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SHORT COMMUNICATION

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Giving bad news: a GPs' narrative perspective

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Abstract The purpose of this study was to explore GPs' perspectives on giving bad news during consultations. To this end, 168 GPs were asked to recall, and record on the first page of a questionnaire, an occasion when they had given medically related bad news to a patient. The stories were analysed with a qualitative and interpretative approach. Two axes, each with a semantic polarity, were identified: a relational axis (semantic polarity: escape vs accompanying) and an ethical axis (semantic polarity: the doctor's choice vs the patient's choice). Furthermore, two main topics appeared to be common to almost all the narratives: the need to reassure the patient and the account of the doctor's emotions. Two different relational patterns appear to be described by doctors. A substantial number of GPs implicitly describe a disease- or doctor-centred consultation: in these cases the physicians refer to signs and symptoms, diagnosis and treatments; they decide for themselves whether to tell the truth or not. On the other hand, a smaller number describe consultations that could be defined as patient centred: these doctors consider that their duty of care for the individual ill person is paramount and try to respect the patient's right to decide. In both these relational patterns, GPs feel it is a fundamental professional duty to reassure the patient; furthermore, they feel the most difficult aspect is managing their own emotional responses.

Keywords Giving bad news · Family practice · Narratives · Physician–patient relationship

Introduction

Breaking bad news is a difficult but usual part of the health professional's job, and of the physician's in particular. This issue has been largely explored in the literature (for review see [10]): an ethical perspective has been assumed in discussing whether and how to tell the truth (e.g. [3, 13]); doctors' communication skills have been analysed (e.g. [8, 15]), and communication training on giving bad news has been presented (e.g. [2, 12]). In this study, an atheoretical perspective has been assumed. The aim of the study was neither to propose a theory nor to present an analytic tool defined once and for all: instead, it was to provide an incentive for thinking about breaking bad news from a more complex and challenging viewpoint. In the course of this, we collected stories of physician–patient meetings in which bad news was broken, narrated from the physician's viewpoint in each case. A narrative approach was adopted [9] through the use of an open questionnaire in which doctors were asked to relate a clinical encounter in which they had to give bad news to the patient concerned.

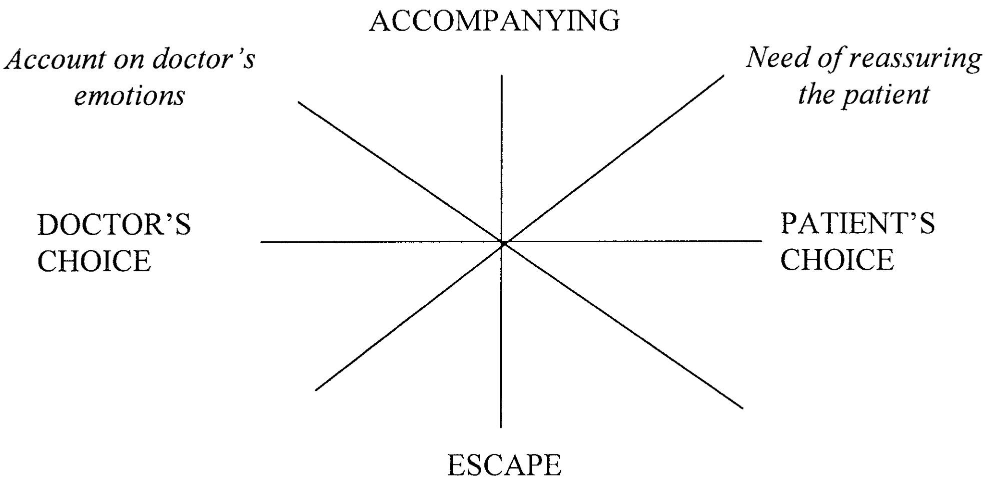

Fig. 1 Main axes and *cross* semantic issues identified in GP's narratives

Methods

The study involved 168 general practitioners (GPs) at the beginning of five training programmes devoted to breaking bad news (for a definition of "bad news" see [3]). None of them had previously participated in a continuing medical education (CME) programme on this issue.

