Lonely patients in general practice: a call for revealing GPs' emotions? A qualitative study

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Background. Loneliness is a universal phenomenon that influences one’s health and health perception. GPs are confronted with lonely people quite often. Yet, what GPs think of this phenomenon and how they deal with emotions lonely patients evoke is not known.

Objective. We aimed to explore GPs’ experiences with lonely patients. We wanted to gain insight in GPs’ feelings regarding consultations with lonely patients and potential resulting behaviour from these feelings.

Methods. We performed a qualitative study based on semi-structured interviews. We interviewed 20 Dutch GPs. Transcripts were analysed according to a grounded theory-like method in order to bring to surface key concepts and relations between them.

Results. GPs considered loneliness as something subjective, a feeling. They found it relevant to know whether their patients were lonely. However, they had difficulty defining their task and experienced a lack of therapeutic options. Beside feelings of pity and interest, lonely patients could evoke feelings of frustration and powerlessness. These feelings were more pronounced when patients were chronically lonely and could cause GPs to spend less time on these patients or refer them more often. GPs did not constructively use their own emotions during consultation.

Conclusions. When confronted with lonely patients, a helpful distinction could be made between transitory and chronic loneliness. Chronically lonely patients are more likely to evoke negative feelings and behaviour in their GPs. GPs should try to recognize these emotions and make sure they do not harmfully influence consultation.

Keywords. General practice, loneliness, psychosocial, qualitative research.

Introduction

Every human being has the need to be seen, to be heard and to be touched. During one’s whole life, people need others to confirm and value their existence. The nature of this need differs for each person and it changes during phases of one’s life. It seems inevitable that at some point, a discrepancy develops between the desired relationships and the actually perceived relationships. This perceived lack of contact can cause negative unhappy feelings. This phenomenon is known as loneliness.1-3

One-third (32%) of the Dutch population of ≥55 years were found to be lonely and as much as 4% suffered from severe loneliness.4 Literature describes different types and appearances of loneliness in people (and not only in the elderly) and its possible negative effects on mental, psychosocial and physical health. However, a prototype of a lonely patient does not exist.1,3

In The Netherlands, as well as in other western societies, the GP seems to be a person who is confronted with people’s loneliness quite often. For patients, the GP is easily accessible and seeking help from a GP is relatively free from social stigma.5 Additionally, the understanding of patients’ psychosocial context, feelings, behaviour and cognitions is high on the GP’s agenda. It facilitates the long-term relationship with
patients, improves meaningful therapeutic actions and thereby attributes to GPs’ work satisfaction. However, involvement in this area when there is a problem can be difficult. Patients with mental health problems induce more time-consuming consultations, which increases the perceived burden of GPs. Next to this, lonely people in particular tend to consult their GP about twice as often as non-lonely people.

Consultations with difficult patients, which could refer to both the problem as well as the frequency or intensity of the consultations, puts GPs at risk of being personally affected in an adverse manner, which is known to lead to (compassion) fatigue and burnout. Especially, unexamined emotions may lead to distress, disengagement, burnout and poor judgement in doctors.

Little is known on how patients’ loneliness affects GPs in their work. Our hypothesis is that lonely patients evoke emotional and behavioural reactions in GPs. As far as we know, no research has been done on this topic. Therefore, we performed an exploratory study. We wanted to explore GPs’ perception of the phenomenon loneliness in general practice and gain insight in GPs’ emotions and consequential behaviour resulting from interaction with lonely people.

Methods

We chose to perform individual interviews in order to explore this topic since we wanted to create a convenient and safe environment for GPs. A total number of 89 GPs in both rural and urban areas were invited by letter to participate in this study. Participation was on a voluntary basis. The sample originated from a database of practitioners related to Maastricht University, The Netherlands. GPs had the option to contact the first author by telephone for further questions and for confirming participation. A week after sending the invitation, the first author started contacting each practice by telephone and asked whether the GP wanted to participate. After 2 weeks, all GPs except those who were on holiday were reached and a number of 20 GPs agreed to take part (see Table 1). A lack of time was the most common reason why GPs did not participate.

