental change

The majority of my workload at the minute as a GP trainee in a busy maternity unit is the diametric opposite to the care we give people at the end of their lives. Babies are planned for meticulously, their birth plans are discussed with their parents, and the mother is meticulously screened to ensure that the pregnancy has every chance of succeeding. People decide how and when they are to attend hospital, in what circumstances they will deliver, the type of pain relief, and often the position in which they choose to deliver. Babies are given the best possible welcome to a cold, frenetic start in life.

Compare this to 70 years later, on average, and you will find a different picture. People languish in symptoms of their progressive disease states, remember that diabetes mellitus, chronic heart failure, and dementia are all incurable diseases. On reflection most current medicine is palliative; there are few curable disease states within medicine. Death is a certainty, no one has escaped and no one will escape. Some of us will develop end-stage chronic lung disease, end-stage heart failure, or dementia and we should plan for how the end of our lives is spent.

The reality is, demonstrated by the King's Fund report,¹ that we are getting older and that the years added are not necessarily healthy years. We do not realise that as time passes we are less likely to tolerate an acute deterioration in our already faltering chronic disease. Hospitals and further medicines can buy time; further unhealthy months or years to our lives, but as patients and doctors we should be realising that there are finite limits to what can be done.

Let us recognise that death comes to us all, some of us can plan for the end and let us embrace the end of our lives as we celebrate birth. Plan for how or where you would like to be cared for, what symptoms of dying concern you the most, what spiritual needs you should have honoured at the end of your life, and importantly how you should be remembered. Death is inevitable, but empower yourself, make a plan for how you see the end of your life, and allow friends and family to support you

as you leave this world, just as the friends and family of your parents supported you into it.

David Casey,

*GPST2, University Hospital, South Manchester Foundation Trust.
E-mail: doctordc81@hotmail.com*

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HIV testing: the danger of keeping secrets

During the 1980s and early 1990s, the advocacy group ACT UP (AIDS Coalition To Unleash Power) had a slogan: 'ignorance = fear, silence = death'.¹ McElveen's comment on information silence about HIV infection between primary and secondary care reminds us that the message is still relevant today. However, the solution is more complicated than making communication of a patient's HIV status to their GP automatic.

HIV infection hidden from primary health care is already a sizeable challenge: 20–49% of people living with HIV choose not to disclose their status to GPs,^{2–8} a legacy of the historical and deep-seated stigma surrounding this condition. Without action, this challenge will grow with HIV prevalence.

Non-disclosure becomes a more significant problem in the context of economic constraint. Previously, the HIV specialist could manage a variety of ailments for the HIV patient, but prescribing of non-antiretroviral therapy (ART) is increasingly being devolved to primary care. ART interacts with many commonly prescribed medications; for example, simvastatin, omeprazole, midazolam. Drug interactions are exceedingly complex and need considered management with expert advice. An invaluable and comprehensive resource is the Liverpool drug interactions website (www.hiv-druginteractions.org). Benn *et al* found devolution of statin prescribing from HIV specialists to GPs led to life-threatening drug reactions, where GPs were fully informed of HIV status.⁹

Clearly, if the primary care prescriber is unaware of the patient's HIV status and ART use, they cannot consider the risk of drug interactions.

Non-disclosure originates in discrimination of people living with HIV: fear of discrimination drives the insatiable need for confidentiality. McElveen is quite correct in that we are only strengthening this attitude by allowing it to overshadow information sharing for comprehensive care. Yet discrimination is an unfortunate, and unacceptable reality. Some fear communication between HIV specialists and GPs will cause information to leak out to non-clinical staff.^{2,8} From experience, this can happen and lead to enacted stigma. Such experiences can erode the patient-doctor relationship, which is of utmost importance in HIV. A poor relationship may lead to patient dissatisfaction, related non-adherence to medication, resistant, and progressive disease as well as transmission of hard-to-treat virus.

To draw an oft-presented analogy, confidentiality is the plaster to the infected wound of stigma and discrimination. Policies of non-discrimination are more effective than policies of confidentiality in facilitating patients to disclose their HIV status to GPs.² GPs are positioned to address patient concerns: participatory action techniques using group discussion would allow local problems to be unearthed, understood, and addressed through education and personal experience. The HIV specialist is positioned to perform surveillance of non-disclosure, and encourage disclosure. McElveen argues that we change practice to protect the patient. We agree, but the balance between patient safety and confidentiality is underpinned by discrimination. We must act to make our spaces safe: there should be no legitimate fear of discrimination for people living with HIV within health services.

Chris G Williams,

*School of Medicine, Cedar House, Ashton Street, University of Liverpool, L69 3GE.
E-mail: CGWilliams@doctors.org.uk*

Alastair Miller,

Consultant Physician, Tropical and Infectious Disease Unit (3Z), Royal Liverpool University Hospital, Liverpool.

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GP nomenclature

I am a newly qualified GP, and would be interested in readers' thoughts about the nomenclature used by GPs in the UK to describe their role. It is of course important to accurately describe this both to colleagues, and provide a transparent description of this to the public. Looking through various social media and employment websites, I see other UK GPs describing themselves as primary care physicians, family physicians, medical practitioners, and variously as portfolio/locum/freelance/independent/

private GPs. These are in addition to the more traditional terms of salaried/partner/principal/non-principal GPs. I feel rather mundane describing myself as a 'general practitioner', but is there any guidance from the College about this area? Also, do certain titles give an over-commercial label to GPs, such as, 'freelance GPs', and although an accurate description, how do these affect the public's view of our specialty and role?

I think my ideal name would remain general practitioner without an additional descriptive term, because this is in common usage with both patients and healthcare professionals.

No doubt a few of my freelance private locum friends will disagree!

Liam Piggott,

E-mail: liam.piggott@doctors.org.uk

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Euthyphro dilemma

I was interested to read your article on the Euthyphro dilemma. In stressing the common stance of moral realism between conflicting views, the author seeks to assert that we have a sufficient basis for 'campaigning for a better world' whatever our particular viewpoint.¹ While generally true, I do not think the meta-ethical question can be avoided forever, especially when deep tensions between views obtain. For example, I as a theist feel a moral duty to raise my children to know God, whereas a well-known atheist would consider this tantamount to child abuse.

Whose 'better world'?

In these discussions it is all too easy to confuse moral ontology (its' ultimate grounding) with moral epistemology (how we come to know moral values). Do you need to believe in God to live a moral life? Of course not, the Bible says as much (Romans 2:14–15). There are many ways to become aware of morality that don't involve

religion. Rather, what you actually need is a transcendent ground of morality to have any objective values whether you believe in God or not. And please, please note that the Euthyphro dilemma won't help you as a disproof of a theistic God as the ground of objective morality. It isn't a true dilemma for a start as the theist has recourse to a third option, namely that God IS the good, it is His nature, and thus neither decided arbitrarily by his will nor external to him.

Daniel Mounce,

*Sunnybank Medical Centre, Towngate,
Wyke, Bradford, BD12 9NG.*

E-mail: danielmounce@doctors.org.uk

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Correction

The authors' affiliations were incorrectly published in an article from the May 2013 issue of the journal: Shaw EJ, Sutcliffe D, Lacey T, Stokes T. Assessing depression severity using the UK Quality and Outcomes Framework depression indicators: a systematic review. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X667169. The correct affiliation is Health and Social Care Directorate, National Institute for Health and Care Excellence (NICE), Manchester. The address for correspondence is Tim Stokes, Primary Care Clinical Sciences, School of Health and Population Sciences, University of Birmingham, Edgbaston, Birmingham, B15 2TT. We apologise for this error.

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