An open narrative questionnaire was drafted, entitled: "The story of a dying patient and of a doctor taking care of this patient". GPs were instructed to give a written report of a doctor–patient relationship in which they were personally involved. In order to leave the GPs as free as possible in telling the story, no definition of bad news was proposed before GPs completed the questionnaire. No instructions were given about specific clinical pathology or other aspects. On the back of the sheet with the narrative questionnaire, there were five open questions directed at the doctors, dealing with the following issues: the main aims of the doctor–patient encounter reported; the doctor's feelings; the patient's feelings; how much of the truth the doctor told the patient. The total time allowed for completion of the questionnaire was 20 min. As the GPs completed the questionnaire, they were asked also to complete a form with their personal (gender and age) and professional data. The questionnaires were anonymous.

Data were analysed following an hermeneutic approach [1, 7]. The stories were read several times to gain in-depth theoretical understanding according to an interpretative analysis. The goal of analysing narrative data is more to disclose the constructive processes and less to reconstruct factual processes. Common to all the procedures for analysing narrative data is that in the interpretation of statements (1) the analysis starts from the *gestalt* of the narrative, so that the statements are viewed in the context of the flow of the narrative; and (2) furthermore, the analysis includes a formal (semantic) interpretation of the material. In analysis of the stories, two researchers worked on the same texts, applying two methods for interpretations of texts:

1. Sequential analysis aimed at reconstruction of the linguistic structure of the text (e.g. what word the doctor uses for the dying patient, whether more than one episode in the story is narrated, and if so how the episodes are linked to each other)
2. Content coding of the material with the aim of categorizing topics

Data were examined for similarities and differences, repeated themes or core issues in each story being focused on until synthetic and satisfactory categories were identified. Answers to the five open questions were used to test the narrative interpretation for coherence.

Main results

All 168 doctors taking part, 123 male and 45 female, were regular GPs. Their average age was 48.7 (range 29–74 years). On average, they had been in practice for 19.8 years (range 2–42 years).

Through analysis of the questionnaires, two main axes, each with a semantic polarity, were identified: namely a relational axis (semantic polarity: escape vs accompanying) and an ethical axis (semantic polarity: the doctor's choice vs the patient's choice). Furthermore, two main topics seem to be common to almost all the narratives: the need to reassure the patient and the account of the doctor's emotions.

All but five questionnaires could be analysed in terms of these axes and/or these main topics (e.g., the story of a man waiting for a transplant was not considered consistent with other narratives).

Relational axis: escape vs accompanying

There were 143 questionnaires that contributed to the definition of the relational axis. The axis is characterized by the semantic polarity "escape vs accompanying". On the basis of the questionnaires, escape can be defined as the hidden refusal to accept the (emotional) situation. Empty questionnaires ($n=5$) are a prototypical example of this pole. Accompanying can be defined as caring for the person with an illness, although it is untreatable, as in the following example:

> My duty was to accompany him through the consciousness and acceptance of a definite time.

> And in accepting that he wouldn't be left alone. (Questionnaire Code MG76)

The *gestalt* of narratives is very different in the polarities. On the one hand, in the escape polarity doctors usually do not narrate a story; rather, they place events side by side, using a grammatical structure of coordinate clauses. On the other hand, in the accompanying polarity, a grammatical structure with dependent clauses is preferred, and stories with a more complex narrative texture appear.

The three following relational issues appear to be tackled in both poles but with a diametrically opposed manner: the description of the patient; the decision-making process; and the health/illness concept involved.

As far as the description of the patient is concerned, descriptions of sign and symptoms are usual in the escape polarity. In these examples note the grammatical structure of each of the narratives:

> Female, 61 years of age, radical right mastectomy 6 years before; widow, 2 sons; no other pathologies; ... 6 months earlier right axillary lymph node and metastasis. (MG105)

> A month ago in my practice a 'lung cancer'. (MG106)

> Patient, 64 years, with temperature, diarrhoea, loss of weight, a refractory mycosis in the oral cavity. Married, 3 children. (MG110)

In contrast, with the accompanying polarity the story of a *person* is present in the narrative:

> He was a guy, 28 years old. He was a bricklayer; I remember him all right: curly hair, wide, black eyes. I invited him into my practice and we talked for a long time; I tried to talk about ordinary and trivial matters. (MG113)

As far as the decision-making process is concerned, the polarity is defined with the opposite of the doctor's clinical decision vs a negotiation.

