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Health (London) 2012 16: 569 originally published online 7 March 2012

DOI: 10.1177/1363459312438565

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Health
16(6) 569–584
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DOI: 10.1177/1363459312438565
hea.sagepub.com



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Abstract

An important part of GPs’ work consists of attending to the everyday and existential conditions of human being. In these life world aspects, biomedicine is often not the relevant theory to guide the GP; nevertheless they are a part of GPs’ professional domain. In cancer care, previous studies have shown that GPs with a biomedical perspective on medicine could feel subordinate to specialists, and that doctors with a curative focus could see disease progression as a personal failure. The aim of this study was to explore in depth the experiences of being a GP for people with advanced cancer. Fourteen Norwegian GPs were interviewed about accompanying patients through a cancer illness. Their stories were analysed using a narrative approach. The GPs expressed a strong commitment to these patients, a loyalty which in some cases could be weakened due to judgements of distant specialists. In view of the GPs’ close knowledge of their patients’ background and history this subordination was a paradox, mirroring a hierarchy of medical knowledge. The GPs had an ideal of honesty and openness about death, which they sometimes failed. To reach the ideal of honesty, clinicians would have to abandon the biomedical ideal of mastering human nature through interventions and acknowledge the fundamental uncertainty and finiteness of human life. GPs may learn from being

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with their patients that bodily and existential suffering are connected, and thus learn implicitly to overlook the body–mind dualism. This practical wisdom lacks a theoretical anchoring, which is a problem not only for general practice.

Keywords

cancer and palliative care, narrative analysis, patient–physician relationship, primary care, profession and professionalization

His situation was one of the greatest challenges I have had as a doctor. There was a mortal fear shining in his eyes regardless of our efforts. Regardless. (Dr J)

Introduction

In this article, general practitioners' (GPs') stories of caring for people with cancer are interpreted as a search for a trusting relationship to the patient and for a professional identity within the existential situation of shared humanness. The experiences are discussed in relation to two coexisting perspectives of medicine: medicine as the science of biomedicine or medicine as a clinical practice of moral and relational origin, which uses biomedicine as a tool.

Medicine as natural science or as clinical relationship

According to Pellegrino (1979), medicine *is* a relationship, a 'specific and unique kind of human relationship', between a doctor (or another clinician) and a patient. In contemporary medicine, however, these two close protagonists are often separated and even disappear from the stage. If medicine is seen as the (applied) science of biomedicine, neither the patient as person nor the doctor as person has central roles. In the biomedical model, disease resides inside an organ of the individual human body, and is treated by interventions specific to the disease process. Treatment is aimed at the disease, not the person, and the body is regarded as a passive target of interventions (Checkland et al., 2008). As the disease is the target, the doctor might as well be a disposable evidence-based technician. For example, people with cancer may meet around 30 different doctors during the first year of their illness (Smith et al., 1999).

Both patients and doctors are suffering in this model (Hunter, 1991). Patients want to be treated as human beings. They want doctors to recognize them, be with them and be involved with them. They want to be listened to, respected and valued, to have a feeling of being understood, their symptoms taken seriously and be given honest information (Arborelius and Bremberg, 1992; Epstein and Street, 2011; Kvåle and Bondevik, 2008). People wish to be cared for by the same professionals over time, but only if they are recognized, remembered and respected (Frederiksen et al., 2009). There are fewer studies of the doctor–patient relationship seen from doctors' perspectives. It has been shown that general practitioners (GPs) value personal continuity in their daily work (Ridd et al., 2006), and their most satisfying experiences during consultations occur when they can use their prior knowledge of patients to promote restoration (Fairhurst and May, 2006).

Seeing medicine as a biomedical science is obviously too narrow a perspective for general practice. An important part of GPs' work consists of attending to the everyday and existential conditions of human being. Several generations of families pass by the GP's practice; growing up, giving birth, being beaten, being ill and getting well, losing work, growing old, facing death. In these life world aspects, biomedicine is often not the relevant theory to guide the GP; nevertheless they are part of GPs' professional domain. In medical education, there is much focus on the biomedical approach, little on the existential aspects and even less about how the two are connected. As a species, human beings search for and create meaning in relation to their condition. McWhinney (1989) stated that medicine is an 'acquaintance with particulars'; human beings with a unique history. However, GPs identify themselves as doctors by the biomedical approach, as the existential aspects of a clinicians' work is not equally acknowledged in the medical world (O'Flynn and Britten, 2006).

