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ORIGINAL ARTICLE

How to deal with a crying patient? A study from a primary care setting in Croatia, using the 'critical incident technique'

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Abstract

Background: Expression of strong emotions by patients is not a rare event in medical practice, however, there are few studies describing general practitioner (GP) communication with a crying patient. *Objective:* The aim of this study was to describe GP behaviour with a patient who cries in a family practice setting. *Methods:* A semi-qualitative study was conducted on 127 Croatian GP trainees, 83.5% female, and 16.5% male. The study method used was the 'critical incident technique.' GP trainees described their recent experience with patients who cried in front of them. Textual data were explored inductively using content analysis to generate categories and explanations. *Results:* All 127 (100.0%) GP trainees initially let patients cry, giving them verbal (81.9%) and/or nonverbal support (25.9%). GP trainees (69.3%) encouraged their patients to verbalize and to describe the problem. Most GP trainees (87.4%) tried to establish mutual problem understanding. Approximately half of the GP trainees (55.1%) made a joint management plan. A minor group (14.2%) tried to maintain contact with the patient by arranging follow-up appointments. The vast majority of GP trainees shared their patient's emotion of sadness (92.9%). Some GP trainees were caught unaware or unprepared for patient's crying and reacted awkwardly (4.7%), some were indifferent (3.9%) or even felt guilty (3.1%).

Conclusion: GP trainees' patterns of communication with crying patients can be described in five steps: (a) let the patient cry; (b) verbalization of emotions and facilitation to express the problem; (c) mutual understanding and solution finding; (d) evaluation—maintaining contact; and (e) personal experience of great emotional effort.

Key words: *Family practice, communication, crying patients*

Introduction

Good and effective communication is essential for the provision of high quality medical care (1). Professional conversation between patients and physicians shapes diagnosis, indicates therapy and establishes a caring relationship. The degree to which these activities are successful depends, in large part, on the communication and interpersonal skills of the physician (2). Unfortunately, physician-patient communication has frequently been judged to be inadequate (3). According to McBride, patients considered communication to be one of the top three competencies a physician should possess, yet they frequently rated their own physician's communication skills as unsatisfactory (4).

In the physician-patient relationship, the communication of expert knowledge and emotion is central (5). Dealing with patients' intense negative emotions is one of the physician's most difficult responsibilities in medical practice. If those emotions are expected, as in situations when physicians must deliver bad news, physicians can at least prepare themselves and follow an established practical model using the mnemonic 'ABCDE' (Advance preparation—Building

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the therapeutic relationship—Communicating well—Dealing with patient and family reaction—Encouraging or validating emotions) (6).

An even more difficult duty for the physician is the situation when strong emotions, like crying, are not expected. Many studies have described patient's crying as a part of psychiatric and neurological disorders (7–12), or among cancer patients in palliative care (13,14). Furthermore, there is growing evidence that people cry more in hospitals and medical practices than in public places, so it could hardly be expected for any physician to go through his or her professional career without seeing such a patient (15). In spite of this, medical school offers little formal training in how to deal with crying patients, while communication skills are considered a minor professional ability (6). Furthermore, only a few studies were found describing patients crying in a GP setting, and these focused more on physician/patient emotions, without describing any model or pattern of physicians' behaviour with such patients (16–18).

The aim of this study was to describe GP trainees' pattern of behaviour in communication with a crying patient.

Methods

Sample

Owing to the semi-qualitative nature of the study and the intention to maximize the richness of information obtained pertaining to the research question, subjects were selected purposefully and not randomly (19). Croatian GP trainees who participated in the Postgraduate Course for Family Medicine Trainees, at the Medical School of Zagreb University, particularly within the educational module 'Difficult communication' were chosen. The recruitment and the study were carried out before the educational module started. Out of 136 GP trainees, 128 signed an agreement of participation and 8 refused because of the sensitivity of the subject. One GP trainee was excluded because he described his attitude and not a real event (incident) with a crying patient. Out of 127 GP trainees, 106 (83.5%) were female, and 21 (16.5%) were male. The average working experience was 13 years, ranging from four months to 33 years.