On the one hand, the patient is the passive object of the doctor's choice:

> My answer was to proceed with clinical tests and to be ready for the following medical, surgical, or radio-therapeutic treatments. (MG111)

> During a stay in hospital for clinical tests, after routine examinations (abdominal echography, chest X-ray) HIV infection was suspected. ... a laboratory test was performed and the result was positive. (MG110)

In these stories selection of the passive voice for the narrative (mostly rather rare in the Italian language) was extensive:

> The patient was informed. (MG110)

On the other hand, in the accompanying perspective the process of decision-making is negotiated and the doctor counsels or suggests:

> ... and I counselled her to let me refer her for a mammography. (MG69)

> ... to suggest to the patient a series of clinical tests and to prepare him to deal with pathology and treatments. (MG144)

The subject of the sentence is frequently plural ("we"):

> Mr. L.N. had been suffering from aching bones for a long time. The suspicion that something very serious was wrong was becoming evident, both to him and to me. We decided together to do a CAT. (MG76)

As the doctor is a counsellor, the patient is a participating and conscious subject of clinical decision:

> I was present but trying to be unassertive. I left him to think it over by himself and with the family. I tried to respect the patient's capability of understanding and his autonomy to decide. (MG71)

As far as the concept of health is concerned, the focus of the consultation appears to differ with the different polarities.

In the escape polarity, doctors talk about health in dichotomous terms: the total health that is completely lost to the disease. Before the disease event, the patient:

> ... was always in good health. (MG116); ... always enjoyed good health (MG105); ... had good health, looked after himself, a nonsmoker, a nondrinker. (MG138); ... moreover, he was a good-looking man. (MG124)

In the face of the untreatable disease, everything appears to be lost:

> ... as I perceived the real situation, I felt my complete uselessness. (MG108)

In the accompanying polarity, health is not totally "present or absent", and the concept of quality of life is introduced:

> ... a 90-year-old patient; she wanted to spend the time remaining to her at home. ... the patient's quality of life had to be protected. (MG53)

The doctors' decisions appear to be focused not on health/recovery, but on achieving and maintaining a sufficient level of well-being and an acceptable general condition that can be maintained until the death of the patient. In this polarity, health, or illness, is part of a course made up of multiple steps: according to this view, a doctor's duty is not exhausted with the recovery of biological health:

> [Since the husband's death] ... it has been necessary to follow the wife's mourning for over a year. (MG70)

> The patient's daughter asked me whether her mother was suffering. ... She agreed not to proceed with resuscitative measures, conscious of the patient's general condition. I accompanied the daughter to her mother's bed, saying that I was available for everything she needed. (MG101)

Ethical axis: doctor's choice vs patient's choice

There were 64 questionnaires contributing to the definition of the ethical axis. In the literature, a common ethical perspective is consideration of the semantic polarity 'to tell' vs 'not to tell' the truth. Questionnaires showed a deeper complexity. The breaking point was between doctors who decide independently of the patient and doctors who explore and negotiate the patient's view. In both perspectives, doctors may or may not tell the truth. As regards the perspective of the doctor's choice, the doctor's decision to tell the truth may depend on several reasons, e.g. the duty to inform the patient or the perceived lack of alternatives:

> It was my responsibility to break the news because I'm the family doctor. (MG10)

> I had to, because in the hospital they only gave generic information. (MG7)

> I had to, because my colleague didn't. (MG48)

> ... because I was standing in for the family doctor. (MG46)

In a similar way, a doctor may choose not to share the truth for general reasons:

> Based on my experience, a fatal diagnosis should never be told, because of the unexpected reactions. (MG21)

> Most oncological patients unconsciously reject the idea of a neoplasm and prefer a false diagnosis. Patients accept an openly fake chemotherapy holding out hopes of recovery. (MG20)

or on the basis of a specific situation:

> I didn't break the bad news to him, because of his low cultural level. (MG23)

> I couldn't bear to think about seeing the girl; the idea of communicating the truth to her froze me. I hadn't the heart to tell her the truth. (MG24)

In a completely different manner, the doctor's choice to tell or not to tell the truth may be affected by the patient's decision/desire:

> The husband asked me not to break the bad news. Afterwards, during an in-depth interview with the patient, I became conscious of her desire to be informed. I said we would have a battle to fight together. ... until the end, she was always convinced that we were fighting together, that she wasn't alone. (MG42)

> I was driven by the husband's questions, and with this he became more and more conscious of the seriousness of the situation. (MG100)

> I offered hope, because the patient asked me with tacit agreement. (MG70)

> I tried and tried to start breaking the bad news; at every attempt, she got troubled and didn't consent. Then I offered hope and I helped her to live holding onto this hope. (MG90)

