Letters

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Editor's choice

Why are MUS conflated with heartsink?

In response to the two letters regarding medically unexplained symptoms (MUS), in the April issue of *BJGP*, I would like to question why MUS are being conflated with 'heartsink' patients?[1,2] Although MUS provide the often fascinating detective work challenges that we should be using to attract potential new recruits into general practice, heartsink patients, in my view, are the ones that challenge me on an emotive — rather than clinical — level. My heartsink patients are the ones that make me feel inadequate, cross, or miserable for a variety of reasons that are rarely simply my lack of diagnostic acumen. Some of the 'consultation models' help us understand these reasons: personality clash, communication problems, manipulative behaviour, and issues of consultation dominance, and sometimes the challenges of fixedly held cultural beliefs or illness behaviours.

To move beyond heartsink labels, we should learn to understand the psychology of ourselves first — more than furthering my clinical knowledge, learning to be aware of my own set of prejudices has helped me to avoid letting them govern my consultations. I'm an imperfect human and doctor — but I shouldn't have to feel omnipotent towards my patients in order to act professionally.

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Non-maleficence: perspective of a medical student

My experience of ethics at medical school has been patchy, at best.[1] Mostly lectures. The definitions of beneficence, non-maleficence, autonomy, and justice learned by rote for exams and then ignored again. Holistic care mentioned once or twice. Maybe in a joke about orthopaedic surgeons. No one can really remember.

And then reality. My grandfather coughing blood. Losing weight. He smoked for 60 years. What did we expect?

Almost a year later my grandfather was on a syringe driver at home. He was becoming increasingly confused and agitated. It had been a long road. He had been so tired. He had said more than once he was ready to go.

It was clear to everyone that this was the end of his life, yet I was left fending off frequent requests for blood taking from the palliative team, carers, and district nurses. What if his sodium was low? Did I not want to know why he was confused? Maybe he had liver mets too. Maybe we should keep checking his LFTs?

It seemed irrelevant. And my overwhelming instinct was to tuck him up in bed and hold his hand.

My saving grace came with a GP home visit later one afternoon, coinciding with the nurses and palliative care team. It was very crowded.

He simply asked: *'Will any of this change your management?'*

I never saw the palliative care team again. More morphine and some midazolam, and he passed away peacefully a few days later surrounded by family.

Of course there is a place for investigations in medicine. But I quickly learned something we aren't taught: that there is a place for standing back and letting things be.

Six months later on an A&E placement I was digging around in a 90-year-old's arm desperately trying to fill an arterial blood gas bottle. She was septic and clearly minutes from passing away.

I wish I had asked how it would change her management. I wish I had tucked her in and called her family. Instead, her last few minutes were spent with me, bright strip lighting, and a needle.

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Exposure of Chinese undergraduates to general practice teaching

I read with interest the article by Alberti *et al*,[1] which investigates the correlation between general practice exposure and future choice of career. The study corresponds with the findings of a study in China by He and Wang.[2] In their study, the authors reported that, for undergraduate medical students, increased exposure to general practice education was associated with greater interest in general practice, and could possibly increase the general practice employment rate.

As a fourth-year medical student, I have seen that, in recent years, a lot of measures have been taken in Chinese medical schools in order to promote general practice, and a number of changes have already taken place. For example, Introductory Family Medicine was launched in 2002 as an elective course in Fudan University Shanghai Medical College, one of the elite medical schools in China, taking the lead in the reform of general practice education and residency training in China. In 2011, the Chinese government launched a plan to promote general practice,[3] in an attempt to establish a nationwide general practice system by 2020. Shortly afterwards, Introductory Family Medicine became a mandatory course in most undergraduate medical schools.[4] In particular, fourth-year medical students at Shanghai Medical College need to spend at least one session of authentic clinical placement in general practice at one of the primary healthcare facilities in Shanghai. Students like me who are familiar with tertiary medical centres, where doctors bear an overwhelming workload and