Letters

WE COMMEND the editorial titled 'The paradigm shift in our approach to skin problems' and the associated articles published in the *Australian Journal of General Practice* in October 2023.[1] Australia has a remarkably culturally and linguistically diverse population, which is one of our greatest strengths and central to our national identity. Despite this, implicit, explicit and institutional racial biases within our health system continue to predispose minoritised ethnicity communities to poorer health outcomes. The use of reference ranges not validated in minority populations,[2] the under-representation of people of colour in clinical trials[3] and the bias of medical devices against darker skin individuals[4] continue to prejudice against individuals and groups explicitly and implicitly. These few examples illustrate the continued reinforcement of suspicion within medicine and the health system at large that typically further marginalises patients with minoritised identities. Yet, as we know that trust is critical to health, we strongly support the leadership of the *AJGP* editorial team for initiating these difficult and long overdue conversations. This leadership can be supported by improved access to carefully curated information, including the Black and Brown Skin movement and their *Mind the gap* clinical handbook,[5] which is a crucial resource that provides practical steps to reduce misdiagnosis or diagnosis delays. Although conceived in the United Kingdom, this resource is equally applicable to the Australian context where there has been limited exposure to the diverse ways in which skin conditions might manifest for darker skinned patients in medical education and the literature more broadly.

We must all ensure that the colour of a person's skin does not compromise their medical care. However, if we are to provide quality care and ensure our health systems represent and address the needs of our patients, we must each go further to reflect, acknowledge and dismantle internal, explicit and institutional biases. It is the very least we can do for our patients.

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SURELY IT IS TIME to banish the term 'heartsink patient' from contemporary general practice, with or without the inverted comments. While the editorial by Dr Evans in the January–February 2024 issue of the *Australian Journal of General Practice* was thoughtful and patient-centred, he did ask: 'What can we do about the "heartsink patient?"'[1]

The first published use of this epithet was in the *British Medical Journal* by a general practitioner (GP) in 1986.[2] Dr Ellis wrote that he preferred the label 'dysphoric patient' for the person who causes a feeling of unhappiness, 'intangible, like an invisible halo of spiritual dampness'. Two years later, O'Dowd, a GP in England, wrote about 'five years of heartsink patients in general practice'.[3] He compared these patients with another historically maligned group, the 'frequent attenders'. Thankfully, we no longer classify patients as did one American psychiatrist whose pejorative terms for 'hateful patients' included 'dependent clinger', 'entitled demander', 'manipulative help-rejecter' and 'self-destructive denier'.[4] Groves did emphasise that the dread felt on meeting such patients was important clinical information to help plan management,[4] but I wonder how such stereotyping would engender the empathic listening that Dr Evans promotes.[1] However, my quick Google search indicates that 'heartsink' remains a commonly used adjective. This word concerns me as much as Flexner's phrase 'clinical material' to describe patients during his overhaul of medical education, which I still hear used occasionally by educators.[5]

Dr Evans suggests useful and practical ways to overcome a doctor's tendency to blame the patient when consultations go astray.[1] It is better to reframe these interactions as challenging consultations or conversations, acknowledging difficulties on both sides, and the diverse reasons why these arise. What we require is time in such situations to alleviate the frustration arising from the unmet needs of the patient and the professional.

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Competing interests: None.

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Reply

Dear Professor Thistlethwaite,

Thank you for writing this letter to the editor. Upon reflection, you are quite correct. The term 'challenging conversation' is far superior and leads us to consider – as you rightly state – the difficulties on both sides of the consultation.

I appreciate the contribution of this important point to *AJGP*, and I will be using this term in the future.

Sincerely,

Brendon Evans

Author

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RESEARCH LETTER

Tele-exercise to promote health in women with postpartum depression: A feasibility study

In Australia, postpartum depression (PPD) is a leading cause of health loss among women of reproductive age.[1] There is growing evidence for the positive effects of regular exercise on PPD symptomology.[2] Mothers often have a well-developed rapport with their regular general practitioner, providing the opportunity to identify and support the treatment of PPD, specifically supporting the optimisation of physical activity behaviours.[3]

Previous interventions for exercise and PPD have demonstrated poor participant compliance and adherence to prescribed exercise programs.[4] Telehealth offers a unique opportunity to deliver exercise interventions with healthcare professionals in primary care settings and could address numerous barriers to exercise that women with PPD face.[2–4] To date, no study has investigated telehealth as a mode of exercise delivery for women with PPD. The aim of this study was to assess the preliminary feasibility of a six-week tele-exercise intervention for mothers with PPD. This study was approved by the Griffith University Human Research Ethics Committee (reference no. 2021/584).

Five women with PPD (3–29 months postpartum; 28–40 years of age) participated in a six-week single-arm, individualised exercise intervention to assess preliminary feasibility (ie demand, acceptability, implementation and preliminary efficacy).[5] Outcome measures were collected at baseline and follow-up. Preliminary efficacy was measured using health-related outcomes, including the Harvard step test (ie to measure cardiorespiratory fitness), grip strength, quality of life, PPD symptomology and body composition.

The acceptability of this intervention was high, with all participants demonstrating high exercise adherence (>75% of exercise sessions completed; 100% telehealth sessions attended). All participants reported being strongly satisfied with the intervention and, in particular, its flexible delivery mode through telehealth. Improvements were demonstrated across all health-related outcome measures; notably, this included four of the five participants no longer being clinically indicated for PPD. Future-powered telehealth exercise interventions for women with PPD are needed to determine the magnitude of the relationship between PPD symptomology and exercise and to better identify a dose–response relationship. The results of this limited study support the inclusion of physical activity counselling in primary care at all stages of the postpartum period.

