

MSSVD
President's
address

Passion, stigma, and STI

G R Kinghorn

“Any Stigma will do to beat a Dogma.”
Philip Guedalla (1889–1944) Historian and irreverent biographer

Introduction

To be invited to deliver a presidential address is a great honour signifying, firstly, the support of peers in being elected to the presidency and, secondly, the impending conclusion of this responsibility. It is, in accordance with tradition, the single occasion on which the opinion of the president is not questioned, when he can even discuss the taboo subjects of sex, religion, and politics without fear of contradiction. I intend to make full use of this opportunity.

Presidential addresses come in a number of guises. Some look to the events of the distant or more recent past, while others are more firmly rooted in the present and explore an area of clinical practice or personal expertise. Each is, to some extent, autobiographical. My intention today is to combine something of each of these approaches in my vision for genitourinary (GU) medicine at the start of the 21st century.

The inspiration for my presidential address came from an excellent essay¹ published in the *Lancet* in 1999 by Christopher Whitty, an infectious diseases specialist working at the University of Malawi. I would strongly recommend this as required reading for both established clinicians and their students. He was reflecting that Africa is currently facing a sexually transmitted infection (STI) epidemic even more catastrophic than was the introduction of syphilis to Europe in the late 15th century. Now, as then, reactions to the crisis were frequently hysterical. He argues that a public health strategy based upon stigmatising individuals with sexually transmitted infections is not only unhelpful but also inevitably counterproductive.

The “flower power” generation

I was a student and young doctor in the late 1960s and early 1970s, at a time when student rebellion, the Vietnam war, riots for peace, and flower power were in vogue. Subsequently, the most astonishing and dramatic event of my professional career has been the advent of the AIDS pandemic.

In the early days of AIDS, some of the most effective promotion of safer sex was by means of some extremely beautiful photographs from Scandinavia, which made use of the overt sexuality of flowers. To reflect both my generation and the explosive growth of the AIDS pandemic, I have chosen to illustrate some of my talk with botanical material.

The derivation of passion is from *passio*, the Latin for suffering. It has been used for three main purposes; firstly, to describe the sufferings of Christ between the night of the Last

Supper and his death; secondly, to describe the intensity of sexual attraction; and, thirdly, to describe the quality of intense, driving emotion, associated with conviction, enthusiasm, and zeal. It will be the second and third of these definitions that will be the principal concerns of my address. They represent both the root cause of our professional concerns and what is required if our response is to be effective.

The passion flower, which is indigenous to the tropical Americas, was first discovered in Peru in 1620 by a Jesuit priest who saw in the plant and flower symbols of Jesus's scourging, crowning with thorns, and crucifixion (fig 1). The three pistils of the stigma became the nails of the cross; the five petals and five sepals became the 10 apostles (omitting Peter and Judas), the anthers were the five wounds, and the purple corona of filaments was the crown of thorns.

Although I would claim no strong personal religious convictions, I have mentioned this religious connection because in matters of sexual health religious dogma, stigma, and medical practice have frequently clashed. The conflict between the righteous and the reasonable still continues.

The Sheffield cultivar (fig 2), illustrates the interrelation between STI and the various adverse health consequences of sexual passion. The petals are also indicative of the professional linkages we need to forge if we are to optimise our effectiveness.

When I was a student in Sheffield, medicine had far more public respect than currently appears to be so in these days when there are everyday reports of errors, incompetence, and scandal.

Robbie Morton was one of those charismatic teachers and clinicians who was highly respected and admired by his students. Robbie



Figure 1 *Passiflora caerulea*.

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Figure 2 Adverse health consequences of sexual passion.

had arrived in Sheffield in 1960, and was the only consultant then responsible for services in Sheffield, Rotherham, Barnsley, and Doncaster, and was supported by three senior hospital medical officers. Subsequently, all were promoted to consultant posts and although his responsibilities were reduced to Sheffield only, clinics were still held in each of the city's three main hospitals.

Robbie had stated at his interview that it was his intention to centralise the service in a purpose built unit. This took him 10 years—much longer than expected. Then, the regional board was responsible and provided the funding for the venereology service, but the premises were housed in board of governors' establishments—they were required to provide the site for the new clinic.

The final site chosen for the new clinic at the Royal Infirmary was the sixth site looked at. Four were promptly used for other purposes. The fifth was the unused tennis court in the grounds adjacent to the consultants' car park. The joke was that when this site was proposed, 14 consultants were so upset at the idea that they all dashed out and bought tennis rackets!

