Who Cares for AIDS?

Who should care for AIDS? The suddenness of the HIV epidemic and the increasing complexity of AIDS care led to required innovations in designing comprehensive care systems. In these, care was provided by “experts,” knowledgeable about the latest developments but, to a large degree, educated in this expertise outside conventional medical specialty training. Although AIDS is clearly an infectious disease, many physicians trained in the specialty of Infectious Diseases (ID) were either trained before the onset of the epidemic, had trained in areas of very low HIV prevalence, or were not interested in providing this type of care. Physicians not trained in infectious diseases are even less likely to have received formal or supervised education in HIV medicine. On the other hand, many infectious disease-trained and “generalist” physicians became knowledgeable regarding HIV and have provided excellent care.

If this is so, what, then, are the problems? Does our system of training and care need to further respond to HIV? These are the issues that lie behind the article by Landon et al. in this journal.¹ In an important study, the authors sought to explore the confidence and expertise of a randomized group of physicians actively caring for HIV-infected patients. As part of the large HIV Costs and Service Utilization Study (HCSUS), Landon et al. surveyed nearly 400 physicians, exploring their training, current HIV case load, HIV referral patterns, and performance on a standardized 12-item test designed and validated to rapidly assess the depth of their HIV fund of knowledge.

The principal results of the Landon study will surprise few in the field of HIV medicine, but are important in current debates. The authors separated physicians (the HCSUS cohort did not include non-MD providers, so important in caring for AIDS patients) into those trained in Infectious Diseases and those not. The ID and non-ID physicians—a mix of internists, family physicians, and others—were further divided by the degree of the physician’s self-identification as an HIV/AIDS “expert.” While almost all ID physicians claimed HIV expertise, only 60% of the “generalist” physicians providing HIV care held themselves as experts in this care. In the end, nearly identical numbers of self-identified “experts” were ID trained or not, and together these expert physicians provided almost 75% of the care of patients in this randomized nationwide survey. Experts, regardless of specialty training, performed comparably in the knowledge assessment and cared for similarly large caseloads of HIV-infected patients. Experts who were ID trained did score slightly higher in the administered test and were more confident in their knowledge, at least as evidenced by less-frequent patient referral to others for advice in complex management. The nonexpert generalists, however, performed less well. They scored lower on the knowledge

assessment, cared for many fewer patients, and frequently referred patients to other physicians. Also, of importance, expert physicians attained information by attending more HIV-specific continuing education lectures than did those not claiming HIV expertise.

Why are these results of note? A debate is longstanding as to the best approach to organizing HIV care in the United States. Early in the epidemic, when its expansion seemed unlimited, many argued that all physicians needed to be recruited to this effort.² While the number of physicians needed was debated, the specific training needed in this case was barely addressed. The epidemic in the United States did not continue to expand. While new infection rates in some regions are tragically on the rise, HIV incidence nationwide is low, and care in the United States is today provided by a rather small and stable number of physicians. These physicians have access to a plethora of local, regional, and national educational programs. There are specialty HIV/AIDS journals and websites, and the government supports a training network, the AIDS Education and Training Centers.

Early debates often addressed the role of “generalists” versus “specialists” in providing HIV/AIDS care. The terminology used in discussing these was often part of the problem and may have delayed the solution, since it triggered fears that care would be restricted to certain specialties. The work of Landon et al. may help clarify this. If “specialist” refers to ID-trained physicians providing HIV care, this may well equate with expertise. But non-ID-trained “generalists” may also have this expertise and are providing as much care as the ID-trained experts. What’s important to recall is that *all* of the physicians surveyed by Landon et al. were chosen *because* they were providing HIV/AIDS care. It would be potentially dangerous to believe that those physicians not actively providing HIV care, regardless of training, would have comparable expertise. It would stand to reason that a general internist, for example, who had never seen an AIDS patient would neither have nor claim expertise. Similarly, ID training in and of itself would also not necessarily lead one to hold oneself as an expert absent interest and experience. Nor should that care provided by generalists who don’t claim expertise be discounted in importance. In many cases, “experts” may not be available. Even when higher volume “experts” are available, primary care by generalists but supported by experts may well be an acceptable model of care.

The debate about HIV expertise is freshly urgent as political and economic forces are coming into play. Health care plans in some states, such as California, are required to allow consultations by “experts” in all HIV cases, and organizations are attempting to define, credential, and certify this expertise. Seen through this debate and competition is the increasingly obvious fact that HIV expertise is real, and that it resides more in the

interest, education, and commitment of the physician than in when, where, or in which specialty that person was trained. The organization with which this writer is primarily affiliated, the HIV Medicine Association of the Infectious Disease Society of America (IDSA), has addressed this debate directly. The parent organization, the IDSA, has changed its bylaws to invite full participation by HIV providers regardless of training, and the HIV Medicine Association Board intentionally and permanently includes members with training in General Internal Medicine, Family Medicine, Pediatrics, and other specialties. The other HIV organizations are similarly broad-based.

If training doesn't precisely define expertise, however, what "marks" of expertise can we use? The Landon work, although not addressing this important policy directly, might offer some direction. One could begin with self-declaration as an HIV/AIDS expert. This, combined with those demographic descriptors found in Landon's study, such as HIV caseload size, conference participation, and comfort with difficult management may bring us close to an acceptable working definition. Certifying exams would be largely redundant, and the perceived need to "legislate" access to experts may be somewhat misguided if, in fact, the large bulk of care is already being given by physicians with this set of interests and skills.

The Landon study is an important one, but obviously not the final word on this topic. We don't know the degree of HIV expertise in physicians—ID trained or not—who were not eligible for selection in the survey. Nor do we know anything about the care provided to many HIV/AIDS patients by nonphysician providers. It might be very important, in fact, to do a similar study of those providers' training and expertise. We can hope, however, that this report moves us forward in HIV care organization. Expertise is, of course, a desired element in complex medical care. How one has gained that expertise is less important, and systems should seek to recognize and support HIV experts regardless of specialty training. Finally, we must continue to address HIV training to ensure that those interested in becoming experts are able to do so. — **PAUL A. VOLBERDING, MD**, *University of California—San Francisco, San Francisco, Calif.*

REFERENCES

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