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How to protect general practice from child protection

I am grateful to Danny Lang for providing a reading list to help me in struggling to cope with my role as a GP in child protection.¹ I suspect that his safeguarding colleague Janice Allister would suggest more robust measures of support to help me to overcome what she regards as my 'cynical denial of what is a very real problem'.² Both Dr Lang's readings and Dr Allister's exhortations confirm the very real problems I sought to highlight in the column that has so upset them: the presumption that the box-ticking bureaucracy currently dominating child protection in general practice is effective in preventing abuse or neglect, and the apparent indifference of the safeguarding zealots to the adverse consequences of further medical intrusion in intimate relationships.³

I do not intend to revisit the child protection controversy here (though I note in passing that if we accept Dr Allister's judgement, that to hold a case conference in the absence of a GP would be 'farical', then the majority of case conferences that are taking place must be so described). I would, however, like to respond to Dr Allister's challenge to what she found 'most disturbed' her in my article: my contention that GPs should not seek to 'adopt the roles of social worker, psychologist, police, or priest'.

Dr Allister proclaims the mission of general practice in evangelical, almost messianic terms: 'we are GPs; gatekeepers to all the specialist treatments the NHS has to offer; and called to know, love, and care for people in the context in which they find themselves, at every stage in their lives.' The notion that doctors are 'called' to their medical mission implies some sort of a divine summons to their good work of saving bodies (improving health), and souls (enhancing wellbeing). But doctors are paid professionals who are consulted by patients who seek the benefit of their expertise and experience, they have no mandate to extend their interventions into patients' intimate

personal and spiritual lives.

The idea that doctors have a duty to 'know, love, and care' for their patients reflects a confusion between the professional duty of a doctor to provide medical services and the responsibilities of a parent, a family caregiver, or a lover in an intimate personal relationship. This conflation of the personal and the professional, and the implicit collapse of the boundary between the private and the public spheres, carries a heavy cost for both doctor and patient. For the doctor, a certain distance, a respect for the privacy, and autonomy of the patient, is essential to the provision of dispassionate assessment and advice, and appropriate treatment. The patient should be able to turn to their doctor for a degree of objectivity that they would not expect, or even welcome, from their close relatives and friends.

Dr Allister's mission statement reveals the intrusion of a baleful sentimentality into medical practice. It approves the expression of an inappropriate degree of affection in relations between doctors and patients: an excess of feeling that is, in reality, likely to be superficial and false. The inherent insincerity of the posture of the loving, caring doctor proposed by Dr Allister is exposed in the wider roles for general practice that she upholds. The touchy-feely GP is also the hard-nosed 'gatekeeper' to secondary care. The GP as commissioner regards the patient not as a person in need, but as a demanding consumer to be managed and contained. The GP as child protection police officer is invited to 'think dirty' and to regard all parents as potential abusers and all children as 'at risk'.

The GP as agent of the new public health is encouraged to regard the patient as a mere unit of population, requiring nudging or nannying into approved healthy behaviours. In all these roles GPs are advised to take advantage of their intimate knowledge of patients and their families to facilitate surveillance and regulation.

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HIV: low prevalence is no excuse for not testing

The article on HIV testing provides a compelling argument for identifying high-risk patients and attempting to diagnose HIV infection early.¹ It provided an impetus to review the recorded HIV status of patients from countries of high HIV prevalence in our practice, and we searched and identified 124 patients born in sub-Saharan African countries. Among these, there are a variety of ages and ethnic groups. For the vast majority of these, no HIV status is recorded.

In your editorial, based on 2008 UK National Guidelines for HIV testing, HIV testing should be routinely offered to people from countries of high HIV prevalence. However, no further guidance is offered regarding if we should attempt to contact these patients systematically and, if so, how we should contact them. Clearly the language used in such a communication would be important given the stigma still associated with HIV. Opportunistic testing is an option, but given that some of these patients have not consulted for a number of years could mean that some time could pass before there is an opportunity to discuss HIV testing with the potential for delayed diagnosis.

Could the authors provide some guidance on the next steps we could take having identified a patient from high-risk countries with unknown HIV status?