We developed an interview schedule based on literature research and four pilot interviews. Three GPs and one medical student participated in the pilot interviews. We adjusted the topic list after the interviews when GPs brought up new relevant themes. The interview schedule consisted of a range of open and closed questions covering three topics: GPs’ view on loneliness in general practice, GPs’ feelings evoked by consultations with lonely people and questions about improving care for lonely patients (see Table 2). For this manuscript, we focused on the first two main topics.

Each interview was held by the same researcher (JZ) at the GP’s surgery. We audio taped each interview with the GP’s permission. Field notes were taken during and directly after the interview. The taped interviews were anonymized and transcribed verbatim (JZ). We did not perform a member-checking procedure since talking on the subject already could have changed the GPs’ opinion and/or reflection on their experiences. Asking them to confirm the transcripts for truthfulness would suggest the presence of an absolute fixed truth, which is not what we are aiming at.

Two researchers (JZ and MA) coded the interviews individually and discussed these codes until agreement was reached. Open coding was used, and eventually, much overlap was present between codes and interview guide. Codes were added or changed if relevant. We made use of N-VIVO to manage and arrange the coded data. Then, we used a grounded theory-like approach in order to identify the key concepts that GPs held on the topics and to bring to surface patterns in the data and/or relationships between concepts. Focus was put on the first descriptive part, which was done by inductively analysing the data. Comparison between codes, categories and themes was done deductively and resulted in a description of relations between key concepts, which enriched our findings. Since the level of analysis did not include development of a more general analytical framework, a modified grounded theory approach was performed.

Results

Interviews lasted on average 26 min (ranging from 16 to 40 min). We achieved data saturation after conducting 20 individual interviews: the final three GPs who were interviewed did not bring up any relevant concepts that were not already mentioned. We will report the most relevant findings based on the GPs’ statements, categorized according to the following categories: GPs’ definition and perception of the phenomenon loneliness, loneliness in daily practice and GPs’ emotions and behaviour (see Table 3). Wherever ‘he or him’ is written could be interpreted as ‘she or her’.

**GPs’ definition and perception of the phenomenon loneliness**

Initially, many GPs had difficulty describing the phenomenon loneliness. Some of these GPs first put an emphasis on social isolation and developed their definition throughout the interview.

I think it [loneliness] is a lack of communication with other people. ( . . . )

Although one could be lonely while being surrounded by a hundred people, don’t you think?
And then you could wonder: What is the definition of loneliness? I think everybody is lonely once in a while, right? [Q1]

Most of the GPs eventually came to the conclusion that loneliness is subjective: a feeling or an emotion. Lonely people are unhappy due to a lack in the number and/or quality of relationships. Despite the emphasis on the grief that comes with loneliness, some thought that loneliness was a physiological phenomenon, like the process of ageing. Elderly face the loss of dear people and experience physical and mental degeneration. This could lead to a withdrawal from the life they used to live.

Once you’re 92 years old, I would expect that at some point, your world becomes smaller. And loneliness will be a part of it, I guess. (…) It shouldn’t get out of hand, but I think you will retreat from the world. (…) You will no longer feel the need to hang around in a soccer-canteen saying: ‘Joy! The favourite team has won again!’ [Q1]

If elderly cannot accept this ‘physiological withdrawal’, less effective social skills (to enter new friendships) and a potential generation gap could make it harder to overcome loneliness. Moreover, due to the changed position of family in contemporary society, parents no longer seem to come first. GPs frequently mentioned the lack of children’s interest in their parents’ well-being.

For the younger generations, the quality and character of social interactions changes due to increased mobility, a more individualistic mindset and the macho behaviour people propagate. People rather brag to each other instead of revealing their vulnerable sides. These aspects of the society eventually make both generations prone to loneliness.