Study method

This study is semi-qualitative, and the method used is the 'critical incident technique.' According to Flanagan, a critical incident is a real event the participant has experienced in the past (20). As Patton said: 'importance of a real event is based on the notion that if it happened once it could happen again' (21). At the beginning of the course participants were asked by the course director to describe precisely, in written form, a real, recently experienced event with 1 crying patient, answering the following questions: Who was the patient and what was his/her reason for crying? What was your first, initial reaction when the patient started to cry? What did you do next—explain your behaviour step by step? How did you feel—explain your feeling? To achieve data richness and avoid researcher influence, the participants were completely free to choose which of their recent experiences with patients who cried in front of them they are going to describe. All participants were given the questionnaire with the open-ended questions listed above and blank spaces to fill them. Furthermore, every participant stated her/his sex, age, and working experience. Anonymity was guaranteed. Time left to fill out the questionnaire was limited to 30 min.

Data analysis

Three researchers performed the first analysis by reading the written description of the crying patient independently and coding text fragments or words to build a codebook. The coding process was guided by the research questions. Textual data were, as described by Pope et al., typically explored inductively using content analysis to generate categories and explanations (22). In the first stage a code was attached to words or text fragments, in the second stage codes were categorized to create themes and sub themes, all leading to an explanation. At the end, all the three authors sought agreement by reading together each case and arguing whether all data had been extracted and categorized. The analyses resulted in five major explanatory model themes of the GP trainees' behaviour in communication with the crying patient. Frequencies of categories were also calculated, so the study is semi-qualitative.

Results

Patient characteristics

Out of 127 described crying patients, 105 were female (82.7%), and 22 were male (17.3%). All patients were adults and well known to the GP trainees.

Causes of crying

As shown in Table I, patients mostly cried because of: malignant disease (37.8%), family problems (22.0%), death of someone close (18.1%), chronic diseases (13.4%), other reasons (acute illness, trauma, loneliness) (5.5%), and social reasons (poverty) (3.1%).

Table I. Reasons for patients crying.

Reasons for patients crying	Male (n = 22)	Female (n = 105)	All (n = 127)
Malignant disease	8	40	48 (37.8%)
Family problems	3	25	28 (22.2%)
Death of close person	2	21	23 (18.1%)
Chronic or incurable disease	3	14	17 (13.4%)
Other problem	4	3	7 (5.5%)
Social problem	1	3	4 (3.1%)

Patterns of GP trainees' behaviour

Five major themes and explanatory models of GP trainees behaviour emerged from the data (Table II): let the patient cry, support and verbalization of emotions to express the problem, mutual understanding and solution finding, evaluation—maintain contact, and GP trainees emotions.

(a) Let the patient cry. Letting the patients cry was the initial reaction of all of 127 GP trainees (100.0 %). It was combined with verbal (81.9%) and/or nonverbal (25.9%) support, defined in the written descriptions:

'I sat on the bed next to her, put my hand on her shoulder, and let her cry….' (Female GP trainee, 30 years old.)

'I gave her a paper tissue, put my hand on her shoulder, stayed with her in silence….' (Male GP trainee, 43 years old.)

'I moved my chair closer to hers, took her hand in mine and patiently waited for her to weep herself out....' (Female GP trainee, 26 years old.)

'I didn't say anything, just moved my stool closer, leaned forward, looked at him with compassion and let him cry.' (Female GP trainee, 48 years old.)

Some GP trainees even cried with the patient (7.9%). They said:

'My first reaction to seeing terrible sadness on her face was words of compassion, after which we both burst into tears....' (Female GP trainee, 39 years old.)

'I cried with her, telling her at the same time, that all the things she had done for her husband had been correct. But his disease was stronger than all of us….' (Female GP trainee, 45 years old.)

'When I saw that young lady, dying from cancer, and her two small children in the room next to hers, looking so innocent, I started to cry with her....' (Female GP trainee, 42 years old.)