Patient-centred medicine – an expanded biomedical approach

The psychoanalysts Michael Balint and Enid Balint were especially concerned about the relationship between the GP and the patient. The Balints encouraged GPs to improve their capacity to understand their patients' thoughts, feelings and imaginations, and also to explore their own. To promote this, they organized supervision groups where GPs told and reflected on stories about encounters with patients (Balint, 1957; Davidsen, 2010; Davidsen and Reventlow, 2010). Eventually they termed the way they described this relationship 'patient-centred medicine' (Balint, 1969).

Reviewing the literature of the following 30 years, Mead and Bower (2000) conclude that patient-centred medicine has been most strongly advocated within general practice. Several definitions of the concept coexist – 'understanding the patient as a unique human being' (Balint, 1969: 269), using the patient's knowledge and experience (Byrne and Long, 1976) and entering into the patient's world to see the illness through the patient's eyes (Levenstein et al., 1986). Patient-centred medicine differs from the biomedical model in five key dimensions (Mead and Bower, 2000):

1. The *biopsychosocial* perspective of understanding patients' illness within a broader contextual framework (Engel, 1977).
2. The 'patient-as-person' perspective of understanding the individual's experience of illness (Armstrong, 1979).
3. The ideal of an egalitarian doctor–patient relationship of *shared power and responsibility* (Byrne and Long, 1976).
4. The concept of *therapeutic alliance* adapted from client-centred psychotherapy (Rogers, 1957).
5. The 'doctor-as-person' perspective concerning the personal qualities and the subjectivity of the doctor.

An aspect of patient-centred medicine was the separation of the patient's and the doctor's agendas, asserting that the doctor's agenda was 'the explanation of the patient's illness in terms of a taxonomy of disease' (Levenstein et al., 1986: 24). By defining the

doctor's agenda in terms with the biomedical approach, the patient's agenda becomes just a reminder for the doctor that the patient is not only a diagnostic problem but also a human being. 'Turning to the patient becomes a separate thing, a *humane* (benevolent) endeavour on top of a professional endeavour, which basically is not regarded as *human*' (Rudebeck, 1992: 162). Bensing (2000: 20) found the concept important, but bizarre: 'it should be a pleonasm; the term "patient-centred" should be a superfluous addition to the term medicine. All medicine should, by definition, be patient-centred.' Such a definition would acknowledge that 'the application of the principles of science to the diagnosis and treatment of disease is only one limited aspect of medical practice' (Peabody, 1984: 813).

Studies of doctor–patient relationships, especially in cancer care

In a synthesis of the qualitative literature on patients' perspectives of the doctor–patient relationship, Ridd et al. (2009) concluded that the depth of the doctor–patient relationship depends on four foundations – trust, loyalty, regard and mutual knowledge – developed through consultation experiences and longitudinal care. However, some doctors do not have the interest or ability to engage deeply with their patients, and lack of time can be a barrier to asking about patients' lives or reflecting on the therapeutic relationship (Davidsen, 2009; Davidsen and Reventlow, 2011).

Cancer hits human beings in their physical existence, throwing them out of their ordinary lives and into health care. Fear, stigma and uncertainty about prognosis and treatment add even more emotion to the doctor–patient interaction than usual (Arora, 2003). The feeling of 'being known', of having made some form of human connection, of being recognized as a unique human being, is a vital experience for people with cancer when meeting their health care providers (Thorne et al., 2005).

Rosser and Maguire (1982) pointed to dilemmas in GPs' relationships with cancer patients from the doctors' perspectives. Their study showed that GPs had a biomedical perspective on medicine, which led to a subordinate status for them in cancer care. At the same time, they stressed their primary obligation to relieve people's suffering, thus they also had a specific role. Still and Todd (1986) found that GPs' attitudes towards their work with terminally ill people revolved around two ideal types: a technically equipped curative agent and a caring doctor, emphasizing palliative and social skills. As a caring doctor, GPs could still be the *primary* doctor. Most GPs integrated both types in their work. Field (1998) reported that GPs' care of dying people contributed significantly to their job satisfaction. Honesty about prognosis was important, but should be adjusted to the needs of patients and their relatives. It was helpful to consult specialist palliative care, but GPs felt that they had the best knowledge of their patients and families, and did not want to lose control of patient care.

