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## A systematic review: the role of spirituality in reducing depression in people living with HIV/AIDS

Vermandere *et al*'s<sup>1</sup> article highlighted end-of-life care as a particular area where spirituality can play an important role. In a link between spirituality and another chronic disease we looked at spirituality and HIV (R Amuzie, unpublished data, 2009). Vermandere's literature review proposes that spirituality has a key position in the management of HIV sufferers. HIV infection is a major global problem and in 2007 was present in 33 million people around the world.<sup>2</sup> Antiretroviral therapy has been successful in slowing the progression of HIV infection and reducing AIDS-related mortality. But by doing so, HIV infection is now widely considered as a chronic illness and therefore HIV sufferers are beleaguered by similar challenges as those living with chronic illnesses like epilepsy and diabetes mellitus. Research suggests that people with HIV/AIDS are at greater risk of depression,<sup>3</sup> and that depression in HIV sufferers is linked with more rapid loss of immune function, accelerated disease progression, and lower survival time.<sup>4</sup>

In clinical research, spirituality has been broadly defined as a belief in a higher power than oneself that is not thought to be God. Another definition is that spirituality is similar to an individuals' experience of meaning and life purpose.<sup>5</sup> It has been reported to reduce the risk of depression in people living with chronic illness. This review was conducted to examine the possible benefits and impact of spirituality on depressive symptoms in people with HIV/AIDS.

Systematic literature searches of PubMed, PsycInfo, and Embase were carried out, along with backwards and forwards citation tracking of key studies, identified 21 qualitative studies, of which five studies<sup>6-10</sup> met the predetermined criteria for eligibility and were included in the review. Formal meta-analysis was not possible due to the nature of the studies.

This review found that a large number of

people with HIV/AIDS report experiencing depressive symptoms that are suggestive of mild-moderate depression. Studies provide statistical evidence that a greater level of spirituality in a person with HIV/AIDS is linked to fewer symptoms of depression. However, further research is required to examine the association between spirituality and clinically-diagnosed depression, as well as the impact of spirituality-focused interventions in reducing depression in people with HIV infection or AIDS.

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This study was a dissertation undertaken as part of the UCL intercalated BSc in Primary Health Care. R Amuzie. The role of spirituality in reducing depression in men and women living with HIV/AIDS. UCL iBSc dissertation 2009.

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## Buprenorphine versus methadone use in opiate detoxification, are there other factors that should be considered?

The recent research on the 'comparison of methadone and buprenorphine for opiate detoxification (LEEDS trial): a randomised control trial' raises an important point with regards to utilising buprenorphine and methadone in opiate detoxification.<sup>1</sup>

The authors quite rightly conclude equal clinical effectiveness between the two agents, a statement that is supported by previous studies.<sup>2,3</sup>

However, there are additional factors that should be considered when determining which one of the two would be best suited for purpose. There is evidence to support the use of buprenorphine over methadone, especially when taking into account the risk of morbidity and mortality.

Nielsen *et al* identified an increased risk of overdose and adverse outcomes associated with methadone when compared to buprenorphine.<sup>4</sup>

In addition to the increased number of adverse incidents, they also concluded that presenting signs (respiratory rate and Glasgow Coma Scale score) were lower in methadone-related attendances hence indicating a heightened risk of complications and death.

This was further supported by Bell and colleagues who concluded that buprenorphine was associated with lower overdose risk and lower mortality when compared to methadone.<sup>5</sup>

Although the cost of buprenorphine is higher than methadone,<sup>6</sup> and the clinical effectiveness of both agents is on a par, it is

worth bearing in mind the increased risk of overdose, hospital admissions, morbidity, and mortality associated with methadone, that may negate the cost difference.

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## QOF should be more about disease and risk factors prevention

I urge a radical re-thinking of the obesity QOF system. QOF should be far more about disease and risk factors prevention. As there may be debate around the concept of obesity as a problem rather than a disease, there should be little doubt that obesity is a significant problem.<sup>1</sup> Obesity has been associated with cardiovascular disease, premature death, stroke, non-insulin-dependent diabetes mellitus, gout, gallbladder disease, GORD, asthma, joint problems, and several types of carcinomas. Abdominal obesity [increased waist-to-hip circumference ratio (WHR)] should be recorded as more closely correlated with metabolic disease and even malignancies.<sup>2</sup> Clinically I find it difficult to accept that patients may be diagnosed as obese without

being first warned to be overweight and advised accordingly. Healthy lifestyle education should be a core activity of primary care workers and I am concerned that some non-profit organisations may be better at managing weight than GPs are.<sup>3</sup> The paper from Phillips and colleagues told us that dietary counselling by clinicians in primary care is sub-optimal, and perhaps the same could be said about physical exercise advice.<sup>4</sup> Bobbioni-Harsch and colleagues have shown how metabolically normal obese subjects could be at increased risk of cardio-metabolic diseases. Furthermore, their findings suggest that high BMI, alone or with fasting insulin, negatively affects the cardio-metabolic profile.<sup>5</sup> Interestingly, patients may be more upset by being told that they are obese, or scared of having their weight checked, than being told about high cholesterol or abnormal glucose tolerance. GPs tend to avoid using the term 'obese' and often prefer to use a euphemism. They are aware that the term obese may upset the patient. It has been shown that the term obese makes patients believe that the problem has more serious consequences and makes them feel more anxious and upset than when the same symptoms are labelled using a euphemism. I strongly advocate for more regular use of the weight scale in primary care, as there is a continuum from normal body weight to obesity and the early identification of a trend of excessive weight gain may be both clinically more beneficial and less upsetting for the patient.

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## Let us take blood

Medical students nowadays often report difficulty in gaining experience in performing routine venepuncture. In the past, students were regularly expected to take blood from hospital patients, allowing them to become very competent in the procedure before qualification. However, phlebotomists now do the majority of in-patient venepuncture, leaving few opportunities for students to learn and improve their confidence with this procedure.

One excellent way to overcome this problem is for GP practices to take on students as phlebotomists. This benefits both the student and the practice staff. Not only is the student given extensive opportunities to practice blood-taking, but he or she also gains experience of working efficiently in a clinical setting and putting knowledge from medical school into practice. In addition, if the post is paid, this can help fund student life [although many students will still be prepared to undertake this work on a voluntary basis].

Having a medical student phlebotomist allows the practice to offer more appointments for venepuncture and allows practice nurses to carry out more specific nursing tasks. The university holidays are times when practice staff will want to take holiday, so the student can be employed on a regular basis during the vacation periods. Staff can delegate simple patients to the medical student for venepuncture and blood pressure monitoring, in order to focus their own time on more complex patients or on management tasks.

As a medical student, I was extremely keen to work as a phlebotomist when the opportunity arose and have now worked at the same GP practice for three vacation periods. Due to my relative inexperience with venepuncture initially, I was given 4 days of training by the practice nurse. Learning to use the computer system was also an important skill that I had to get to grips with early on. There is no doubt that my ability to communicate and relate to patients has really been enhanced by this experience.

It appears that taking on medical students as phlebotomists is uncommon in general practice, even on a voluntary basis. This seems a shame as employing a student to take blood can be highly advantageous to everyone involved. We would really urge GPs to consider this option in the future when approached by medical students.