The service was eventually rehoused in the purpose built clinic in 1970, still traditionally located at the bottom of the hospital drive, with separate entrances for men and women. Access was controlled by a rather stern nursing officer who had been trained in the services (who had an intense dislike for most children and all doctors, but who was the best STI microscopist I have ever met), and a charge nurse who counted down the seconds to the appointed hour when doors were locked, whether or not patients were still walking up the hospital drive. This profoundly influenced my views on exclusively walk-in clinics, and I think patient interests are far better served by a partial appointments system.

Within a few years, the rest of the hospital had closed and moved to the new Royal Hallamshire Hospital, and Robbie Morton had retired, leaving the special clinic and the adjacent chest clinic in isolation. The refusal to countenance their inclusion within the new hospital had no little to do with a microbiologist who profoundly disapproved of patients with either STI or tuberculosis: a strange case

of differentiating between those with supposedly good and bad microbes! It was also opposed by a hospital governor, a lay preacher, whose Christianity did not extend to being non-judgmental about our patients. It took a concerted effort, coordinated by Barbara Turner and supported by an enlightened professor of obstetrics and gynaecology, over the next 5 years to move to the new Royal Hallamshire site in 1982.

By then, the department had become known as GU medicine, a title fiercely resisted by the urologists, lest any of their patients might become tainted if they inadvertently walked into the clinic. They were less than joyful that the departments by chance became located in adjacent parts of the outpatient block of the Royal Hallamshire Hospital. Over the years these fears have disappeared and we now enjoy a close friendly working alliance with our local urological surgeons.

Stigma and syphilis

I mention the historical stigmatising attitudes of colleagues because they have often hindered the development of GU medicine as a discipline. Stigmatisation of GU medicine patients has long been institutionalised within hospitals and their staff, and has had a potentially adverse effect upon the care of our patients who should always have been afforded the same respect as those attending any other service.

Stigma has traditionally been applied to those medical conditions for which the cause was perceived to be related to controllable and avoidable behaviours, and for which the afflicted should bear some personal responsibility. Stigma was exaggerated where the condition was contagious to others. This contagion, which affected physical, moral, and social health, was not limited to the sufferer but also extended to their families and carers. Stigma is also increased where the consequence of the illness is serious degeneration or death, and was further exacerbated where there were manifestations perceived as ugly, repellent, or upsetting that were readily recognisable by a well informed public.

Whitty illustrated his article with the famous early 16th century Durer woodcut showing the typical skin rash of secondary syphilis. Later, the saddle nose deformity and ulceration associated with congenital syphilis became easily recognisable. For most of the next 500 years, the fear of being marked as "unclean" through the means usually associated with "love" and "reproduction" made syphilis the most stigmatising disease in Europe.

Stigma and AIDS

Only when the origin of syphilis was identified in the late 19th century and a specific cure for it developed in the 1940s, did the anxiety and trauma associated with this disease abate. Between the 1960s and 1980s, during the so called sexual revolution, a window of destigmatisation of STI existed. However, the advent of AIDS in the 1980s, initially perceived as both an STI and a "homosexual" disease, showed

that public prejudice had just been latent, and AIDS came to replace syphilis as society's apparent need for a stigmatising disease associated with the means of reproduction.

AIDS also illustrated a further characteristic of stigmatised diseases, especially when they occur in marginalised groups within society. They can serve to exacerbate pre-existing hostility and prejudice to members of disliked social groups—for example, immigrants, non-white populations, homosexual/bisexual men, drug misusers, the poor. The anxiety about AIDS linked the fears about the uncleanness of its “racial” origin with its “sexual” origin. The driving force behind the stigma was the anxiety about AIDS's incurability and its potential for a literal invasion of the body.

The consequences of stigmatisation of individuals are well known—discrimination in housing, health care, insurance, and employment that could result in social isolation and bewilderment. This discrimination impairs public health control by driving the disease underground. At worst, it can also induce such bloody mindedness among affected people that can increase the risk to the community.

The initial responses of politicians to stigmatising transmissible diseases is to ignore the problem, which is often followed by viewing the disease as part of an alien culture, or as foreign. Syphilis was blamed on the French, Spanish, or Italians, according to which country one resided in, and who was the least liked of neighbours. Similarly, AIDS was Haitian or African in the Western developed countries, or a sinister plot of Western imperialism if you lived elsewhere.