Society, as it is right now, partly causes it [loneliness], right? Superficial contact, small social networks … in this neighbourhood too, you see that people not originated here (…) feel lonely. [Q10]

During the interviews, GPs spoke about different types of loneliness and explored causes for it.

One GP said that loneliness is a situation in which there is a lack of stimuli. According to him, every human being has the need to be stimulated; people need these incentives in order to live. The intensity and appearance of these essential stimuli differ for each person. In case of loneliness, people suffer by a lack of stimuli.

It [a stimulus] can be anything. It can be something personal; stimuli by other people, or interaction with others. It could be represented by the ideas you have about people, right? For example, when you like or even love someone, you can pass your time with having pleasant thoughts on that. But it can be anything, I guess. Some people need a lot of stimuli and easily feel lonely when there are little, others find it comfortable if there aren’t many. [Q6]
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Section 2 Emotions

behaviour towards people in their environment by factors. They described people who show off-putting personality and coping strategies important causing external features. Most of the GPs considered one's loneliness were put down to both patients' internal and external environment, for example moving or seeking for asylum, who is oppressed by her husband. A change of environment, for example concerning personal loss, could warranting good quality care in case of illness. It could be relevant when dealing with frequent attenders, referring adequately to secondary care and substance abuse. Furthermore, loneliness would decrease the likelihood of success when treating a psychiatric disorder. Also, knowing that someone is lonely could put his somatic complaints in perspective. It could be relevant when dealing with frequent attenders, referring adequately to secondary care and warranting good quality care in case of illness.

Why are people lonely? It has something to do with the incapacity, or the lack of coping mechanisms to deal with your own problems. Because sometimes, people are doing well initially, but they suddenly become lonely after having gone through something. [Q8]

I know a woman who is terribly lonely, but this is also due to her own behaviour. She is [GP laughs] a horrible person, to be frank. Everyone is repelled by her. (…) She made herself lonely. [Q9]

Putting it together, loneliness was seen as something subjective, a feeling, which could change over time or remain present, often depending on external factors (e.g. life events) and personality traits (e.g. coping strategies).

Loneliness in daily practice

Most GPs found it relevant to know whether or not their patient was lonely. This relevance was mainly based on the ambition for ‘best practice’. First of all, one should care because the patient is obviously suffering. Moreover, GPs reported that it is an important determinant of someone’s (perceived) health. It was seen as a risk factor for psychiatric disorders and substance abuse. Furthermore, loneliness would decrease the likelihood of success when treating a psychiatric disorder. Also, knowing that someone is lonely could put his somatic complaints in perspective. It could be relevant when dealing with frequent attenders, referring adequately to secondary care and warranting good quality care in case of illness.

Of course, the most important relevance is the humane relevance. Being someone’s GP, you don’t want anybody to be lonely. I think you are better off having pneumonia than being lonely. [Q6]

People tend to feel off when they experience loneliness. Then, they try to find a way out through physical problems that were present anyway, although it is not really a solution to their problems. But of course it influences the image one has of his illness and the severity of his ailments. [Q6]

Although GPs considered loneliness a relevant phenomenon in general practice, they find it hard to define their task when confronted with loners. Because

Also, another type of loneliness is the one that exists within close relationships. This could be an adolescent who feels distanced from his family or a woman who is oppressed by her husband. A change of environment, for example moving or seeking for asylum, was also mentioned as a trigger for people to become lonely.

One can experience loneliness within a relationship as well, isn’t it? (…) You could have the feeling you cannot develop yourself in your relationship, or you feel repressed. (…) If that lasts long enough, you will start feeling lonely. [Q18]

Other potential causes for the development of loneliness were put down to both patients' internal and external features. Most of the GPs considered one’s personality and coping strategies important causing factors. They described people who show off-putting behaviour towards people in their environment by being cold, unfriendly and complaining. As a result, people end up alone, receiving little feedback on their personal behaviour, completing the vicious circle and remaining lonely. Also, coping strategies after life events, for example concerning personal loss, were considered of great importance in the potential development of loneliness; coping strategies could make the difference between transitory and chronic loneliness.

