I recently participated in a registrar education discussion about ‘heartsink’ patients. What is a heartsink patient? O’Dowd\textsuperscript{1} appears to have coined the phrase and refers to patients who ‘exasperate, defeat and overwhelm their doctors by their behaviour’. He implemented a plan to identify, discuss and actively manage the heartsink patients at his practice and his definition has led to a classification of typical trigger patients and guidelines on how to best manage these patients.\textsuperscript{2}

Another approach explores the characteristics of doctors who report high numbers of heartsink patients. A study from the US found that doctors who are younger, work longer hours, have more symptoms of anxiety or depression and those who sub-specialise report higher numbers of heartsink patients.\textsuperscript{3} Similarly, in the UK, those with higher perceived workloads, lower job satisfaction and working conditions and establishing systems that promote team discussion.

I’ve found the ‘holding strategy’ to be the most effective and intuitive to implement. For me, heartsink patients involve curbing my natural desire to heal, help, cure and solve problems. For these patients, I have consciously shifted my expectations and goalposts. Clearly understanding what is happening during the consultation, acknowledging the patient’s concerns, incremental improvements and maintenance can actually be a good clinical outcome that warrants celebration.

As a general practice registrar, I found heartsink patients quite problematic. I now find the heartsink encounter far more concerning and common. This has little to do with the patients themselves and everything to do with the type of problem they are presenting with. For me, these fall into two broad categories: consultations that require ample time or emotional energy, and consultations in areas in which I am uncomfortable. The first category more readily fits with the heartsink philosophy – areas such as palliative care, mental health and medicolegal consultations. For me, the ‘uncomfortable’ encounters are the most confronting: acknowledging that I have gaps in my knowledge, that I’m not a true generalist and that there are clinical areas that make me squirm. Identifying and acknowledging these deficiencies is important, as is devising a plan to address the gaps.

Skin cancer management has been a heartsink area of medicine for me, so I relished the opportunity to edit this issue of Australian Family Physician, which focuses on skin cancer detection and management. Sinclair\textsuperscript{6} tackles the somewhat controversial topic of skin checks, providing a review of the evidence and some tips for a more systematic approach to skin assessments. Rosendahl et al\textsuperscript{7} focus on dermatoscopy, outlining an algorithm for assessing pigmented lesions based on identifying ‘chaos’ and then carefully checking for the eight ‘clues’ of malignancy. Clarke\textsuperscript{8} reviews nonmelanoma skin cancers and provides a timely update on treatment options for the more common skin cancers, and Thompson et al\textsuperscript{9} provide a concise outline of melanoma management, including the role of sentinel node biopsy, how to provide accurate prognostic information and how the newer approaches to treatment fit into the bigger picture.

The focus articles in this issue of AFP have begun to address one of my heartsink topics. I hope they provide you with a valuable update and enhance your confidence in identifying and managing skin cancers in your everyday practice.

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### References

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