(b) Verbalization of emotions and facilitation to express the problem. In subsequent reactions, understanding of the problem and its verbalization (e.g. expression of patient's emotions and facilitation of the discussion) was performed by 88 GP trainees (69.3%), which can be seen from the following descriptions:

'After that she started to talk. I didn't say a word but listened and listened and listened….' (Female GP trainee, 43 years old.)

'I embraced her, and then very slowly, she started to talk. Holding her hand, nodding my head from time to time, I listened to her sad story….' (Female GP trainee, 39 years old.)

'… and when she stopped crying, I asked her to speak, nodding my head, touching her hand from time to time …' (Female GP trainee, 30 years old.)

'I tried, in a gentle and calming manner, to find out as much as I could about her recently diagnosed disease….' (Male GP trainee, 28 years old.)

Only 4 GP trainees (3.1%) distanced themselves from the patient's problem, describing their behaviour:

'I didn't want to hear any detail and reasons for her crying. While listening to her, I was writing notes in her medical record, and let her talk and cry, and when I finished writing, I tried to stop her by asking some questions about her son and neighbours. She finally stopped crying and I felt relieved.' (Male GP trainee, 34 years old.)

(c) Mutual understanding and solution finding. 111 (86.7%) GP trainees tried to establish

Table II. Pattern of GP trainees' communication with crying patients.

(a) Let the patients cry
(b) Verbalization of emotions and facilitation in order to express the problem
(c) Mutual understanding and solution finding
(d) Evaluation—maintaining the contact
(e) GP trainees' experience of great emotional labour

mutual understanding of the problem and 70 GP trainees (55.1%) tried to find solutions and make plans for future actions. They said:

'We also agreed to discuss the problem with her husband to support her. We arranged a new appointment in a week's time to check if everything was going as planned and to see her husband's reaction.' (Female GP trainee, 29 years old.)

'When he calmed down I asked him if I could help him in any way. He told me that if I made a house visit and talked with his wife, maybe she would cooperate more in treating her illness. We arranged a house visit for the following day….' (Female GP trainee, 36 years old.)

'… and after that I explained what medical checkups she had to undertake and what treating procedures she could expect….' (Male GP trainee, 29 years old.)

As a part of management plan, 32 GP trainees (25.2%) performed clinical procedures (examination, referring for diagnostic procedures, or referrals). They said:

'After our conversation, I measured his blood pressure and examined his heart and lungs. I explained to him the nature of his disease and made a plan for lab tests. To his question about the necessity of taking these tests I advised him to do so.' (Male GP trainee, 48 years old.)

'When she told me about her fears that cancer had already spread in her body, I examined her nodules and referred her to have a body scan. I hoped she didn't realize how afraid I also was….' (Male GP trainee, 25 years old.)

(d) Maintaining contact. 18 GP trainees (14.2%) tried to keep in touch with their patients, by making appointments for follow up consultations, explaining their decisions as follows:

'I understood how difficult her situation was with her depressed husband who had not gone out for the whole month after his mother's death, and realized how helpless she was. So, I told her that we could try to solve that problem together; I could either make a house call or she might bring him to the practice. She thought a house call would be better to start with. I agreed. I made a house call the following morning. It was hard, but in the end we arranged the next appointment in my practice….' (Male GP trainee, 31 years old.)

'I realized that I had to offer her some hope. I talked about new ways of treating her malignant disease and told her I would always be there whenever she needed me. We made a new appointment for the following week, I advised her to write down whatever concerned her so that we could discuss it….' (Female GP trainee, 38 years old.)

(e) GP trainees' experience of great emotional labour (Table III). It was an uncomfortable consultation for all the participating GP trainees. Descriptions of their feelings support that conclusion:

'When the lady finally calmed down and went home, I was completely drained out, exhausted and blank. I said to my self—God, it was a really hard thing to do!' (Female GP trainee, 43 years old.)

'I was confused, uncertain and sad ...' (Male GP trainee, 40 years old.)