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...
of loneliness’ potential consequences on health, it is something one should be aware of and pay attention to, but GPs obviously struggled with the question if, and how they should be involved with a patient’s loneliness as a professional. It was described as a grey area, an area of ambivalence. GPs searched for a balance between being a good GP and coping with the urge to demarcate their responsibilities.

People need to talk about things, and they [lonely people] have nobody to talk to (…) This is a danger to your time schedule, because, if you have the guts to ask the right question, ten minutes turn into 45 minutes. (…) But, if only the baker or butcher would ask the same question, someone would be relieved as well. (…) And then, the baker would take the time for it. [Q11]

I think it’s relevant to … certainly if they would frequently visit, to put their complaints into a certain perspective. But, when people are lonesome and do not frequently visit, and when they do not have a request for help, I have the opinion that it’s not my task to detect and solve their loneliness. That’s a bridge too far for a GP. [Q10]

Do you find it relevant to know whether someone is lonely? [JZ]
Yes, because I’m absolutely sure that eighty percent of my activities are related to psychosomatic complaints [Q3]
(…) And with respect to the phenomenon loneliness, what’s your opinion on that? What does it mean to you as a GP? [JZ]
I think it’s a difficult problem. On the one hand, it’s meddling with someone’s personal life … How far can you go? That’s a question, of course. Am I my brother’s keeper? On the other hand, I think it’s my task to think in other perspectives than in ‘pain or no pain’, or ‘healthy or not’, if I think there is more [going on] … And loneliness can be part of that. [Q3]

GPs mentioned that their gut feeling and previous knowledge on patients would help them recognize someone’s loneliness. But, both patients and GPs find it difficult to openly discuss loneliness. Patients seem to be ashamed for being lonely and experience feelings of failure and fear for another’s reaction. GPs have to deal with a (perceived) lack of time and little therapeutic options. For some, this was a reason not to discuss it, others try to explore why someone has become lonely and offer practical solutions. But, what to do next if this is not sufficient?

People will not easily admit that they are lonely … And whether this is caused by taboo, or because they blame theirselves for a lack of social skills … I don’t know. [Q15]

Well, I think that the word loneliness is too emotionally charged. Therefore, I wouldn’t easily use it. Because when I would do so, I could reveal a large problem. This could mean that I should find a solution to it as well. And I can’t. [Q13]

Well, I’ll let them talk about it [their loneliness], but, you can’t really intervene, can you? (…) Well, you do strike up a conversation with someone, in order to find out whether they recognise that it causes their complaints. (…) If people have the opportunity to express their feelings, it already makes

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a difference. It doesn’t really solve anything, but at least it has made a subject to discussion. [Q9]

Even GPs who found ways to manage lonely patients, said that whether or not any results will be achieved eventually, depends on whether or not the patient wants it. It will only succeed when patients take in control. GPs described that especially the group of lonely patients are difficult to motivate to undertake actions. Some GPs experienced a discrepancy between the lonely patients’ expectances or wishes and their own; patients seemed to want to overcome their loneliness by visiting the GP more often.

As a GP, we are very solution minded of course, and then I tell this man: ‘You should go and play billiards, (...) or have dinner with others at organised sites’, those kind of things. But that’s disappointing. If people don’t like the idea, they won’t do it. [Q16]

**GP’s emotions and behaviour**

The emotions GPs experience as a caretaker for lonely people seem to find different origins. Firstly, GPs respond to the humane aspect of the phenomenon loneliness. They feel pity for the lonely, experience empathy and are intrigued by the phenomenon.

Well, often I feel so sorry for them. (...) When you visit a lonely patient, and you just know that about three houses further down the street another person lives, who is alone as well. [GP4]

If you think about the category of lonely people, do they evoke certain emotions in you? [JZ]
Yes, they do! Compassion, pity … And also curiosity … Like, how did it happen? How did you function previously in your life? How did it come about? [GP17]

Being confronted with loneliness also makes GPs look at their own situation. They speculate on how they will grow old. They wonder why some people become lonely after an event and question themselves how they would cope with such events. Sometimes, this reflection was reported to be a valuable experience.

