A farewell to heart sink?

INTRODUCTION

This is a testament of 26 years spent in general practice. I completed the testament after some years' gestation, when I retired from work at the end of 2005, with disseminated breast carcinoma and a prognosis of weeks. The references to my evidence base are therefore entirely inadequate, though I have indicated the areas where some may be found. But as this is primarily narrative medicine, I feel my small testament may stand as it is, and go, in Beethoven's words, from the heart to the heart; with not a sink in sight.

The word 'she' or 'he' is short for 'she' or 'he' wherever it crops up in the text: the writer is a bona fide 'she' who finds conventions such as 's/he' obtrusive and jarring.

Being a doctor myself, I have the incorrigible tendency in what follows to refer most often to doctors in connection with heartsink encounters. These are of course not limited to doctors, or even to medical professionals. As humans, we all encounter them in our daily lives and all get the chance to do something about them, and to make a difference. The case histories, which are entirely fictional, were provided by a non-medical collaborator who has had much to do with medical professionals in the course of her life, and hopes in her turn to make a difference to them.

Is 'heart sink' a term of abuse? I don't think so: speaker and listener may truly bring a sunk heart to their meetings. That this is a sign of life and hope, is what I aim to demonstrate: if anyone comes to see it in the same light as a result of reading this series, I shall have achieved my aim.

CHAPTER 1

Scrolling through this morning's appointment list, I see A is coming to see me. In a cruder era a few years ago A might have been labelled a 'heartsink patient': a patient whom I just can't seem to help, and who all too frequently comes to remind me of the fact.

Every consultation with A leaves me aware of a turmoil in myself out of all proportion to the presenting problem. Turmoil made up of many feelings on my part: anger, misery, irritation, fear, rejection, blame, manipulation, exploitation, contempt, hopelessness, helplessness, uselessness, and confusion. So much confusion in fact, that I hardly know where in all of this my feelings towards A begin or A's towards me end.

It's a consultation we're all familiar with: we all know A. Some of us might defend our own negative feelings towards A as entirely justified; others would prefer to bundle them hurriedly out of sight, ashamed of a supposed lack of professionalism and compassion. But we could adopt a more practical approach, and treat these difficult feelings as part of the objective history and examination. They are as present in the consulting room as any other physical sign might be: a cough say, or impetigo — or bursting into tears.

Monica asked to be taken on your list 18 months ago, after 'misunderstandings' with her previous GP, in a practice on the other side of town. She has tried everything for recurrent bouts of IBS, which she is convinced stems from a food allergy; she's even attempted an exclusion diet a couple of times, but neither of you felt that it proved anything. She often responds to your suggestions with a sigh, opening her eyes very wide; then silence. As she lives on the edge of your practice area, she has difficulty arriving punctually for appointments. It's impossible not to feel irritated yourself by Monica's behaviour; you are being challenged to discover the secret source of her irritation, in every sense …

Of course, A can be 20, 30, 40 years, or older; male or female; of any or of mixed ethnic origin. Dominating all the feelings A has ushered into the consulting room, there is a sense of ill-usage, on the part of patient and doctor. Both appear to experience the consultation in terms of: 'I don't deserve this' and 'Why are you doing this to me?' Where does all this come from, and what does it mean? Could it literally be telling us that we are dealing on some level with a history of ill-usage, of maltreatment — of some kind of abuse?

What is abuse? The term is generally reserved for harm inflicted on children by adults or by older children: inflicted by those in a position of power and/or trust, on someone more powerless and defenceless than themselves. The abuse may be overt or may have come in disguise; as love, as discipline, as protection or 'good parenting' even.

Most of us would have no difficulty in acknowledging the criminal end of the spectrum where physical or sexual abuse are concerned, and would expect the victim to be deeply and lastingly scarred.

Jake is 19 years old, in his first year as an art student, still living at home; he seems a shy young man, who moves awkwardly. He has presented quite frequently in the past few months with headaches and trouble sleeping. None of the remedies you suggest seem to help much. Examining him for a shoulder injury, you discover that his arms are heavily scarred. He has little to say about this, except 'I do it when I feel bad'. Nobody in his family is aware that he cuts. When you find time to look back over his early notes, you see that he was on the At Risk Register for possible abuse when he was 10; shortly afterwards, his father spent 2 years in prison.

Many heartsink patients will turn out to have suffered such gross and overt abuse; though feelings of confusion, intolerable shame and self-blame may still be preventing them from disclosing, or

even from consciously remembering it.

There are other forms of ill-treatment: as well as less extreme physical and sexual abuse, there is a whole spectrum of gross and subtle emotional damage. If, as I propose, we're right in linking heartsink behaviour in the consulting room to an origin in a 'major' or 'minor' abusive experience, then A, without knowing it, has already given us a map to a troubled and largely unexplored interior. Here be dragons, belonging to A's past, but not of A's making.

Geraldine is a woman in her late 50s who relies heavily on laxatives. She is overweight and, you suspect, a more than moderate drinker. She claims to have suffered chronic constipation 'ever since I was at boarding school, really', and is reluctant to give details of her diet. In her presence, you have the sense of things being held back … from a long way back …

All these examples are of patients who can't tell their stories openly. The origin of their pain is hidden, even from themselves.

Gwenda Delany

General practice for foundation doctors: an easy option?

The role of the GP is poorly understood by many doctors. It is a common misconception among my contemporaries that the world of general practice is an 'easy-deal', where doctors work 9 to 5, Monday to Friday, with nothing more challenging than a patient with the common cold. Hospital doctors are quick to criticise these hard-working GPs who, in reality, have to work 10-hour days, during which they juggle surgeries (with sick patients!), visit patients at home, teach their juniors and run a business.

Despite having a career goal of cardiology, I chose to undertake a 4-month foundation 2 placement in this enigmatic world of general practice, to gain a greater understanding of what life is like on the other side of the fence.

Running my own surgeries is challenging but immensely enjoyable — it amazes me that patients expect me to know everything about everything. I'm dealing with problems I've never encountered in secondary care. What do I do with Mr X who is depressed? Or Miss Y who is distressed with her positive pregnancy test? In addition, I have to think on my feet as the patient isn't going anywhere until I've come up with a management plan! Come back the days when I could say, 'I'm just going away to write in your notes and will be back with you shortly …' as I raced to the nurse's station to consult my Oxford Handbook!

Having spent 16 months in secondary care I know first-hand how cumbersome prescription summaries and discharge letters are to organise. But never again will I put off dictating these vital pieces of information. Apparently it's the norm to wait months for these letters to arrive; the patient has long since filled you in on what happened to them; 'Well they said it was my heart doctor, and I just have to keep taking those little white pills ...'

Has this time in GP land changed my career ambitions? Is it an easy option? My career goal is unchanged, but I believe there is a lot for all foundation doctors to learn in primary care which is fundamental to the foundation curriculum. I have gained a realistic insight into general practice, which is most definitely not an easy option and have learnt an immense amount of medicine. And finally, (perhaps most importantly) I solemnly promise to be more understanding of, and considerate to, these doctors who have, what I consider, to be one of the hardest jobs in medicine.

Rebecca Dobson