Religious leaders have often initially denounced these diseases as being the “work of the devil” because of associations with behaviour that conflicted with perceived morality or society norms.

Doctors and nurses often fail to perceive the conflict between their non-judgmental clinical role in treating disease and promoting good health and their personal morality and standing within society. Too many, in their role of upstanding community figures, adopt the stigmatising tone and righteous attitudes of the prejudiced.

Confronting stigma in GU medicine

When stigma associated with STI is perpetuated, it will inevitably be projected onto the services for their care and control.

Members of the public often have very negative perceptions about GU medicine clinic attendance. There are often erroneous notions about the types of person who acquires STI, the associations with dirty diseases and lack of personal hygiene, with certain types of sexual practice, and fears of personal humiliation and painful examinations. Clearly, these are issues that need public education to remedy and we need to try and create a more positive image of our service.

In Sheffield, we have comments cards for patients to give anonymous feedback about the service, which are then analysed on a quarterly basis. Happily, they invariably give a large

majority of very positive comments that can be used as supportive propaganda as well as being potentially useful for both appraisals and revalidation.

There is a common misconception among the public and professionals that STI only affect the least desirable members of society. This is, of course, a non sequitur. As Whitty writes, it was Erasmus, the leading 16th century theologian and thinker, who pointed out that it was only those who were “*ignobilis et rusticans*” (the country bumpkins) who had not suffered from syphilis. Historically, in the United Kingdom, STIs have tended to increase during times of prosperity. In Africa, it is the middle classes in which the initial brunt of AIDS has been most destructive.

We are privileged to share the secrets and to be the advocates of our stigmatised patients. Yet, I have heard distinguished public health and even GU physicians say, “Patients won't come to GU medicine clinics because of the stigma.” If this was true in the past, the virtual doubling in the numbers attending clinics since 1990 appears to contradict this assertion, as does the growing problem of impaired access to GU medicine services, reflecting the imbalance between demand and supply. If it remains true for some clinics, where are they and why does the reluctance persist? Certainly not in Sheffield, where virtually all gonorrhoea cases and 85% of the chlamydia cases diagnosed in the city are referred to GU medicine clinics.

We should be seeking to applaud positive health seeking behaviour by those who attend our clinics. If it persists, stigma should more appropriately apply to those who do not attend, especially those whose continued sexual behaviour with new partners in the presence of undiagnosed infection represents a far greater risk to public health.

Patients will attend any clinic that has a reputation for good care, respect for patients, and rapid service. Those clinicians whose prejudice prevents their referring patients need to be re-educated. It is often useful to remind GPs that for every patient they refer, we are already seeing four or five self referred patients from their practice. For hospital based clinicians joint research projects can also stimulate mutual respect and a strong evidence base for referral. Courtesy and good communication are prerequisites for collaboration. Converts to the GU medicine ethos can then be invaluable allies when support is necessary to overcome resource constraints that impair patient access.

I have heard it said by very senior public health figures, in part to justify their reluctance to adequately invest in GU medicine services, that education of the public about STI is the only sensible strategy to control STI. Public education is undoubtedly an important strategy but can only ever be partially effective. Policies that promote young people continuing in education are to be applauded. However, sexual health education should encourage not only behaviour that benefits primary prevention but also encourages positive attitudes and knowledge that supports health seeking behaviour. We have every right to expect, even

demand, that directors of public health support the crucial role of GU medicine clinics.

Cost effectiveness of GU medicine services

Sometimes, it is also asserted that the use of NHS resources on STI patients is not cost effective. It is even asserted that such resources would be far better spent on patients whose illnesses are no fault of their own.

Recently, the annual numbers of new HIV diagnoses have been increasing at over 10% per annum. If there is a continuing 10% annual increase in the numbers of patients receiving care, by 2010 their numbers will have increased to 54 000. If the annual increase were 15% these numbers would increase to over 80 000. The lifetime treatment costs of these patients can then be calculated at each of these annual growth rates, assuming annual treatment and drug costs of £17 500, 70% of patients under care are eligible for treatment, and an average 10 years of treatment costs. For a 10% annual increase in numbers they rise to in excess of £8 billion. At the higher rate, the lifetime costs increase to more than £13 billion. The £5 billion difference between these two extremes should be viewed as the minimum cost of failing to pay sufficient attention to sexual health; it is also the premium from which the funding for implementation of the national sexual health strategy should be obtained.