How do you feel about providing care for lonely people? [JZ]
Well, it’s not always easy for me, especially when dealing with the elderly. Then I start wondering, how will I grow old myself? (...) When people, you now share a lot of your life with, pass away … This can be instructive … How does someone cope? Yes, it’s an option to totally drown in it [the loneliness], or you could try to find a way to deal with it. [Q14]

Secondly, GPs feelings depend on whether or not they are able to achieve any improvement. Once patients open up and reveal their vulnerabilities, it is a positive experience for GPs. It is a unique event when people let a stranger enter their personal life. Moreover, if this means that both the GP and the patient see daylight and complaints and problems are more easily managed, it is very gratifying and interesting.

Most of the time, however, it is difficult to achieve any improvement. It can take quite long before patients realize that their loneliness plays a role in the experience of their health. And even when patients acknowledge that role, GPs perceive little or no options to manage the loneliness, and patients have difficulty coping with loneliness.

When I have the feeling that I brought about a change in someone’s way of thinking, or that he or she opened up for this process, then I find it very rewarding. If there’s friction, like when I’ve got the feeling we’re not moving forward, we’re not reaching anything. Well then, it’s merely frustrating. [GP12]

I think that as a GP, I deal more easily with transient loneliness, than with people who remain lonely endlessly. In that case, I will soon experience feelings of insufficiency. (...) It is a thousand times as difficult as managing someone’s diabetes. [Q8]

GP’s perceived that lack of therapeutic options causes feelings of guilt. Moreover, GPs described fatigue, feelings of insufficiency, powerlessness and annoyance. Some GPs had resigned themselves to the situation and accepted that there is not much they can do.

I strongly feel that I shouldn’t be the one trying to solve everything [the loneliness]. Because often, I simply can’t. But talking about it is important, though it’s very strenuous. That’s what I’ve noticed. It becomes a weight on your shoulders and can cause headaches, you might start feeling tired and become grumpy. [GP18]

… Some of the emotions it [loneliness] evokes is guilt! (...) Because I do so little about it. Because I can’t. [GP13]

Thus, with respect to GPs emotions, we could speak of an important difference between handling transient loneliness versus handling chronic loneliness. This distinction is not always easy to make and causes feelings of ambivalence among GPs. However, moving forward is important. Whether or not a patients’ loneliness improved depended on its cause and how the patient coped with it. GPs also mentioned personality traits that lonely patients tend to have. Although they did not want to generalize the lonely people, they did associate them with people who show off putting, complaining and demanding behaviour.
When you see that someone has made an appointment, and you know that he or she is lonely, does that evoke certain emotions? [JZ]
No. [GP2]
And during the consultation? [JZ]
No, not particularly. The patients who show demanding behaviour do so, however. Like this lonely old lady who’s very demanding; she calls time after time and then I have to visit her again ... And it takes so much time ... That annoys me. Though it’s not so much ... It’s because of their behaviour and not merely because of the fact that they’re lonely. [GP2]

I have someone in mind of whom I think: ‘No wonder you’re lonely. Your complaining behaviour drives everybody away’. Therefore, I never take any pleasure in visiting this patient. [GP3]

Well, if people are lonely, do nothing about it, but do request a lot of care and attention from me, well, then I tend to keep them off, thinking: ‘Find your own support system. Don’t merely rely on me., Then, I feel irritated (...) When I’m irritated or feeling incapable of helping the patient, I tend to refer people more often. (...) Saying: ‘Okay, then we’ll have the orthopaedic take a look’ or ‘we’ll have your blood tested’ or ‘we will have an X-ray made’. Even though you already know what the test results will be. [GP12]

Most GPs try to be aware of their emotions. Only some GPs explicitly make sure that evoked emotions do not influence their consultation. They either keep their emotions separated or they channel the emotions in another direction. For other GPs, the practical consequences of evoked emotions depend on the origin and nature of the emotion. Positive, empathic emotions or feelings of guilt make the GP invest more time and attention in the patient. On the other hand, negative emotions, such as anger, irritation and the feeling someone is responsible for his own loneliness, results in less time and attention and more unnecessary open-handedness regarding referrals and diagnostic testing.