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Authors' response

Dr Smith raises an important issue concerning the implementation of HIV testing strategies.¹ Recent guidance from NICE echoes that of the 2008 UK guidelines, and recommends that men and women known to be from a country of high HIV prevalence should routinely be offered and recommended an HIV test from healthcare professionals in primary and secondary care.² NICE acknowledge, however, that there is a lack of evidence of the effectiveness of different interventions to increase uptake of testing.

Approaches include simply increasing the routine offer of a test at a time when individuals attend primary care services or, alternatively, directly contacting registered patients inviting them to attend for a test. Recent research has shown there is high level of acceptability by patients, including black Africans, of being routinely offered a test when attending various health services including primary care and that this approach is associated with high uptake of testing.³ Frequently, the barrier here lies with the reluctance of healthcare professionals to offer a test rather than reluctance by patients to accept a test when the offer is seen as part of routine care.

The acceptability of contacting patients directly has not been established and there is an absence of published research evaluating this approach. The concern is that such an intervention would lead to increased stigmatisation among the targeted group with low uptake levels of testing. In a survey of black Africans newly diagnosed with HIV, a high proportion (76%) reported seeing their GP within the 12 months prior to diagnosis, and of those attending the issue of HIV testing was raised in only 17%.⁴ This suggests that increasing the routine offer and uptake of testing at the point of access to health services may result in a significant number being diagnosed earlier and that this may be a more effective case finding approach than other screening interventions.

Reducing the barriers to and increasing the uptake of testing in primary care is an important first step and we would encourage Dr Smith and his colleagues to undertake this as outlined in the NICE

guidance. We would also welcome and encourage the evaluation of other approaches to increasing the uptake of HIV testing in primary care, including systematically contacting those from the target populations, to assess their acceptability and effectiveness.

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'Heartsink' patients in general practice

Dr Andrew Moscrop has carried out an interesting analysis of the impact of my paper on heartsink patients in general practice published 23 years ago.¹ I was a young GP when I started the lunchtime management meetings on heartsink patients in the practice, without any intent of it ever being published as a paper and having the impact that it has had. I have been aware of its unselfconscious use, particularly among practising clinicians, as they often use the term in discussion or in

presentations to colleagues. I have also been aware that it has been controversial among my academic colleagues who, like me, find it somewhat politically incorrect and difficult to research.

I have seen articles on 'heartlift patients' designed to counteract the perceived negativity of the heartsink phenomenon. I have never felt the need to defend or explain, as it is what it is, and I have kept my distance from it. Since the recent *BJGP* paper, colleagues in Ireland and the UK have expressed surprise to me that the term had a descriptive origin as it has been part of the unreferenced clinical vernacular for so long.

When we originally discussed heartsink patients in the practice in 1982, it was noticeable that the discussions were quite positive and converted a sometimes very negative situation into a more purposeful if authoritarian one. The study contains several weaknesses, of course, and, despite the prompt acceptance of the paper by the *BMJ*, I developed anxieties about it and considered withdrawing the paper. My most pressing anxiety at the time was that it was self-disclosing. The manuscript accepted by the *BMJ* had a number of case descriptions that they agreed to remove from the published paper. Rather amazingly, no one thought of seeking ethical approval at the time.

Some think it may be more useful to talk of heartsink relationships rather than heartsink patients. This sanitises the term and moves the focus on to a relationship that means the heartsink feelings are shared between the patient and the doctor. We don't know if this is the case.

As a senior GP now, I recognise the self-sacrificial nature of practice wherein a GP continues to look after a heartsink patient, year in and year out, despite the feelings engendered. I haven't used the term for many years but I still experience the phenomenon after 32 years in practice, albeit much less frequently. Having a vocational training scheme in this academic department, I notice that each year one of our GP-registrars presents a case of a heartsink patient at our grand rounds. I view it as a socialisation process — as a step made by young doctors entering the world of general practice.

The heartsink paper reflected the rough and tumble of clinical life in a way that has resonated with doctors and others for years now. Such reflections on practice still occur but often as humorous opinion pieces by medical writers based on