



Rachel Lee

Heartsink

Patient, doctor or consultation?

I recently participated in a registrar education discussion about 'heartsink' patients. What is a heartsink patient? O'Dowd¹ 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.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.³ Similarly, in the UK, those with higher perceived workloads, lower job satisfaction and less training overall – particularly in counselling and communication skills – reported more heartsink patients.⁴ This approach turns the tables, prompting action centred on doctors themselves.

Butler and Evans⁵ take a more philosophical approach, where heartsink stems from 'clinicians feeling helpless in the face of those patients who seek salvation for psychological, social and spiritual problems at a biomedical level'. They conclude that the phenomenon 'seems to be a symptom of tension within the philosophical foundations of general practice' and call on doctors to embrace heartsink patients as 'presenting with genuinely medical and not pseudomedical problems'. I'm not sure how this particular advice translates to everyday practice, but they identify five common approaches to managing heartsink patients that are practical and have the potential to address both patient and doctor factors: improving clinician self-awareness and consultation skills, Balint and other techniques that help focus

the doctor on what the patient is trying to say, implementing a holding strategy, improving doctors' 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 goal posts. 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. Sinclair⁶ 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 al⁷ focus on dermatoscopy, outlining an algorithm for assessing pigmented lesions based on identifying 'chaos' and then carefully checking

for the eight 'clues' of malignancy. Clarke⁸ reviews nonmelanoma skin cancers and provides a timely update on treatment options for the more common skin cancers, and Thompson et al⁹ 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.

Author

Rachel Lee MBBS, BA, MPH, FRACGP, is Medical Editor, Australian Family Physician, Board Director, General Practice Education and Training, Medical Educator, Victorian Metropolitan Alliance and a general practitioner, Melbourne, Victoria.

References

- O'Dowd TC. Five years of heartsink patients in general practice. *BMJ* 1988;297:528–30.
- Tan Y. The "heart sink" patient. *The College Mirror* 2004. College of Family Physicians Singapore. Available at www.cfps.org.sg/collegemirror/30/304/304_heartsink_patient.pdf.
- Krebs EE, Garrett JM, Konrad TR. The difficult doctor? Characteristics of physicians who report frustration with patients: an analysis of survey data. *BMC Health Serv Res* 2006;6:128.
- Mathers N, Jones N, Hannay D. Heartsink patients: a study of their general practitioners. *Br J Gen Practice* 1995;45:293–6.
- Butler CC, Evans M, and the Welsh Philosophy and General Practice Discussion Group. The 'heartsink' patient revisited. *Br J Gen Pract* 1999;49:230–3.
- Sinclair R. Skin checks. *Aust Fam Physician* 2012;41:464–9.
- Rosendahl C, Cameron A, McColl I, Wilkinson D. Dermatoscopy in routine practice: 'chaos and clues'. *Aust Fam Physician* 2012;41:482–7.
- Clarke P. Nonmelanoma skin cancers: treatment options. *Aust Fam Physician* 2012;41:476–80.
- Thompson JF, Scolyer RA, Kefford RF. Melanoma: a management guide for GPs. *Aust Fam Physician* 2012;41:470–3.

correspondence afp@racgp.org.au