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Are We Doing All We Can to Stop the AIDS Epidemic?

ISSUES CHALLENGING PUBLIC HEALTH POLICY

Our presidential elections is only days away, 48 million people in America are uninsured and healthcare costs are rising 2 to 3 times faster than our nation's GDP. Where will America's healthcare system be in 5 years, welcome to RechMD's monthly series focus on public health policy. This month, we explored many questions facing healthcare today.

Are we are doing all that we can, to stop the AIDS epidemic. You are listening to a special segment on healthcare policy at ReachMD XM 157, The Channel for Medical Professional. I am your host, Dr. Maurice Pickard and our guest today is Dr. David Hardy. Dr. Hardy is Director of the Division of Infectious Disease at Cedars-Sinai Medical Center. He is also the associate professor of medicine in residence at the David Geffen School of Medicine at UCLA.

DR. PICKARD:

Thank you very much Dr. Hardy for joining us.

DR. HARDY:

My pleasure. I am glad to be here.

DR. PICKARD:

To begin with, Could you tell me the significance of the recent evidence that CDC has been underestimating the incidence of HIV in United States?

DR. HARDY:

In August of 2008, the CDC made public its new projection for the number of new cases of HIV infection. Previously, we had been hearing that there had been about 40,000 new cases of HIV infection every year for about the past 10 years and there are new estimates based upon a more sensitive testing tool an ELISA test called the detuned ELISA. They actually upgraded that estimates from 40,000 per year up to 56,000 per year at 40% increase and not only was it occurring through their last accounted year in 2006, but actually back through the past 8 or 9 years. So, this was not a new increase, this was just better estimation of what has been happening for the past many years in terms of new cases of HIV infection.

DR. PICKARD:

Within that statistics, could you break it out were there any surprising evidence that minority groups, gender groups had a disproportionate new part of this incidence?

DR. HARDY:

We were insured the epidemic was falling along many of the same lines it had before, about 70% men, 30% women, primarily young individuals between the ages of 13 to 29, got 36% of more in that group. The remainder being older and some even about 10% over 50, but the major concerns for me in terms of looking at this, was that while the proportion of the persons from risk group such as high risk heterosexuals and injection drug users was decreasing over the past 10 years. There was a significant increase among men, who have sex with men, particularly young men of color. The great preponderance of these new cases, were among African-American men and women and also among Latino men and women followed by Caucasian and then in lower numbers, in Asian and pacific islanders. This increase among men, who have sex with men, was very troubling because of the fact that I think it really points out how our prevention message has really missed that group of individuals.

DR. PICKARD:

The obvious question, why do you think were missing it?

DR. HARDY:

Well, in large part, I think, it is based upon the fact that much of her HIV testing is based upon old outdated information since this is only program familiar for physicians, my strong strong emphasis is to encourage physicians to stop trying to test people based upon their perception of their lifestyle or their habits that all idea that you could pick out persons based upon what you thought and what they told you in the medical history really doesn't hold water any longer and instead follow what the CDC told this 2 years ago and that is to test every American between the ages of 13 and 64 at least once and if those persons indicate that they do have more than 3 sexual partners per year, use drugs, not just injection drugs, but any drugs including alcohol, they should be tested on an annual basis. Just like we check blood pressure, just like we check cholesterol, just like we check a lot of health and maintenance issues on a regular basis.

DR. PICKARD:

Then, you are saying we should no longer use these kinds of exceptionalism when we select people who should have an HIV test?

DR. HARDY:

You know, in the years past, they was a place for HIV or AIDS exceptionalism, back when there was huge amount of discrimination, when there was no treatment, when there was only problem often times, with finding out as simple as positive as opposed to therapeutic interventions that really worked now. The days of exceptionalism really should start coming to an end in my opinion because it is a very important reason why person should find out if they are positive or not because of the fact that we now have therapies just like we do for high cholesterol, for high blood pressure, for diabetes, that we can now treat this infection very very successfully and therefore

screening for it on a regular basis, makes perfect sense.

DR. PICKARD:

I had to question, one think you said is that doctors always try to pick the people who should have it, I think doctors really wanted to do HIV on everybody and felt uncomfortable suggesting it to their patients that they could possibly be HIV positive. And like you say, if it became part of the routine of checking a cholesterol, then there would be no judgment that the doctor would be passing by saying you know, think you should have an HIV test?

DR. HARDY:

You are very right Maurice, I mean, I think the thing that made the HIV testing difficult in the past was because it involved 2 very sensitive issues, sex and drugs and people are kind of limited to those areas entirely. The fact that also in many states the testing required that a written informed consent be done before the test be taken. Also, set of word blocks they really made the test difficult for health practitioners to do. In many states including my own, here in California, the requirement for written informed consent has been eliminated and while we cannot test people against their will on a regular basis, there are situations, which can be covered for that legally, but not in routine practice. It is important, I think, for physicians to simply suggest or recommend that is part of an annual examination, but at least once in everyone's lifetime that HIV testing be done and if sex or drugs or those kind of issues are too sensitive to talk about, just recommend the test and say, I do this for all my patients. That way, it gets the job done without perhaps broaching topics, which were difficult for the patient and physician to discuss.

DR. PICKARD:

The question of concern certainly, many states are still struggling with this. California is ahead of lot of states. The other part of CDC's recommendation, is that counseling be offered, but that is, in itself, is often a difficult thing. How do you answer CDC's recommendation that not only is consent being weighed and you don't need consent to draw this, but also that counseling be offered?