In the sociological literature, a sick role (Parsons, 1951) and a dying role (Noyes and Clancy, 1983) of the patient have been compared with a curative role and a caring role of the doctor, respectively. The transition from one role to the other during the course of illness is crucial for both the patient and the doctor. Friedrichsen and Milberg (2006) found that, in breaking bad news to terminally ill patients with cancer, doctors were afraid of losing control of their own feelings and of the reactions of patients and family. The lack of a cure for the patient could cause feelings of guilt and failure in the doctor.

Jackson et al. (2008) found that physicians who integrated both biomedical and psychosocial aspects of care into their professional identity did not view disease progression as a personal failure, and found end-of-life care meaningful.

Aim of the study

In an earlier article (Johansen et al., 2010), we explored how GPs perceived their role in health care for people with cancer. They saw their place as being close to their patients: working as mediators in the health care system, as local ‘handymen’ and as personal companions. The curative and caring aspects of being a doctor seemed to be quite integrated in their daily work, as Still and Todd (1986) also found. The aim of the current study was to explore in depth the experiences of being a GP for people with cancer at different crucial points in the course of the illness.

Methods

The setting of the study was Norwegian primary care, a part of the national public health service. The participating GPs were recruited through a national survey about cancer in general practice. A purposeful sampling was carried out among GPs who in the survey had agreed to an interview and who had taken part in various stages of their patients’ cancer illness, ensuring that the selection included male and female doctors with varying degrees of professional experience from both rural and urban areas. During autumn 2007, 14 of the 16 selected GPs were interviewed; two were omitted for practical reasons. The participants altogether related stories about 18 patients whom they had attended. All these patients already had advanced cancer when diagnosed. Ten patients had died at the time of the interview with their GP, six were receiving palliative care and only two were survivors.

The interviews were conducted by MLJ in the GP’s office. The doctors were encouraged to tell the stories of one or two patients whom they had recently accompanied through a cancer illness, and how they were involved as GPs. To ensure that relevant topics were covered in the dialogue, the interviewer followed an interview guide. Interviews lasted for about an hour, were recorded digitally and transcribed into fluid written Norwegian. Quotes used in this article were translated by MLJ from Norwegian to English, and revised by an English language consultant.

We applied a thematic narrative approach (Riessman, 2008) and focused on relational aspects. Our analysis was mainly aimed at the content to which the stories referred (Riessman, 2008). However, knowledge about common structural elements in storytelling and the typical ways in which stories were told helped our interpretation (Thomas, 2008). According to Labov and Waletzky (1997: 4), narrative is a ‘verbal technique for recapitulating experience’, ‘usually told in answer to some stimulus from outside and to establish some personal interest’ (1997: 29). Labov and Waletzky underline both the performative and the evaluative function of narrative. The evaluation is the part of the story that reveals the attitude of the narrator about the complicating actions – the event sequence, or plot, usually with a crisis or turning point, in the story (Riessman, 2008). Evaluation can be quite hidden, or a direct statement of the narrator about his feelings at

the time (Labov and Waletzky, 1997). In our analysis, looking for complicating actions was useful to identify crucial events in the narratives, and looking for evaluations of such events by the GPs was important to explore values.

The narrative analysis went through several phases. The 14 interviews were re-read as a whole. The interviews altogether contained stories about the GPs' attendance of 18 patients through a cancer illness. For each of these 18 stories, we wrote a synopsis, identifying the protagonists, the crucial events and the challenges, dilemmas or conflicts for the GP. We identified substories within the main stories, which typically dealt with crucial events such as diagnosis, recurrence, recovery, deterioration and death. In addition, the interviews contained other minor stories, often very short ones, about 18 other patients. We also wrote a summary for each of these. In the next step, we compared the 18 main stories with regard to their content, looking for what was at stake for the GPs and for their evaluations, moving back and forth between our synopsis and the interview transcripts. We noted recurrent topics in the stories – considerations, dilemmas, conflicts and values – and in which stories each of these topics was present. Thus, we got a picture of the recurrent topics and how often they occurred. Then we looked for thematic connections between the topics, and finally found that we could group them into three main themes: loyalty; honesty; and shared humanness.