Targets to reduce the incident cases of gonorrhoea and HIV are now being considered as part of the national sexual health and HIV strategy.² Earlier diagnosis of HIV incurs more screening, medical, and social costs. Because of the high costs of drug therapy, the benefit of earlier diagnosis may exceed current national criteria for affordability. However, if earlier diagnosis can also be shown to reduce subsequent transmission to others, it is likely become highly cost effective. Calculation of the benefit to the country of preventing one HIV transmission, is based upon the expected number of years of medical treatment for each infected person; the average annual costs of treatment and the number of quality adjusted life years (QALYs) saved. Using these figures, it has been estimated that it may be worth paying £0.5–1 million to prevent one HIV transmission.

We know that the key factors in reducing HIV transmission are to modify behaviour by reducing partner numbers and encouraging condom use and safer sex; to control STI by effective treatment and partner notification; and to reduce viral load in infected people. Interventions to influence each of these key factors are needed if we are to better control the spread of HIV. In my view, the acceptance of realistic and acceptable targets is essential if GU medicine is to be able to compete with cancer, heart disease, mental health, and other priorities for new resources.

If the value to the country of preventing HIV transmission is so high, then concerted effort on all of these fronts, as part of a comprehensive strategy, should be achievable, at a fraction of the affordable cost. The draft targets include

25% reduction in both HIV and gonorrhoea incidence by 2007. If the annual incident HIV cases in the United Kingdom currently number 1500–2000, then a 25% reduction is equivalent to 375–500 cases each year, and is worth an estimated annual amount ranging from £187 million to 500 million. An additional annual investment in sexual health prevention and treatment services of even the lower figure would have an enormous impact. Moreover, concerted action to prevent HIV transmission would more than likely fund comprehensive sexual health services to all, effectively at no cost!

GU medicine and HIV

A final myth that I should like to tackle concerns the relation between the services for HIV and STI care.

There has been evidence in some centres of the high cost but low volume HIV patients drawing resources away from the low cost high volume GU medicine services. This is health economic madness and unfair discrimination. Patients, whatever their cause of ill health, are worthy of equal care and consideration. Some patients cost more but no patient is worth more than any other.

HIV has been seen as high profile and at the cutting edge of medicine. During the 1980s and 1990s, this was a powerful force that attracted large numbers of high calibre individuals into GU medicine. For some, their HIV role has assumed far greater personal importance than has their involvement in STI. It remains a paradox that for those whose interest is in health care, the management of end stage or life threatening chronic disease still appears to have more importance and prestige than the prevention of such disease.

The separation of HIV medicine from GU medicine must be avoided. Recent events, especially the resurgence of syphilis and other acute STI in HIV positive patients, have shown that we ignore the need for continuing sexual health care for HIV patients at their peril.

STI and HIV care in the next decade

Although we are still awaiting the publication of the consultation document about the national strategy, it is highly relevant that, in this, sexual health and HIV have become inextricably linked.

It seems probable that there will be calls for managed clinical networks for HIV care. I hope that this will result in better support for district general hospital (DGH) services and will allow high quality care near to where patients live. Inpatient care may be concentrated in larger centres, but I would suggest that, where possible, each DGH consultant has contractual sessions in the nearest inpatient centre to maintain continuity of care. To achieve this within North Trent, we have set up either shared appointments and/or university links for all consultant posts.

It also seems inevitable that there will be more involvement of other disciplines in sexual health and STI care, and better linkages

between service providers and sexual health promotion.

I also think that GU medicine services need to have better communication with their neighbours and we should consider how to make our clinical networks more effective. Now that competition is no longer in vogue, we need to share information so we will improve surveillance and audit. I believe that the time of locally autonomous, secretive, and isolated GU medicine service has now passed. Networks of GU medicine and HIV providers that work together with other sexual health services and freely share information in the pursuit of improved health for their populations are not only inevitable but also desirable in both London and the provinces.

They should be at the centre of STI surveillance efforts and also of both teaching and research about STI and other sexual health issues. Joint work with health promotion will help to ensure that national and local targets are achieved.

GU medicine should, in conjunction with consultants in communicable diseases control, seek formal acknowledgment of their joint responsibility for local control of STI and HIV, and in liaison with local diagnostic laboratories collect data about local STI incident cases. This would help ensure comprehensive local surveillance and reporting. It will also allow geographical targeting of local interventions, and coordination of high quality clinical services in both secondary and primary care.