'It was so difficult for me, but I didn't cry. My palms were sweating, I felt hot in my head, but at the same time I was saying words of compassion to that old man....' (Female GP trainee, 46 years old.)

Most GP trainees (118 or 92.9%) experienced the same feelings of sadness as the patients. They said:

'I felt so sorry for that old granny who lived alone in that house even though she had children and grandchildren.' (Female GP trainee, 46 years old.)

'I felt so bad and unpleasant, my palms were sweaty, I had a lump in my throat and wanted to run away and be somewhere else….' (Female GP trainee, 25 years old.)

Table III. GP trainees' emotions regarding a crying patient.

GP trainees' emotions	Male (n = 21)	Female (n = 106)	All (n = 127)
Shared the same feelings with patient	15	103	118 (92.2%)
Surprised and confused	1	5	6 (4.7%)
Indifferent	4	1	5 (3.9%)
Guilty	2	2	4 (3.1%)

Six GP trainees (4.7%) were caught unawares or felt unprepared for patients' crying and admitted to have reacted awkwardly in a way that he/she:

> 'Was completely disorientated and confused … I talked about weather and breakfast....' (Male GP trainee, 29 years old.)

> 'Didn't know what to do. I continued to write something. Time was passing so slowly, too slowly, my cheeks were red….' (Male GP trainee, 31 years old.)

Four GP trainees (3.1%) even felt guilty about the patient crying, describing:

> 'I never felt more awkward in my practice, and I could not help feeling guilty for not having sent this patient to get examined earlier. It was too late now, cancer has begun to spread and her tearful eyes asked desperately for my help.' (Male GP trainee, 27 years old.)

However, a few of the GP trainees (3.9%) did not have empathic feelings. There were almost indifferent to patient's suffering:

> 'I was indifferent to her crying but pretended to be listening to her, and said something about hope.' (Male GP trainee, 40 years old.)

> 'I think it was unnecessary for her to cry in my practice. Nothing changed after that in her life!' (Female GP trainee, 33 years old.)

Discussion

Main findings

Patients in this study mostly cried because of a malignant disease (their own or of someone close), family problems, and the death of someone close, chronic disease, or social reasons.

Since the GP trainees were imbued with strong emotions when patients started to cry, they reacted primarily as human beings and let patients cry in peace, providing verbal and nonverbal support, assuming that crying had therapeutic value.

Even though the emotion of sadness did not disappear completely, it gradually abated enough so that the patient eventually stopped crying. At that point, GP trainees, keeping their own emotions under control, started to act as medical experts, supporting and encouraging patients to verbalize their problem. GP trainees helped patients to express their emotional status and to talk about their problems. This conversation had simultaneously both a therapeutic and a diagnostic effect. After reciprocal understanding was obtained, GP trainees tried to involve patients in planning possible future actions.

For all the participating GP trainees, it was an uncomfortable consultation. Most GP trainees experienced the same feelings of sadness as the patients, some were caught unawares or felt unprepared for patients' crying and admitted to have reacted awkwardly, or even felt guilty about the patient crying. Only a few of the GP trainees did not have empathic feelings and were almost indifferent to patient's suffering.

Patient-doctor relationship

As in other studies, in this study, women cried more often than men (82.7%) (16, 23–25). In addition, Williams et al., pointed out that the leading causes of crying were the death of a close person and break-up of relationships (16).

Although in this study GP trainees did not expect in advance patients' strong emotions, most of them acted very similar to the previously mentioned established mnemonic ABCDE model (except its first step—advance preparation). Most of them tried to build the therapeutic relationship, communicated well, dealt with patient and family reaction, and encouraged/validated emotions) (6).

All of GP trainees in this study initially let the patients cry assuming that crying had therapeutic value. Indeed, Frey proposed a theory that people feel better after crying due to the elimination of hormones associated with stress, specifically adrenocorticotropic hormone (26). Some of the GP trainees in this study even cried in front of the patients. Physician's identification and bonding with patient's suffering were also the findings of a Swiss study (27). In addition, other studies also stressed the importance of physician's acting not only as medical experts, but also as empathic human beings (28).