Results

Loyalty

They knew that I was the one who was going to accompany them ... (Dr L)

The GPs expressed a special loyalty towards their patients with advanced cancer, a stance that went beyond normal duties. The existential threat that had hit the patients seemed to move the doctors to reach for the limits possible in their work. Sometimes the GPs did not see the patient or hear from the hospital during the treatment period, and this could be a barrier to the connection between the GP and the patient. Dr L told about a woman receiving palliative cytostatic treatment at the GP's clinic, so they met every week:

We should not lose patients out of our hands simply because they are diagnosed with cancer. I have one of them very much in my hands now; she attends once a week. We get to know each other very well ... And it is very convenient to keep in touch, because I know that, also for her, it will gradually get worse, since she has breast cancer with pronounced metastases to the skeleton, liver and lung, and is weak and frail. I imagine that after we have completed this (cycle), I will accompany her until she is gone, through good and bad. (Dr L)

Dr L expressed a readiness to be at the patient's side whatever would happen, until she died. This availability, devotion and responsibility were, however, possible towards only one or two patients at the same time. Knowing each other and staying in touch were important for the close role that the doctor saw for herself at the end of her patient's life. The interviewees all emphasized the significance of knowing their patients, and not losing contact with them when they received treatment in hospital. Personal knowledge

was particularly emphasized as a precondition for being a good doctor for the patient at the end of life.

In many situations, the GPs' role as mediators in the health care system was challenging and resulted in conflicts of loyalty. An experienced GP, Dr S, related about her patient, a child with a brain tumour, who after some years of illness was judged by specialists to be in a terminal stage. The parents and the local health team were instructed to prepare for the child's death. Dr S disagreed with the experts' judgement. She had known the child all her life, and there was no dramatic change in the child's condition. Dr S discussed the situation with the parents over and over again. Although understanding that her own judgement probably was right, she felt confused:

We had a meeting head-on when I got home. All the involved people were there, and we were supposed to make a good ending for her. I still did not understand anything. This was a very strange experience. In my head, the girl was not terminal. And then we sat there and planned ... The atmosphere was bizarre, very unpleasant. ... This is one of the worst things I have ever experienced. However, when the X-hospital claims something, maybe we bow a little too much to the ground ... It is as if, I feel somehow, yes, I deal with the small things. (Dr S)

This and other stories showed that the GPs were humble about their own expertise – an expertise that combined the longstanding knowledge of the patients with actual knowledge of patients' conditions. This could, in situations of disagreement with hospital colleagues, lead GPs into a situation where they unintentionally abandoned their own professional integrity and thereby also ran the risk of failing their patients.

Honesty

I think it would be wrong if I caused more worries. (Dr K)

Many of the GPs' stories concerned openness about dying. A wish to relieve, instead of augmenting, the pain for the patient was expressed. Informing about the prognosis should not deprive people of hope, but should honestly prepare them for accepting the truth. Several stories emphasized the value of a careful approach to talk about prognosis, dying and death, weighing each word carefully and awaiting the patient's readiness for this. If the GPs sensed that the patient was not ready, they did not introduce the theme. In some stories it was difficult to differentiate who was not ready to talk – the doctor or the patient, or both. However, according to some GPs, there were also silent ways of communicating about prognosis between a doctor and a patient, by means of body language and tone of voice.

Dr L related a story of a patient with incurable liver cancer who restlessly sought complementary and experimental treatments and trials in several countries:

My part, then, was to moderate the expectations for complementary treatment. Make him a little more conscious that tiring himself out with finding other treatment reduced his quality of life for the last period. He seemed not to focus on being at home, calming down and enjoying the time he had left. ... It was a little difficult. One really wants things to take effect and to get

people well. However, the most important thing for now was telling him that he would not get well and that things would not take effect. After all, what they went through was a process of grief, in which maintaining hope was balanced against being deprived of hope – an awkward situation to be in ... (Dr L)

Dr L was clear about her responsibility to stop this patient with incurable cancer from seeking futile treatments, and pointed to the value of spending the limited lifetime left in a meaningful way. The hope of cure had to be abandoned and perhaps replaced by more modest hopes such as being at home with moments of peace of mind, which could open up the process of mentally approaching grief and finality.

