

Practitioner's blog

An emergency by any other name

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Recently a young man presented to an Emergency Department anxious and distressed and requesting post-exposure prophylaxis following an unprotected homosexual encounter. He was embarrassed, indeed mortified, by his predicament, and was very apologetic about what he termed his 'abuse' of the emergency department. It was the weekend, and he had considered waiting until the sexual health clinic reopened on Monday, because he believed that his attendance then would not be questioned, nor would he feel so unworthy. He believed that mainstream healthcare settings were generally unsympathetic towards what he termed 'self-inflicted' presentations, especially those perceived by some to be morally deviant. However, his anxiety and fear of HIV were so great that he could not wait two days for the clinic to reopen.

On arrival in the Emergency Department the triage nurse took a history from him. He was very surprised that not only was she gentle and understanding in her approach, but also she reassured him and requested that he be seen by a doctor and treated as a priority. Follow-up care was arranged for him. Before leaving the department the man thanked the triage nurse, mentioning that he had not expected to be treated either as an emergency or with respect and kindness. He thought that an emergency meant suffering a stroke or a heart attack or being in severe pain. He told the triage nurse that many of his friends in the gay community were disinclined to access emergency care as they felt that they would be judged as undeserving. He subsequently sent an email to thank the staff for not stigmatising or discriminating against him.

Fortunately, in this case, the outcome for the patient was good, but his expectation of stigma and less than optimal care raises questions about judgemental attitudes, and about who and what we perceive as an 'emergency' deserving of emergency treatment. Alonzo and Reynolds (1995) describe stigma as 'a construction of deviation from some ideal or expectation.' Traditionally, diseases associated with stigma have been those that are feared or those that are associated with society's perception of deviance. Patients who

have acquired HIV/AIDS through illicit drug use or sexual activity have often been vilified and are much more vulnerable to stigma than those who are perceived as 'innocent victims', such as babies born of infected mothers (Sontag, 1991). Stigma and discrimination directed at people living with HIV/AIDS may be manifested in a variety of ways, depending on the country, community and context in which they occur. It is not unknown for victims to be shunned by friends and family, and, in the most extreme cases, some sufferers have become refugees (Dodds *et al*, 2004; Keogh *et al*, 2004).

In some parts of the world, stigma is used to justify government inaction, and at a personal level it acts as a deterrent or impediment to people voicing their fears and seeking testing and treatment (Dodds *et al*, 2004; Keogh *et al*, 2004).

The issue of stigma is sufficiently serious for the United Nations Secretary-General Ban Ki-moon (2008) to have written recently in the *Washington Times* that:

Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.

(Ban Ki-moon, 2008)

Stigmatisation of illness and disease is therefore a reality, but one that should have no place in a civilised healthcare setting. Stigma is not only unfairly judgemental, but is also a counterproductive force in the fight against infection, the prevention of complications and reductions in mortality and morbidity. Many treatments and drugs are now time dependent, so the sooner a condition is identified and treated, the better the outcome for the patient in terms of health, well-being and cost. Early intervention can reduce the risk of HIV/AIDS infection following exposure to a high-risk person or situation, but there have been no

high-profile advertising campaigns about this, so it has not captured public imagination in the way that treatment for stroke or heart attack has done. Nevertheless, HIV/AIDS infection continues to be a major global public health challenge. Although the outlook for those affected in the UK continues to improve, especially where there is easy access to early diagnosis and treatment, the potential effectiveness of post-exposure prophylaxis (PEP) and the importance of timely intervention have not been championed in the same way as early intervention treatments for other conditions.

Even professionals seem to be unaware of the benefits of PEP. For example, Bryant *et al* (2009) found that doctors had surprisingly poor knowledge of high-risk body fluids and the action to be taken following exposure. In the light of current statistics on the prevalence of HIV infection and the incidence of AIDS, such shortfalls in medical knowledge are worrying. At the end of 2008 there were approximately 83 000 cases of HIV infection in the UK, of which 7298 were new diagnoses (Health Protection Agency, 2009). HIV particularly affects vulnerable groups that are often also discriminated against for other reasons (e.g. on the grounds of race or sexuality), and although there has been a steep rise in HIV infection among the heterosexual population, men who have sex with men continue to be the group at greatest risk of becoming infected with HIV in the UK (Dougan *et al*, 2007). Other vulnerable groups affected by HIV include people from Africa, injecting drug users and sex workers.

Post-exposure prophylaxis (PEP) is a course of antiretroviral drugs which is thought to reduce the risk of seroconversion after high-risk exposure to HIV, such as sharing needles or having unprotected sex. Timely PEP, within 1 hour of possible infection, and no longer than 72 hours post-exposure, is believed to reduce the risk (Diprose *et al*, 2000). Prophylactic treatment for HIV typically lasts four weeks. Failure of treatment has often been attributed to the delay in receiving PEP, the level of exposure received, or both. The study by Bryant *et al* (2009) on the effectiveness of PEP among healthcare workers suggests that using non-occupational PEP for HIV may be cost-effective in certain subgroups. Based on these findings, it is essential that the use and potential of PEP for reducing the incidence of AIDS are given greater emphasis among both healthcare workers and the general public, to encourage timely uptake of this treatment.

If we are genuine in our commitment to diversity and our promise to deliver equitable care, then we

need, as healthcare professionals, to become more informed about PEP and more intuitive and sensitive to perceptions of stigma. We must be seen as a non-judgemental driving force behind the promotion of universal access to HIV prevention, treatment and care. In the words of Michel Sidibé, UNAIDS Executive Director, in his opening address to the International AIDS Conference in July 2010, 'our vision must be uncompromising. We want nothing less than: Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths' (Sidibé, 2010).

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