Heartsink

Brendon Evans

> *If in doubt, act human.*
>
> – Anonymous

> *Too often ... we enjoy the comfort of opinion without the discomfort of thought.*
>
> – John F Kennedy, 1962[1]

Heartsink – every doctor has experienced it. It's the uncomfortable, disquieting ache following the realisation that the next encounter will be difficult. Your 'heartsink condition' might be different, but as a junior doctor in emergency departments, a woman presenting with pelvic pain was mine.

What caused this emotional reaction for me? It was the feeling that I might not be able to give an explanation or solution for my patient's pain – that after history and examination, blood tests and imaging, they would be left without a satisfying diagnosis or management plan.

I have, unfortunately, witnessed colleagues – confronted with the discomfort from this and other 'heartsink' conditions – respond to *their own* feelings by projecting frustration towards the *patient*. These responses take the form of dismissive or invalidating comments and judgemental attitudes. Data suggests that these responses might be typical to the experience of women experiencing pelvic pain.[2,3] Furthermore, these projections might be destructive to the therapeutic relationship and have the potential to reduce health outcomes.[4]

Medicine has a history of blaming the vulnerable when our therapeutic abilities fall short. Only 50 years ago, schizophrenia was attributed to parenting technique – particularly that of mothers.[5] It is a natural response to situations where we feel powerless or confronted with our own mortality to create protective barriers of blame or to dismiss the patient's reality.[6] It makes us feel comfortable. It is an easy wrong to fall into.

What, then, can we do to counteract these tendencies? What can we do about the 'heartsink patient'? Be kind. Be honest. Stay with our patients and be open to new ideas. This process is not easy.

Kindness is shown through empathic communication. It is listening and accepting the patient's experience. Qualitative data demonstrates that this contributes greatly to meeting the needs of women suffering from chronic pelvic pain.[2]

Being honest removes the burden of perfection from the practitioner. It is unrealistic to expect always to have the answers or to remove all pain. Having the ability to openly say 'I don't know what to do next, but let's find out' or to give a truthful accounting of a treatment's likely (often limited) success is difficult but is also associated with the chronic pain patient having high satisfaction with primary healthcare.[7]

Staying with our patients and being open to new ideas is enabling. Fortunately, I feel more comfortable with assisting women who have pelvic pain without a clear diagnosis than I did as a junior doctor, as I have learned more about what can be done for this. Excellent resources to assist with this topic are included within this issue.[8,9]

Engaging with 'heartsink' issues in this way is demanding and, at times, exhausting. It can be draining. It is often uncomfortable. It is also exactly what we would want a doctor to do for our loved ones, or for ourselves.

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