> I decided to wait a little longer; I had the feeling he didn't want to know yet. (MG65)

In these examples, the intensity of communication typically develops over the course of time: for the doctor, time is needed to understand what to do for the best; for the patient, time is needed to process information:

> I began to communicate with the patient, gradually increasing my input until the patient became aware of his own clinical situation, and he then accepted the diagnosis disclosed with great composure. (MG94)

In limbo, the ethical axis is characterized by doubt, without a definite answer. Doubt is expressed as a general statement in a course of action:

> Is it right to inform him? (MG16)

or doubt derives from a later reflection by the doctor:

> Where did I go wrong? (MG11); I don't know whether I was right (MG12)

> Maybe I was wrong. (MG13)

> Occasionally such doubt modifies the action:

> I had to tone down the prognosis. (MG19)

Common topic I: the need to reassure the patient

A topic common to almost all the questionnaires was the need to reassure the patient. This need appears to be a core aim of the consultation, regardless of the doctor's position on the relational and ethical axes.

Even the choice not to communicate the bad news to the patient seems nevertheless to imply the need to provide reassurance.

Several examples are available from the questionnaires:

> ... calmly and confidently, I tried to give her hope and let her know that the problem could be solved. (MG67)

> ... serious illness but treatable; almost all my patients recovered. (MG64)

> I felt her deep tension. I tried to empathize and explained the situation to her simply and naturally. I felt her relaxing. (MG69)

> ... do not lose faith, and come to me every time you need to. (MG64)

Two general strategies could be identified for reassuring the patient: a "numerical" strategy based on the evidence:

> In 80% of cases current medicine resolves the problem. (MG64)

and a "human" strategy, based on the personal relationship with the patient and on the helpfulness of the doctor:

> I will be here for you. (MG16)

A deeper difference can be identified in the general structure of narratives. In some of the stories a single, sharp reassuring intervention is present:

> Surgery works miracles. (MG140)

Other narratives consist of moments of reassurance following the clinical and personal story of the doctor–patient relationship (a kind of accompanying reassurance):

> I lied; ... you cannot write off a patient by saying, 'Nothing can be done.' ... I held out hope. (MG 24)

Common topic II: account of the doctor's emotions

A topic that is frequently touched on in the questionnaires, implicitly or explicitly, is the matter of the doctor's emotions:

> Saying what was going on wasn't easy at all. (MG80)

> I did not break the news easily. (MG81)

> I was the more embarrassed. (MG87)

> ... fortunately in these situations I'm able to distance myself, because I consider death and suffering to be part of our lives. (MG131)

Doctors appear to avoid emotional participation, because they consider it to be an obstacle to their current (and correct) professional practice:

> It is not easy to remain calm and indifferent, detached; although it wasn't easy to maintain a purely professional relationship, I tried to provide her with all the information. (MG45)

> In that situation I was losing the necessary professional distance that allows us to communicate in a rational and correct manner. (MG120)

> ... to maintain a sufficient distance from the situation because of the need to practise medicine with objectivity and clearness of mind. (MG129)

When emotions break into the consultation, doctors feel unprepared to cope with them:

> The feeling I remember the most is a deep emotional, personal participation, for which I hadn't been prepared. ... It impeded my 'completely rational' relationship with the patient. (MG122)

Other outcomes

The following minor topics were extracted from the narratives.

Which pathology is described?

Most (151 or 89.9%) of the stories were concerned with oncological pathology. As regards other pathologies, 6 questionnaires described degenerative diseases (e.g., Alzheimer's disease); 5, chronic diseases (e.g., diabetes); 2, HIV syndrome; 1, Down's syndrome; 1, an attempted suicide; 1, the death of a baby in utero; 1, an unexpected death after surgery.

When did it happen?

Questionnaires offer indirect indications of the frequency of consultation in which the doctor has to break bad news. Most doctors said it happened "frequently" (10 questionnaires); the stories they narrated referred to their recent practice (8), or to only 1 month (14) or a few months before (17). Some doctors narrated stories that had happened 1 year before (14), 2 years before (8), 3 years before (5), or 8 years before (1). The oldest story referred to a consultation in 1985.

"A doctor and ...": how the patient is presented

The term used to introduce the patient was analysed. Most questionnaires (92) referred to a "patient". In some a more personal term was used: doctors used "guy" or "gentleman", "my patient", the subject's initials, the patient's first name, "my mother-in-law", "my cousin". Conversely, in other questionnaires a more impersonal term was used: "man" or "woman", "subject", "interlocutor", "client", "malignant tumour", or even no subject, e.g.: "it has been diagnosed".

