Molly Cooke – MD
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Prof. Molly Cooke

Molly Cooke, M.D. FACP, Professor of Medicine, is the inaugural Director of Education for Global Health Sciences across the five schools (Medicine, Dentistry, Pharmacy, Nursing and the Graduate Division) at UCSF. Appointed in July 2012, her charge is to develop a portfolio of high impact educational programs for UCSF students, residents, fellows, post-docs and faculty members and to devise innovative and high value ways to share UCSF's expertise in discovery science, health care delivery, professional education and basic science with international partners.

Dr. Cooke has been active in medical education program development and educational research throughout her career. A distinguished teacher, Dr. Cooke has twice received the Kaiser Family Foundation Teaching Award as well as a UCSF Academic Senate Award for Distinction in Teaching. In 2006, she was awarded the AOA/Robert J. Glaser Distinguished Teacher Award by the Association of American Medical Colleges (AAMC); in 2010, she received the Career Achievement Award in Education from the Society for General Internal Medicine. As a Senior Scholar of the Carnegie Foundation for the Advancement of Teaching, she co-directed a national study of medical education. This work culminated in the text, Educating Physicians: A Call for Reform of Medical School and Residency, by Molly Cooke, David M. Irby and Bridget C. O'Brien, published in June 2010 by Jossey-Bass/Wiley.

Dr. Cooke has worked on using education and faculty development to address the health problems of underserved populations. A founding faculty members of the internal medicine residency at San Francisco General Hospital – UCSF, she de-

veloped GME curricula focused on the care of the urban under-served, including community health and advocacy. She is the School of Medicine's liaison to UCSF's regional campus in Fresno and in that capacity and as a member of the San Joaquin Valley PRIME advisory board is addressing health inequities in California's Central Valley. She provided the educational expertise for IDCAP, Infectious Disease Capacity Building Evaluation, a three-year project exploring cost-effective ways to build capacity among mid-level providers in sub-Saharan Africa funded by the Bill and Melinda Gates Foundation. She serves on the Training Advisory Committee of he University of Zimbabwe Medical Education Partnership Initiative (MEPI); the US partner institutions are the University of Colorado and Stanford University.

Dr. Cooke is a practicing internist with a special interest in HIV and other complex chronic illnesses. She has advised the AMA, the American College of Physicians (ACP), and the AAMC on clinical care and ethical and policy issues in the HIV epidemic, and was a founding co-director of the AIDS Task Force of the Society for General Internal Medicine. She testified before both National Commissions on AIDS (1988 and 1990). She was a Department of Health and Human Services Primary Care Health Policy Fellow in 2004 and has been repeatedly selected by her peers as one of "America's Best Doctors." Governor of the Northern California chapter of the American College of Physicians from 2004 to 2009, she currently serves as a Regent and President-elect of the College. She will become President in April 2013.

Dr. Cooke is a graduate of Stanford University. She received her medical degree from Stanford University School of Medicine. She did her residency training at the University of California, San Francisco where she also served as chief resident in medicine and did a Henry J. Kaiser Family Foundation Fellowship focusing on ethics.

Antiretroviral therapy (ART) for the treatment of HIV infection has improved steadily since the advent of potent combination therapy in 1996.
New drugs that offer new mechanisms of action, improvements in potency and activity even against multidrug-resistant viruses, dosing convenience, and tolerability have been approved.
ART has dramatically reduced HIV-associated morbidity and mortality and has transformed HIV disease into a chronic, manageable condition. In addition, effective treatment of HIV-infected individuals with ART is highly effective at preventing transmission to sexual partners.
However, less than one-third of HIV-infected individuals in the United States have suppressed viral loads, which is mostly a result of undiagnosed HIV infection and failure to link or retain diagnosed patients in care.
Despite remarkable improvements in HIV treatment and prevention, economic and social barriers that result in continued morbidity, mortality, and new HIV infections persist.
The primary goal of the Guidelines is to provide HIV care practitioners with recommendations based on current knowledge of antiretroviral (ARV) drugs used to treat adults and adolescents with HIV infection. The Panels reviews new evidence and updates recommendations in guidelines when needed. The Panels's primary areas of attention have included baseline assessment, treatment goals, indications for initiation of ART, choice of the initial regimen for ART-naive patients, drugs or combinations to avoid, management of adverse effects and drug interactions, management of treatment failure, and special ART-related considerations in specific patient populations.

Guidelines generally represent the state of knowledge regarding the use of ARV agents. However, because the science of HIV evolves rapidly, the availability of new agents and new clinical data may change therapeutic options and preferences. Information included in guidelines may not be consistent with approved labeling for the particular products or indications in question, and the use of the terms "safe" and "effective" may not be synonymous with the Food and Drug Administration (FDA)-defined legal standards for product approval. The Panels frequently updates the guidelines. However, the guidelines cannot always be updated apace with the rapid evolution of new data in the field of HIV and cannot offer guidance on care for all patients. Clinicians should exercise clinical judgment in management decisions tailored to unique patient circumstances.
The Panels recognizes the importance of clinical research in generating evidence to address unanswered questions related to the optimal safety and efficacy of ART. The Panels encourages both the development of protocols and patient participation in well-designed, Institutional Review Board (IRB)-approved clinical trials

Stefano Rusconi:

We are here with Dr Molly Cooke, who is a professor of medicine at the University of California, San Francisco. So, the question for Professor Cooke is: what about the discrepancies in the HIV guidelines?

Prof. Cooke:

I think that the discrepancies come about for several distinct reasons. The first is, that there are a number of ways that guidelines are constructed, and if the guideline development process is different then it's not surprising that guidelines may end up with different conclusions. Over time the guidelines field has moved towards a much more rigorous and systematic approach in which all the literature that bears on the important questions is collected and reviewed in a very standardized way. But not all guidelines are built that way, and there is still in the process for some guidelines an earlier approach in which experts in the field are gathered and are asked what they think ought to be done, and then, as a second or third step, the literature to support the strategies is collected. And any time a process involves convening a group of people, one group of people, no matter how expert they are, it's going to differ to some degree from a second and a third group of people. The second issue that, I think, is important is that the guidelines process especially in its current, very systematic form is a bit abstract. It pretends that there aren't practical considerations. But in fact, of course, the practice of medicine is very much in a particular context, and what makes sense in Kampala is not going to make sense in San Francisco and vice versa, though if you think about the systematic rigorous process, a guideline reflects only the sum of the literature, and the strength of the evidence would be the same in Kampala and San Francisco. But I think that the various HIV guidelines do in fact reflect some degree of context, that the panels as saying 'what drugs do we have access to, what are the preferences of the patients we're taking care of, and what can we afford', as three important examples of context.

Stefano Rusconi:

Ok. Thank you