

## Scholarship Winners' Reports 2014

**Report 3: Dr Tommy Palai,**

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**Dates and Programme:** 9–10 October 2014: BHIVA Autumn Conference, including CHIVA parallel sessions  
13–24 October 2014: Observational placement at The Royal London Hospital

### My thoughts

The opportunity of chatting and sharing experiences with not only HIV doctors all over the UK but with world renowned experts provided a good platform to begin the exchange programme. Having been picked up from the Airport the previous day and having started off the trip with sightseeing at Hyde Park, the perfect cloudy and cool weather set off a great mood. I felt blessed to be staying at La Reserve Hotel, on Fulham Broadway a vibrant and lively neighbourhood.

The BHIVA conference covered all the relevant topics in HIV. It was entertaining and educational at the same time. The use of questions and answer sessions with each presentation kept the audience engaged and involved. Personally, my favourite presentations were the ones that spoke about advancement in HIV cure, which is an area I am interested in. The lunchtime workshops kept the flow of learning and sharing of experiences going. This is something I plan to introduce at our next HIV conference back home.

A specific workshop that caught my attention was one that had a panel of patients across all ages and race. They shared their experiences from the day they were infected with the disease up until now. What was encouraging to us as clinicians and as the audience is that we learned what patients with HIV wanted to hear, what they didn't want to hear, the holistic approach they expected, and generally the expectations they had as a whole from an HIV clinician. The two days of the BHIVA conference provided a robust view of HIV care in the UK and a comprehensive report from CROI 2014.

After the BHIVA conference I had switch of coordinates from west to east. With a 45-minute Tube journey to Whitechapel, the new destination was the Ibis Whitechapel Hotel, which was in close proximity to the Royal London Hospital, where I would be finishing off the exchange programme. I spent the first day at Mildmay, a home for severely ill and end-stage AIDS patients. This was something that wasn't initially part of my exchange schedule but I was thankful to the registrars for incorporating it. This is an idea that our health officials at home have been trying to bring about, but unfortunately it hasn't yet happened.

Mildmay is a brilliant idea for the NHS. It provides end-stage patients with more focused and comprehensive care under one setting. Dealing with patients who have end stage AIDS is not only challenging to the patient but to the clinician as well. It provides a strong learning platform for registrars for most WHO stage 3 and 4 conditions, and how to best to deal with them. We still see a good number of patients in Botswana with various stage 3 and 4 conditions who can't benefit from a hospital setting. I hope that we will soon have our very own centre. I believe that currently, patients with these conditions are lost unnecessarily due to lack of sufficiently focused healthcare.

I spent the rest of my time in various clinics, joint clinics and ward rounds. Fortunately, due to more hospitals and more healthcare workers, the number of patients I saw were few compared with the size of clinic I am used to. This also correlates with the number of individuals living with HIV which is much more in Botswana than in the UK. Despite that, there was a lot to learn and bring back to teach at home. The most obvious observation was the difference in the stage of presentation of AIDS in admitted patients and the number who die. Many patients at the Royal London Hospital were admitted either with mild non-specific symptoms or worsening neurological outcome. Most of these patients, however, left the hospital alive and relatively well, which contrasts unfortunately with the situation back home. Our late-stage presenters are usually very sick with multiple opportunistic infections affecting various systems, hence, making it challenging to stabilize and save their lives in most instances.

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The idea of joint clinics (joint HIV-liver, joint HIV-kidney,) was the highlight of my experience in clinics. This is an idea I have never come across before and I thought it worked brilliantly, not only for the benefit of the patient but for the clinicians as well. Every patient that was seen received comprehensive and focused consultation from two experts combining knowledge and ideas. It allows a basic learning platform for students and registrars for a holistic care approach, to understand pathophysiology of both HIV and hepatitis or renal failure. Patients are better cared for, as both experts understand and have experience of the relationship between HIV and specific body systems. Each consultation averages about 30–45 minutes, which of course provides a complete and thorough conversation between the patient and the clinician. This allows the patient to fully express all feelings, while being at ease and without pressure, and allows the clinician time to fully explain all results and explore any possible socio-economic difficulties that may potentially interfere with adherence. For me, I thought these clinics were the foundation and provided a cornerstone to HIV care in the UK, ensuring a longer life for people living with HIV, while ensuring virological suppression and preventing further spread of the virus.

Unfortunately back home specialist consultants are few. Medical doctors are also few and it makes it difficult to have such clinics. Furthermore, we have to balance the consultation time of each patient based on the number of patients we have booked on the specific day. This sometimes makes it very challenging to investigate and explore each and every patient's issues in depth and we can miss important clues relating to that patient.

As for ideas we have at home, which I think may benefit NHS, specifically BHIVA, the idea of adherence partners is something that will almost always work and ensure patients are not lost to follow up. When a patient is initiated on HAART, an adherence partner is required and this has now become a requirement except in a few exceptional circumstances. An adherence partner may be anybody (a wife, girlfriend, best friend, work mate, favourite cousin, aunt, uncle, neice). It has to be somebody the patient trusts, is used to, talks to about life issues and is willing to get involved with the patients' healthcare issues. It helps to stop patients getting lost to follow up and for them to be accountable to someone else other than the clinician. It's an idea I raised at the Royal London and I hope it can be implemented to work within their healthcare strategy.

The second idea is for BHIVA to have a 6-month or annual HIV basic training course for GPs within the NHS. This will allow most doctors within the NHS to have a basic understanding about HIV and when to recognise the need to refer to a specialist. Back home this training course is called 'KITSO', meaning 'Knowledge'. It is provided for all doctors, across all specialities, and each year doctors who work specifically within HIV have a refresher course for continuous medical training.

In conclusion, I am personally grateful to BMS for providing this opportunity to learn and exchange ideas, an opportunity to learn about British culture and lifestyle, an opportunity to grow, as well as an opportunity to have fun. An opportunity to come back home inspired and rejuvenated to combat the HIV/AIDS pandemic. I am humbled to have been treated and hosted with such great thought and care. I salute the great work you are doing and hope that this exchange program is something that will continue to inspire and teach upcoming clinicians both in the UK and Botswana.

**Thank you BRISTOL MYERS SQUIBB.**