In one questionnaire only, the very strong term "victim" was used; it could be included both in the series of personal terms, because of its intense affective connotation, and in the series of impersonal terms: a victim is typically the *object* (other than me) of a sacrifice.

To train or not to train: the young doctor's perspective

The young doctors' narratives deserve special attention: 8 physicians with less than 5 years of practice related stories in which they felt they were "in the trenches" for the first time:

> I felt afraid of being responsible, as you have to be in the medical profession. (MG47)

> I thought that if the doctor in charge had been there, it would have been better. I had to break the news of a bad diagnosis, and that troubled me. (MG46)

They did not feel up to managing the situation, but also they felt a lack of responsibility. During his postgraduate training, one young doctor had witnessed a consultation in which the doctor broke bad news with a cold and detached tone. He comments on the episode:

> I would have liked to close his mouth for him, but I couldn't. ... I was still just a doctor in training. (MG42)

Listening to an emotional release

Five doctors chose to tell stories of bad news where the direction of communication was the opposite of the usual one: not from doctor to patient but from patient to doctor. In these stories the patients had already been given upsetting information by someone else and had gone to the practitioner to relieve their feelings.

> The patient had been informed by another doctor. He kept the truth to himself and every time he came into my practice he wept, telling me about the time he spent with his grandchild and about the effort it took to hide his feelings from the family. (MG59)

> The patient came to my practice appearing very scared as she had been diagnosed with breast cancer. (MG61)

> The mother was opening her heart to me more and more, until she felt a complete release. (Her son had tried to commit suicide.) (MG63)

In these particular cases doctors chose stories in which they had to *listen* to bad news instead of *giving* it: in the doctors' view listening to an emotional release seems to be as troubling as breaking bad news.

Discussion

Reports in the literature suggest that breaking bad news is a core issue in the professional life of physicians [3] and a common experience in practice [11]. In this study we analysed the topic of giving bad news from a qualitative, subjective perspective: instead of describing what happens in medical consultations in which a doctor breaks bad news to a patient, or to point out what should be done, we asked GPs to tell us about their own perception. What do GPs experience while saying to a patient, "You're damned", "You're dying", "There's no hope for you"?

The topic appears to occur quite frequently in the course of a GP's work, or at least GPs seem to be very interested in it: all but 5 narratives were completed without hesitation. Because the experimental subjects were all GPs voluntarily taking part in a course on breaking bad news, it is possible that this result could be related to the fact that our subjects were a nonrepresentative sample.

Two different relational patterns appear to be described by doctors. A consistent number of GPs implicitly describe a disease- or doctor-centred consultation: they talk about signs and symptoms, diagnosis and treatment regimens; they decide for themselves whether or not to tell the truth. This relational pattern is well described in the literature (e.g. [4, 6]). Our data show that this relational style seems to be the dominant style not only in observed but also in the perceived medical relational behaviour.

On the other hand, a smaller number of GPs described consultations that could be defined as patient centred [14]: these doctors consider it to be their duty to take care of the ill persons, trying to respect each patient's right to decide. This observation bears witness to a recent shift in the direction of a more "humanized" type of medicine, where the focus of the health profession is to care for and not to cure the suffering, the goal being not total health but well-being for the remaining time. This model of medicine, according to which the patient is accompanied, is needed more and more, especially in chronic, degenerative, and untreatable diseases such as are reported in these narratives.

In both relational patterns, two core topics were described by doctors. On the one hand, almost all the GPs felt it was a core professional duty to reassure the patient. Despite the crucial importance of the topic in the physicians' view, few contributions in the literature (e.g. [5]) explore doctors' reassuring behaviour in medical practice. The results of our study stress the significance of further research on this topic. On the other hand, in both relational patterns, GPs find it very difficult to cope with their own emotional responses. The GPs stress the extreme importance of this topic within the profession, a topic that is still underestimated in undergraduate medical training and in CME.

Some more questions arise from our research. It would be interesting to find out whether these results can be generalized to other health professionals: do hospital physicians view all this in a qualitatively different way from GPs? Do health professionals with an everyday relationship with dying patients (e.g. oncologists) present the same semantic axes or topics as were observed in these narratives? How do doctors who should be giving patients good news (e.g. gynaecologists) experience a medical consultation to break bad news?

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