A few GPs questioned their own ability to talk openly with patients about dying and death. They felt that they should do it, and regarded it as important, but they experienced that, for some reason, maybe their own fear, the opportunity never appeared:

We never talked about death. Most of the time, we spoke about how she was, about pain and sickness. It was difficult, with her, to approach death. Everything was supposed to be about her looking a little better and feeling a little better. I never talked with her about death. But she had a pastor in, the day before she got worse. (Dr I)

Some of the hardest moments that the doctors related took place in conversations with dying patients who were afraid to die. These talks could take the doctors to the limits of their professional and personal competence, and to the limits of biomedicine. They wanted to help, but were at a loss: 'He was afraid of death. To an extreme degree. An existential crisis; I do not know what to do, how to treat it. No idea' (Dr J).

Shared humanness

Working with the death of patients in their end of life is hard.
It activates my thoughts as well. (Dr A)

Shared humanness was a theme in the stories about GPs searching for a professional identity in the midst of deep emotional experiences with people approaching death. Dr F related about accompanying an elderly woman with cancer of the ovaries. Interweaving the medical and the existential aspects of the patient's suffering was used by many of the GPs in their story-telling. Clinical facts were often not separated from the person who experienced them. Dr F acknowledged the personal loss of abilities for the patient and did his clinical reasoning simultaneously:

She then noticed that she was changing, that she started to forget things. She came here and was a little worried about it. Her husband said that she certainly was not like before. Her handwriting had also changed. She had such a beautiful, old fashioned handwriting with pretty loops, which was now jagged, ugly and had shrunk. She used to write small poems and letters; now she had to give this up. She did not read much either, and was a little unsteady. She was sent to the hospital, suspecting an intracranial spread, which was verified. (Dr F)

While waiting for radiation to her brain, the elderly woman fell badly in her home. She was admitted to hospital and died shortly after. Dr F was comforting the bereaved husband, who also was his patient, by listening. It seemed that the doctor was also comforted by the widower's story, confirming that his patient probably died in the best way – having said goodbye and being touched by a loving hand:

He was very happy that he was there when she died. He held her hand. The day before she died, she had a bright moment, and then they were able to tell each other how much they loved each other and how grateful they were for the life they had had together. He felt that they got to say farewell. (Dr F)

Some of the GPs, such as Dr A, mentioned that their own fear of death could be activated in such situations. Some recounted that patients could come to them with questions about spiritual guidance, especially when patients did not have a relationship with the church. These GPs said that there was an overlap between the doctor and the pastor, both talking with people about hard times in life, but that pastors were rarely called until near the end. When the GPs were confronted with questions of a saliently religious character, they felt outside their professional domain, and preferred to refer the patients to the local pastor. However, advising the patients to consult a pastor was not strange to them. Their impression was that pastoral care was helpful.

Also for the doctors, there was a question of how to say farewell to their patients. In three of the stories, the doctors' holiday was scheduled shortly before the patient's expected death. This situation actualized the ambiguous character of the doctor–patient relationship. On the one hand, the relationship was personal and the doctor was very committed, and, on the other, it was professional and vacations were not adapted to patients' needs, even if these were exceptional patients. The stories revealed that the doctors were ambivalent about going away from their dying patients. They did not explicitly say farewell.

A recurring decision for the GPs was whether or not they should attend the patient's funeral. The tendency was that they considered going if they had a close relationship with the patient and family, especially if they knew the patient privately, which was more common in small places. A busy workday was mentioned as a reason for not going:

We had developed a very close relationship, a mutual relationship of trust, a good doctor–patient relationship over a long time, with frequent contacts. Here, we also mourned, when the patient passed away ... But we did not make it to the funeral. It happens in the middle of office hours and the patients sit in the waiting room anyhow. The schedule was not cleared for this. (Dr F)

After the patient's death it could be difficult to accept that the family gradually distanced again while the GP was still emotionally involved:

It is maybe a little strange when you have been so close to a family, maybe for many weeks visited nearly every day ... And when you meet them in town immediately after (the death), everybody gives a hug. And then you meet them two months later, they greet you and I nod, and then after a year they hardly say hello. It is a little strange. ... They want to be finished with it, of course. ... I am not finished with it ... Everything leaves traces. (Dr S)