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Competing interests: None.

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RESEARCH LETTER

Awareness of and barriers to participation in the National Bowel Cancer Screening Program among Chinese Australians

The faecal occult blood test (FOBT) has demonstrated clear benefits in the early detection of colon and rectum cancers if taken regularly.[1,2] The Australian Government implemented the National Bowel Cancer Screening Program (NBCSP) in 2006, providing free FOBTs for people aged 50–74 years once every two years by mail. However, only 52.7% returned the specimen in the September quarter of 2022, with rates of return from men lower than from women.[3] Participation was lower in non-English-speaking people for unknown reasons.[4] People of Chinese heritage are the third largest group of Australian permanent migrants, comprising 2.3% of the total population. This pilot study assessed this population's knowledge of colorectal cancer and early detection, awareness of NBCSP and willingness to participate as well as the barriers to participation.

We designed an anonymous survey (Ethics: nil risk) and recruited Chinese-born Australians in the Greater Sydney region (Central and Eastern, South Western and Western Sydney) from education seminars on colorectal cancer organised by CanRevive Inc. (www.canrevive.com). We received 135 completed surveys, and the results are summarised in Table 1 (overleaf). Although 40% of participants did not understand the

importance of the NBCSP, 80.5% received the NBCSP kit, and 86% used it. Participants scored the kit's usefulness as 4.07/5. The participation rate for the NBCSP was higher for this study than the national average due to selection bias, as health-conscious individuals often participate in health screening activities. Most participants showed poor knowledge of bowel cancer's early signs and risk factors. Common barriers to not participating included fear, past negative experiences, language barriers and lack of access to facilities or doctors. New immigrants with lower English competency were less likely to participate in the NBCSP, even though dietary change (increased fat and protein) after immigration might increase their bowel cancer risk.[5] Although 27.8% of participants were aware of the Chinese versions of NBCSP information online, the preferred sources of information in the Chinese language were general practitioners, Chinese organisations and the Chinese media.

A more tailored approach is needed to improve awareness of and reduce barriers to Chinese Australians' participation in the NBCSP. This includes more frequent campaigns for the NBCSP in Chinese through both traditional and electronic media, more workshops by local community stakeholders and broader distribution of Chinese information kits assisted by medical professionals.

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Table 1. Survey results

Demographics		Percent (%)	Total number (missing response)
Gender	Male	23.3	133 (2)
	Female	76.7	
English fluency	Fluent average	17.9	134 (1)
	Below average	49.3	
		32.8	
Participation in bowel cancer screening program			
Types of bowel cancer screening	Stool test only	45.9	109 (0)
	Colonoscopy only	11.0	
	Both	43.1	
Resources for stool test	NBCSP	65.6	109 (0)
	Rotary program	32.1	
	GP	5.3	
	Pharmacy	3.8	
	Other specialists	3.8	
Feedback on the NBCSP			
Having symptoms as the reason for using the NBCSP kit	Yes	20.7	84 (8)
	No	41.5	
	Prefer not to say	37.8	
Easiness when using the kit	Easy	74.4	84 (8)
	Fair	12.8	
	Difficult	12.8	
Usefulness of the kit	Not useful	13.1	84 (8)
	Fair	14.3	
	Useful	72.6	
Preferred way to receive the kit	By mail	84.7	85 (7)
	GP	37.6	
	Other specialist	4.7	

Table continued on the next page.

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Thank you

Dr Sophia Samuel has been a Medical Editor at *AJGP* for eight years and in that time has made countless contributions to the Journal. The role of Medical Editor requires careful thought, attention to detail, diplomacy, critical thinking and creativity. Sophia has displayed all these characteristics, and she will be missed as she moves on to new and exciting opportunities. Thank you, Sophia, and best wishes from *AJGP*.

Sophia Samuel thanks her fellow editors, authors and reviewers and *AJGP* readers for eight years of stimulating scholarly discussion on better patient care.

Table 1. Survey results (cont'd)

Demographics			Percent (%)	Total number (missing response)
Overall understanding of bowel cancer				
Confidence in noticing bowel cancer symptoms	Not confident		47.1	121 (14)
	Average		30.6	
	Confident		22.3	
Identification of risk factors of bowel cancer	Alcohol use	Disagree	50	128 (7)
		Neutral	23.4	
		Agree	26.6	
	Diet with inadequate fruit and vegetables	Disagree	54.7	128 (7)
		Neutral	28.1	
		Agree	17.2	
	Consumption of processed or red meat	Disagree	51.2	129 (6)
		Neutral	34.1	
		Agree	14.7	
	Low fibre diet	Disagree	76	129 (6)
		Neutral	15.5	
		Agree	8.5	
	Overweight	Disagree	58.9	129 (6)
		Neutral	28.7	
		Agree	12.4	
	≥70 years of age	Disagree	37.5	128 (7)
		Neutral	22.7	
		Agree	39.8	
	History of close relative with bowel cancer	Disagree	72.5	131 (4)
		Neutral	13.0	
		Agree	14.5	
	Lack of physical activity	Disagree	41.1	129 (6)
		Neutral	33.3	
		Agree	25.6	
	Having other bowel disease	Disagree	58.7	126 (9)
		Neutral	24.6	
		Agree	16.7	
	Diabetes	Disagree	32	128 (7)
		Neutral	39.8	
		Agree	28.2	

GP, general practitioner; NBCSP, National Bowel Cancer Screening Program.

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