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

patients experience long waits for very short appointments, are often surprised to see a good and rewarding relationship between patients and GPs, a totally different picture from the increasingly frequent reports of escalating doctor–patient tensions. It would be interesting to investigate how this increased exposure to general practice teaching would finally affect students' career choice in a few years, when enough data is available.

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What factors influence intention towards a career in general practice?

We read with interest the article by Merrett *et al*[1] on young doctors' attitudes towards a career in general practice and have collated complementary data from students. We surveyed all final-year medical students at Newcastle University, on completion of their rotation in general practice, over the last 2 academic years. Responses were received for 578 students (response rate = 85%). Students were asked whether they intended to pursue a career in general practice and which factors influenced their decision. One-hundred-and-ten (19%) reported an intention to become GPs and 189 (33%) stated it was one of their options.

We identified a range of themes that positively influenced career intention: specific practice-related factors such as good general practice role models (*'Dr X has shown me how important a good GP can be'*); career-related factors such as work–life balance; and specialty-related factors such as variety of presentations encountered (*'Find general practice an interesting career with good opportunity to see a large variety of patients and build up a good rapport. However, main benefit for me was also the work–life balance'*).

Negative influences on GP career intention included stress among GPs, lack of procedural skills, and lone working (*'I feel general practice is slightly exhausting, and there is not as much interaction with other professionals during the day'*). Negative comments from hospital doctors were also cited (*'General practice has appealed to me in the past. However, the berating they get from hospital doctors (for reasons varied and often unsubstantiated) put me off'*).

We believe these studies add to the crucial contemporary literature into why an individual may choose to pursue a career in general practice.[2] In addition to the recommendations raised by Merrett *et al*[1] around funding, workload, and respect, we would emphasise the key aspect of positive GP role models[3] and the need to explore the perception of general practice as a lonely career. Finally, we must take seriously the recommendation in the Health Education England/Medical Schools Council report, quoted in the editorial of the same *BJGP* issue,[4] that *'[w]ork should take place to tackle undermining of general practice as a career across all medical school settings'*.[5] That work must start now.

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Berwick's third era

Roger Jones is right to highlight Berwick's relevance.[1] Don Berwick admires the NHS and has high regard for general practice, so we should listen to him carefully.[1] He offers a manifesto for the NHS that differs from the usual tired exhortations to integrate, collaborate, and become patient centred. His argument about eras in medicine is attractive. Era 1 was the period of noble, beneficent, self-regulating professionalism that powered the NHS in its early days. In the compromises needed to launch the new health service in 1948, the political class conceded to the professions the authority to judge the quality of their own work.

Era 2 began when the variations in the quality of care, the injustices and indignities inflicted on people because of class, gender, and race, the profiteering and the sheer waste of Era 1, became inescapable. Era 2 introduced accountability, scrutiny, measurement, incentives, and market mechanisms, and has promoted discomfort and defensiveness among NHS staff, and feelings of anger, of being misunderstood, and of being over-controlled. Managers and the Department of Health in turn become suspicious, feel resisted, and can become either aggressive (creating a culture of bullying) or helpless.

Berwick has nine suggestions for helping Era 3 into being:[2] stop excessive measurement; abandon complex incentives; reduce the focus on finance but increase attention to quality of care; reduce professional prerogative; recommit to improvement science; embrace transparency; protect civility; really listen (especially to the poor, the disadvantaged, and the excluded); and reject greed (it erodes trust). As we have tried to point out,[3] some of these ideas have