Discussion

The GPs in our study were searching to find a professional and self-conscious way of dealing with the existential and social aspects, the life world, of general practice. We think that shared humanness is the existential basis of the doctor–patient relationship and a precondition for empathy. In accordance with the philosophies of E. Levinas and M. Nussbaum, being moved by the vulnerability of another person happens before any cognitive awareness or reflection, for all human beings. Humans would not feel an ethical responsibility for the other without this emotional movement, and doctors would be less alerted (Nortvedt, 2008). Emotional affectivity is significant for both clinical understanding and its moral implications:

To be emotionally affected by the expressions of illness, of bodily weakness and pain, opens up for a medical gaze that both can capture clinical signs of pathology while at the same time being able to care for the human condition of the patient and sick individual. (Nortvedt, 2008: 218)

The strong loyalty and commitment expressed by GPs in our study could be understood on these grounds, as the doctors being moved by the vulnerability and dependency of their seriously ill patients.

Problems arose when loyalty to the patient conflicted with other loyalties: towards the system of health care and the judgement of hospital colleagues. Rosser and Maguire (1982) also described that mediation between patient and specialist was problematic, and that GPs often silenced their own opinions. Balint (1957: 81) called the relationship between GPs and specialists ‘the perpetuation of the teacher–pupil relationship’. Medical students are trained in hospitals, where the research and curing of cancer also takes place. GPs take care of many other things that, compared with saving lives, can seem ‘small’. These include relational and existential issues of great importance in human life, as confirmed by studies of patients’ perspectives (Arborelius and Bremberg, 1992; Epstein and Street, 2011; Kvåle and Bondevik, 2008; Thorne et al., 2005). Within medicine, however, they do not have the same prestige as the more measurable biomedical issues. Rosser and Maguire (1982) concluded that the biomedical perspective on cancer care led to a subordinate status for GPs. We also found, 30 years later, subordination to the opinions of distant clinicians, despite the GPs’ close expert knowledge of their patients’ background and history. This paradox mirrors a hierarchy of medical knowledge, in which doctors’ personal, continual and contextual knowing of patients still is undervalued. Thinking about medicine from a relational perspective, caring for the dying would not be ‘smaller’ than curing cancer.

Medicine lacks a connection between bodily and existential suffering, both in its theoretical foundations and in clinical practice (Agledahl et al., 2010; Daneault et al., 2006). Several of our GPs’ stories revealed that bodily and existential suffering was implicitly seen as connected. As medical education is dominated by the biomedical model, GPs must learn this connection by experiencing it through their practice. For GPs, experience is an ‘acquaintance with particulars’ (McWhinney, 1989) which can lead to clinical wisdom and a deep professionalism. Working close to people’s lives, GPs’ understanding can be transformed, maybe encouraged by movements like patient-centred medicine. Thus, primary care at its best has both a practice and an implicit understanding of

wholeness which is not contained in the biomedical model. Regarding the discipline's self-consciousness, our study suggests that the explicit formulation and acknowledgement of this aspect is as weak as decades back.

Connecting bodily and existential suffering has practical implications in cancer care. Physical suffering like strong pain is associated with fear and anxiety in people with cancer. Ensuring optimal physical care can alleviate fear. Bourdieu (1999) emphasized that the distress of illness and dying is only partly caused by resistance to disease; suffering also comes from the embodied experience of a particular social location, such as a hospital or nursing home, so-called 'site-effects'. Kellehear (2009) points out that distress often lies *outside* the person, in the loss of control and a sense of disintegration in the hands of others. These site-effects and the loss of self contribute to existential suffering and the 'awfulness' of the patient's experience (Lethborg et al., 2008). By reaching for the limits in their work and making it possible for people to die at home, the GPs aimed at positive site-effects and less losses for their patients.

The patient's fear of death was the most difficult situation. The GPs often felt helpless, and their own fear of death could be triggered. The value of listening, taking worries seriously and being a fellow human being were stressed by several GPs. Being present and looking into the patient's eyes can be helpful for the dying person, but hard for the doctor (Heath, 2008; Suchman and Matthews, 1988). MacLeod (2001) asked doctors how they learned to care for people who were dying, and found that they learned from the dying people themselves, through deep emotional experiences. Such experiences could mean to be emotionally shaken, as there were many examples of in our stories. Without these shaking incidents, a few of them beyond the GPs' professional mastering, they might lack the material for personal and professional development through reflection and supervision. It is possible to be trained to deal with even the most challenging dialogues. Learning to sit on a death bed could be as important for a doctor as learning resuscitation.