DR. HARDY:

We don't, but we have tried to do this situation around the country is not to eliminate the referral for counseling. What we are eliminating is the more onerous process of throwing a 4-5 page document in front of someone asking him to read it, in which very many concerning sort of ideas are put in there and then having the person sign it as if he was signing a contract. Many people bulk just at the look of that and physicians don't do it because they take just too much of time, so while we are eliminating written consent, we are still giving the people the options called up doubt. You know, a physician or healthcare worker would recommend the test with the patient's verbal approval, which can be documented in the written document of the medical record and then the test is done. If the test is positive, then there is certainly lots of available referral counseling centers that are already set up, to which the patient can be send.

DR. PICKARD:

Earlier on, you mentioned the young having a disproportionate amount of new cases. Is this because, like many young people, who drive cars too fast. They really don't think it is going to happen to them or is it a question of education and the young haven't had an opportunity to be educated to the risk of this disease?

DR. HARDY:

Well, I think, it is a mixture of both those things, but you know for many of us who as physicians worked and lived through the HIV epidemic of the 80s and early 90s, you know the horror of how horrible the deaths were that people experienced due to this disease, hold a very strong place in our memory. Not something we look forward to be counting, but something that we need to remember and in young individuals who perhaps were not born until the 1980s or early 90s, at this point now have no idea about what happened during that period of time. You know, AIDS gives a historical memory for them. If even part of their rolls it all and again this is something that really needs to be emphasized in terms of the fact that a sexually transmitted disease, can in fact kill you. You know, again because of the great success story of HIV therapies, the terrible sort of the conditions that HIV can be associated with, have really gotten lost and while in many ways such a wonderful success story, on the other hand it no longer that the source have it turned that people having unsafe sex with the idea of, if I get HIV, I will just take pills, no big deal. You know, I think that's some of the problem that is really harming our young people today.

DR. PICKARD:

Do you think the media is getting this message across and how can they help?

DR. HARDY:

I think, the only think that media could help with is to certainly laud the great success story and tries made the progress of HIV therapies and how people now can take these medications and live very good life. What they can forget; however, is the fact that it is still better not to become infected and really struck putting out the prevention message. You know, one thing that the centers for disease controllers are really unfortunately be very handicapped with, has been talking about sex. You know, just simple, talking about sex and stay forward in clear terms and arming our young people with information that they can use to protect themselves.

DR. PICKARD:

You brought up an interesting point that we now have drugs, the highly active antiretroviral therapy has been a real success story, but do you think that part of the gay population, that is on medications, thinks that they are no longer infected and therefore will have sex and then some patients don't even tell their partner, what their serology might be?

DR. HARDY:

Yaa, you bring up another tricky question there. You know, among many aspect of men, primarily gay men here in United States, the HIV epidemic has been a part of life for, over 25 years now for many of them. This is something that has become so contemplate that often times, it becomes, you know, not even discussed, because it is almost assumed. This you suggest <_____> somewhere consisting 30 to 50% of restricted men in our open community are actually positive. You are right, you know, one of the problems that has occurred, I think, also the therapeutic success has come with the fact that if the patient's virus is undetectable, meaning the SA can't detect it because it is so low, is often times confused with the word gone or zero or no longer present and with that the assumption is made I can't infect anyone else, because I am on medications, which of course is not true, is not true and there is still concern about where the transmission can occur because undetectable virus in the blood does not mean undetectable virus in other body fluids such as semen or even vaginal secretions. So, again that's something that education will need to be put up there to tell people that those who are HIV positive and on medications, do need to practice safe sex.

DR. PICKARD:

So, you are really talking about a terrible epidemic, that really hasn't answer and that we actually even, it sounds like, have the tools if we will apply them?

DR. HARDY:

I think, its very true. I think, its very true and I think that, you know, what I look forward to in the future, is working with the new director of the HIV and viral hepatitis and tuberculosis section of HIV, if I live by the name of Kevin Fenton, a very intelligent physician and epidemiologist, who hopes to be part of the new national plan for HIV in United States and hopefully part of that will be frank discussion about what safe sex is.

DR. PICKARD:

So you look forward to that instead of spending so much of our dollars and the concept of just saying no and abstinence, there will be a shift towards other methods of prevention?

DR. HARDY:

Well, you know, I think, just say no, will work for some. Abstinence will work for some, but the thing that we needed to keep in mind is that, you know, when someone first becomes sexually active and those years of discovery and experimentation takeoff, its very difficult to try to interject any sort of cognitive message. You know, libido is such a strong human force that, I think, by trying to regulate that with ideas just don't do it as my, you know, older individual tell me to do doesn't give individuals much of an option and we need to give young people options for how to take care of themselves and protect themselves.

DR. PICKARD:

You know, we have been talking today about the terrible epidemic that's been going on for 25 years and according to statistics is rising and yet, we heard today from Dr. David Hardy that we do have the tools to prevent and to bring this epidemic under control. I want to thank him for being our guest today and you have been listening to a special segment on healthcare policy on ReachMD XM 157, The Channel for Medical Professionals. I am you host, Dr. Maurice Pickard. To listen to our on-demand library, visit us at reachmd.com, and if you have comments or suggestions, call us at 888-MD-XM157. Thank you for listening.

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