In my view, the continued success of GU medicine will also depend upon the strengthening of other links. I would strongly advocate the formation of local sexual health strategy groups, for example, to develop sexual health improvement plans. The Sheffield group consists of a variety of providers, including GU medicine, family planning and reproductive health, sexual health promotion, and commissioners, together with local authority personnel representing teachers, social services, youth service, and the voluntary sector

The future of the MSSVD

Finally, I want say a few words about the society. The educational role of the MSSVD has increased dramatically during the past 5 years.

When I entered the specialty in 1976, the MSSVD educational activities were restricted to the ordinary general meetings (OGM) and the Spring meeting. The only special interest group at that time was the British Co-operative Clinical Group, which held an annual meeting. This remained the pattern of activity during the 1980s and early 1990s. During the past 5 years, there has been a marked expansion in our domestic and international activities. The traditional pattern of OGM and Spring meetings has been maintained and new special interest groups have proliferated. Within their rules is the requirement to hold at least one open meeting for members annually. The society is also assuming responsibility for support of the national branches outside England and is

discussing whether the tremendous work carried out by English regional groups should also be given more active support.

During the past 2 years, MSSVD has assumed responsibility for running the national GU medicine and HIV specialist training course. During the past year, we have also been developing a national course for non-specialists, the sexually transmitted infections foundation course (STIF). If primary care physicians are to be more involved in sexual health care, it is essential that they should be appropriately trained, and that the society should have a leading role in such training. STIF courses in other UK regions will emerge before the end of 2001, and I hope that there will be further cascade to other large cities and towns within each region before the end of 2002. The demand for training will be enormous if we are to achieve our target of training at least one member of every general practice in the United Kingdom. However, I do believe that training other disciplines to contribute to the diagnosis and management of sexually transmitted infections will enhance the role of GU medicine rather than detract from it.

MSSVD-AGUM merger

Most of those here will belong to at least three specialist organisations that appear to serve different aspects of our work—MSSVD, the Association for Genitourinary Medicine (AGUM), and the British HIV Association (BHIVA)—all of which have developed their own identity, structure, and purpose. All are very successful. Nevertheless, viewed from outside, there has been some confusion as to which organisation represents GU medicine and sexual health with the possibility of viewing separation as being representative of division and weakness.

I am very grateful to James Bingham for leading AGUM into talks about talks about a possible merger with MSSVD, within a unified structure that preserves the best features of each organisation. There are many areas where detailed discussion will be necessary before any firm recommendations can be made to the membership, but the officers of both organisations are taking these issues forward in a very positive spirit. Whether or not BHIVA might also consider an organisational and political linkage remains to be seen and will be a job for my successor.

Titles for a new overarching body will doubtless emerge. I know that James Bingham favours British Society for Sexual Health (BASH). MSSVD owns an alternative website domain whose acronym is *ssshh*—society for the study of sexual health and HIV. I was also initially attracted to the name “British Association for Sexually Transmitted Diseases”; however, I rather quickly discounted this idea because the acronym might cause more than a few to question either our parentage or modus operandi!

My final suggestion is derived from the title of this address and directly confronts the issue that remains the major factor inhibiting better

public health control of STI and HIV—Sexually Transmitted Infections, Genitourinary Medicine, AIDS (*STIGMA*). In an ideal world there would be a trivalent approach involving MSSVD, AGUM, and BHIVA, which this acronym seeks to encapsulate.

Conclusion

In this address, I have tried to articulate my own beliefs and hopes for the future based on my experiences of the past quarter century.

The greatest barrier to encouraging health seeking behaviour in sexually active people is stigma, both that which is publicly overt, that which is institutionalised in our hospitals and, regrettably, sometimes latent in our own departments. Our patients and public deserve

better sexual health services. There is a need to confront stigma, to be committed, and to collaborate with others in order to better protect the public health. I believe that good communication, the development of alliances with adjacent clinics and with other local providers, and acceptance of our responsibility for public health control of STI are the keys to continuing success for GU medicine.

Passion may be the root cause of most of our workload but it is equally a most positive contribution to its solution, especially in our role as advocates for our patients and our discipline.

- 1 Whitty CJM. "Erasmus, syphilis, and the abuse of stigma." *Lancet* 1999;354:2147-8.
- 2 Department of Health. *The national strategy for sexual health and HIV*. London: Department of Health, 2001.