The GPs reflected about honesty, and many had a clear strategy of how to break bad news hopefully. For some of the patients in the stories, hope was connected to the possibility of a miracle. The belief in such a miracle could be so strong that talking about the more probable outcome was complicated. However, recognizing the probability of death could, according to some GPs, open up the end of life for something other than the struggle to survive. We think that honesty about an approaching death would demand personal courage from the doctor, the patient and the family and mutual trust between them. If this atmosphere is lacking at the end of life, the patient's suffering could be prolonged by futile treatments, causing emotional distress for all involved and high financial costs for society. To attain honesty, the limits of the biomedical approach of mastering human nature through interventions would have to be acknowledged and the fundamental uncertainty and finiteness of human life appraised.

The ambivalence that some GPs expressed around saying farewell to their dying patients mirrors the complexity of the doctor-patient relationship. Births and deaths are events that call for open display of emotions among doctor, patient and family (Vafiadis, 2001), requiring both a presence and professional distance. Saying goodbye makes it possible for the doctor to value the relationship with a particular patient, and for the patient to say thank-you to the doctor, leaving them both feeling appreciated (Back et al.,

2005). Patients and their relatives felt abandoned when their doctors disappeared without a farewell, whereas physicians experienced that the doctor–patient relationship lacked closure (Back et al., 2009). Attending the funeral of a longstanding patient can be a gesture of acknowledgement, compassion and support (Arroll and Falloon, 2007) and can provide resolution for the doctor's own feelings (Irvine, 1985). A condolence letter, telephone call or family conference after the patient's death can also serve as mutual closure (Irvine, 1985; Tolle et al., 1984). A worthy closure acknowledges that being doctor for people at the end of life is both a professional and a personal commitment, far from a small thing.

Discussion of method

The patients' or carers' voices are not directly heard in this study. They might have told other stories and questioned their GPs' values. Many people lack a good relationship with their GP. The sampling, although done purposefully, resulted in a predominance of rural practitioners, relating about patients with incurable disease. The interviewees probably have an above-average involvement in the care of people with advanced cancer. Their stories still point specifically to the possibilities of developing palliative cancer care in general practice, describing GPs in search for a professional identity embracing the existential aspects of being a doctor.

Asking for stories was a pragmatic way of keeping the GPs close to the original experience of having cared for this special patient over time, without having to observe or record it all the way. Other studies solved this by asking GPs to write stories about their cancer patients (Aiach et al., 1990), or to write stories about patients with pain (Vegni et al., 2005). We are ourselves GPs, with the same kind of professional experience as the interviewees. Exploring aspects of our own discipline means that we are predisposed by our professional socialization. This could lead to a more open dialogue and to deeper insights, but also blind spots, lack of distance and the danger of idealizing.

Implications

The GPs' stories included professional ideals and aspirations, but also the everyday struggles to reach them or to fail them. They drew on meta-narratives about what it means to be a good physician (Braunack-Mayer, 2005; Jordens and Little, 2004; Pellegrino and Thomasma, 1993). Sharing their narratives could aid the construction of a more conscious and strong professional identity. Reflecting upon the existential depth and weight of their experiences could create a basis for personal and professional learning and development. This could be done in supervision groups, such as those of the Balints.

The theory of medicine has its predominant contribution from the natural sciences. For general practice, the human and social sciences are also highly relevant (Bourdieu, 1999; Hunter, 1991; Nortvedt, 2008; Pellegrino, 1979) but their potential contribution to medical theory is not fully taken into academic consideration. GPs may learn from being with their patients that bodily and existential suffering (and enjoyment) are connected, and thus learn implicitly not to be trapped in body–mind dualism. This practical

wisdom, which has been known within medicine since its origins, so far lacks an explicit anchoring in modern clinical thinking. This is not only a problem in medicine. Taylor et al. (2011) state that as a culture, we are entrenched in the mind–body dualism. As a profession, general practice consists both of its certain practice, and the reflection and theory – biomedicine included – that guides this practice (Rudebeck, 1991). There is the potential for theory to be informed by reflection on practice (Schön, 1991). Therefore we believe that general practice has the potential, in approaching the discourses of human sciences, to make a decisive theoretical contribution to medicine as a whole.

Acknowledgements

Profound gratitude is extended to participating GPs and to all colleagues who have read, discussed and commented during the research and writing process.

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