Professional behaviour

Verbalization of patient's emotions and facilitation to express the problem were subsequent reactions by most of GP trainees in this study. As Nyman said, defining and clearing the problem is important because it is uncertainty that is intolerable and produces much of anxiety and misery. The creation of warm empathy by showing understanding and giving support provides an atmosphere for open ventilation of feelings and, ultimately, enables the patient to relax (17).

According to Pendleton, the desired outcome of a consultation is mutual understanding of the problem (29). To achieve that, a patient-centred approach is required, emphasizing the patient's life situation,

ideas, expectations and feelings (30). Partnership is what patients expect from a satisfactory consultation; they want to be taken seriously by the doctor, to have time for an informative dialogue, and to achieve an ongoing relationship with the doctor (18,31). This is exactly what most of GP trainees from this study offered to their crying patients trying to establish the mutual understanding of the problem, as well to find solutions and make plans for future actions.

Defensive behaviour

However, it is interesting to note that some GP trainees in this study acted as typical clinicians, performing clinical examinations, even referring patients for diagnostic tests. It could be understood as some kind of self-defence against difficult emotions, the patient's and/or their own. The behaviour seen in this study of distancing themselves from the patients could be also understood as a defensive reaction. However, we were surprised that only few GP trainees tried to stay in contact with patients by arranging follow-up appointments. The notion that male GP trainees were more inclined to exhibit defensive behaviour should be carefully examined in other studies. In a study of emotional self awareness in medical students, Roter et al., found that female students demonstrated increased communication proficiency in the verbal domain and enhanced emphatic abilities as well as awareness of patients' and their own emotions (5).

Strengths and limitations

This is a semi-qualitative study whose aim was to describe the GPs' pattern of behaviour in communication with a crying patient. This study offers a new insight into a current approach of communication with a crying patient, particularly in GP's practice.

This study has some limitations. Since GP trainees from the study were participants of the educational module 'Difficult communication', it could mean that they were more interested in this topic than other GPs and/or felt inadequate in communicating in difficult situations. In addition, human behaviour, including professional behaviour, is deeply dependent on the cultural context. The results of this study should not be generalized nor taken to typify other physicians' attitudes, and should only be transferred with care to culturally different situations because the study was performed with a group in single, 'culturally' specific setting (32). Furthermore, the fact that the participants' average working experience was 13 years, which means that many of them were young, could have had an important influence on the results. Steinmetz and Tabenkin concluded that the older and more experienced the doctors are, the fewer difficult patients they testify to having (33). Another limitation on the potential to generalize our findings is the fact that the participants were mainly women: it is known that the physician's characteristics play an important role in the perception of difficult patients (34).

Implications

Consultations with crying patients were perceived as emotionally difficult. It represents a type of consultation that can be defined by: 'I was completely drained out, exhausted and blank', and therefore, demands a great deal of emotional effort (35). The attempt to avoid such emotional effort could be seen in the GP trainees' behaviour in this study. Only 14% of GP trainees made an appointment for a follow-up consultation. Unless appropriately supported and managed, emotional effort may lead to occupational stress and ultimately to burnout (36), which is not rare among GPs (37). As other studies suggest, our study also points out that the topic of dealing with the emotion of sadness and crying should be dealt with in the GP training programme or during continuing professional development (17,24,25,38). Furthermore, because physician's dealing with patients' intense negative emotions remains a major problem area, more studies are needed to assess other various aspects of physician-patient communication—enhancing interventions (i.e. influence of different sociodemographic factors (physicians/patients age and gender) on attitude and behaviour patterns of physician–patient communication).

Conclusion

GP trainees' patterns of communication with crying patients can be described in five steps: (a) let the patient cry; (b) verbalization of emotions and facilitation to express the problem; (c) mutual understanding and solution finding; (d) evaluation—maintaining contact; and (e) personal experience of great emotional effort.

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