

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

DOI: 10.3399/bjgp11X583038

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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DOI: 10.3399/bjgp11X583047

'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

random experiences. There is a continuing need for clinicians to reflect on their clinical experience in a systematic way that provides useful insights that lead to better doctor–patient understanding.

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DOI: 10.3399/bjgp11X583056

Improving cancer outcomes

With regard to earlier detection of cancer in primary care, I was surprised to see no discussion about the value of recording detailed smoking histories as a way of adding diagnostic information to patients' presenting symptoms. Although this was probably outside the remit of the editorial,¹ I have found detailed smoking history recording (total dose and duration of exposure) valuable in my everyday consultations.

Smoking is a major cause of preventable ill-health, especially cancer, and I believe it is vital to record smoking history on primary care computer systems in a way that is both easily visible and searchable. At present, such smoking recording seems to be based on traditional methods that were used in the pre-computer medical records era, and here I specifically refer to the iSoft Premiere software system. In this computer programme the health practitioner can record the type of smoker, an amount for cigarette smoking, and the date smoking stops. This type of data collection is inadequate for modern general practice as it fails to inform the GP of the smoking dose or exposure that an individual patient has received, and it is not computer searchable.

At our surgery, smoking exposure is recorded as 'smoking pack years' (smoking 20 cigarettes a day for 1 year is one 'pack year') on all ever-smokers with a freetext comment attached to the Read Code, for example, 15 cigarettes a year for 27 years. This has been our recording method for over 5 years and as a GP I find this smoking information useful in thinking

about patients' presenting symptoms and in intuitively assessing their cancer risk.

Thus in order to aid smoking-induced disease prediction, I propose that all UK general practice software systems should include 'smoking pack years' and 'duration of smoking' that should be highly visible and searchable.

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DOI: 10.3399/bjgp11X583065

Rubin *et al*¹ make an interesting contribution to the complex issue of the role of primary care in improving cancer outcomes. However, they refer to survival rates from diagnosis as the benchmark of improvements in care. Unfortunately, survival rates from diagnosis are a relatively poor indicator of the efficacy of treatment as they obscure two major biases: (1) the lead-time bias; and (2) the over-diagnosis bias. Lead-time bias results in an apparent improvement in survival rates by diagnosing disease earlier but without affecting mortality. The over-diagnosis bias is the discovery of non-progressive disease, for example, many cases of prostate and breast cancer. Identification of non-progressive disease is highly likely to improve apparent outcomes as it means the disease that never would have caused death is included in outcome data and, therefore, results in a falsely favourable impression of the effect of intervention.

Mortality rates are a far better indicator of treatment effectiveness for cancer.² It is generally not understood that there is a lack of correlation between 5-year survival rates and mortality rates due to the operation of the biases mentioned above.³ If we are going to compare outcomes of cancer treatment it is essential that we use measures that are replicable between healthcare systems: mortality rates achieve this, survival rates do not.

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DOI: 10.3399/bjgp11X583074

Validity of diagnoses in the General Practice Research Database

The article by Khan and colleagues¹ highlights the strength of the General Practice Research Database (GPRD) as a research-quality database providing accurate diagnostic data to researchers on a wide range of conditions, and for millions of patients. While the search strategy for this study was broad and inclusive of prescription data, procedures, and smoking in addition to diagnoses, the authors did not identify as many articles as expected.

We published a similar systematic review of the validity of diagnoses in the GPRD² and found over 200 relevant publications, compared to the 49 articles identified in this study. There are two explanations for this difference. First, many validations were not mentioned in the title, abstract, or keywords of the articles and we therefore broadened our search to all studies using GPRD data. Second, our review included studies that validated diagnoses using algorithms, manual review of electronic records, and sensitivity analysis in addition to those methods included by Khan *et al*. Despite these differences in scope, our results were broadly similar and showed high validity of GPRD diagnoses, with a median positive predictive value across diagnoses of 89% (range 24–100%).

While our study was larger, Khan and colleagues assessed one important aspect of validity that we did not: the accuracy in timing of diagnoses. For some research