

is no excuse for not testing. *Br J Gen Pract* 2011; **61(585)**: 244–245.

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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.

Ewan Stewart,

*Royal College of General Practitioners,
Chair of the Sex Drugs and HIV Group,
Rose Garden Medical Centre, Edinburgh.*

Paul Arkell,

*West Midlands Deanery, 7 Beechlands,
Bishops Stortford, CM23 3PL.
E-mail: paularkell@doctors.org.uk*

Ian Williams,

*Chair of the British HIV Association,
Mortimer Market Centre, London.*

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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