And in consultation, when you’re with a patient, do you have to deal with emotions patients evoke? [JZ]
Yes of course. (...) [GP10]
And what’s that like with respect to loners? [JZ]
Well, that depends on whether I have the impression that, well, someone has bad luck, that it has happened to him, or that he as basically caused it himself. [GP10]
And do these emotions influence your actions? [JZ]
Yes, I think so. I think ... When it happened to someone, I’ll have more sympathy, and maybe I will put that extra step more easily, or think harder for a solution and advices, than with someone who doesn’t evoke those emphatic feelings. (...) Then, I won’t do more than what is strictly necessary from medical perspective. [GP10]

A few GPs described actions in order to control the negative effect that negative emotions might have. Most try to level their emotions and hence create emotional distance. In case of irritation, a few would try to discuss this openly with the patient or they would explicitly draw the line for the patient. Another GP always checks for correct medical and professional behaviour whenever he feels that emotions might be influencing him.

If I become irritated, I talk about it. I will create a time out in the consultation. [GP3]
You would discuss it with the patient? [JZ]
Yes, in that case I literally say: ‘What I feel now, what I begin to feel in this conversation, doesn’t feel good for me, and because of that it won’t do any good to you.’ [GP3]

There’s such a thing as people who are always complaining, frequent attenders, and if they are also lonely ... then I often give up ... [GP8]
And what does that mean, when you give up? [JZ]
It means that ... if I can’t think of any answer ... I stop trying. [GP8]
You will leave it the way it is? [JZ]
Yes, But, being a competent GP, I do ask myself: ‘Do I disregard this because I’m lazy, or because I’ve already tried to provide sufficient and adequate care?’. [GP8]

None of the GPs uses his/her own feelings as a sign to recognize loneliness. One GP did seem to mention such method concerning depressed patients.

Well, that’s the patient who makes you feel powerless, with whom you should keep in mind that he or she could be suffering from a depression, and that you might need to take action. [GP5]

Discussion

Main findings in comparison with existing literature

It was striking to find out, that despite consensus on the relevance of knowing whether or not your patient is lonely, many questions surfaced relating to the GPs’ task in this matter. They struggled to find a balance between so-called best practice and difficulties they experienced when trying to tackle this problem. This issue on GPs’ role was a theme that came up often and was related to different topics that were discussed. Feelings of confusion about roles and obligations are
indeed common among GPs and are related to burn-out. Parallel to this study, van Ravesteijn et al. performed a somewhat comparable exploratory research among GPs educated in complementary medicine. These GPs had similar experiences.

Once loners were recognized, GPs had little options regarding management. This was frustrating and caused feelings of powerlessness and insufficiency, as GPs tend to be solution minded. Research on GPs’ views on late-life depression in the UK reports similar pessimism about the availability of therapeutic options and similar feelings of powerlessness. Especially in the case of persistent chronic loneliness, this perceived lack of options could become more pronounced, as these patients were described as demanding and complaining people with unsuccessful coping strategies. This evoked feelings of frustration, annoyance and fatigue. GPs spent less time and attention on these patients and GPs were more likely to refer, even while they were aware of the fact that the referral was medically incorrect.

Acute or transitory loneliness—often related to life events—was usually easier to manage. It caused more empathic and humane feelings like pity, which in their turn increased the amount of time spent on and attention spent to the patient. This is in accordance with O’Riordan’s findings that ‘overcoming challenges put forward by “difficult” patients sometimes changed the relationship between doctor and patient; some “heartsink” patients turned into “heartlift” patients’. Apparently, personality and coping mechanisms influence the development and course of someone’s loneliness. Moreover, these features determine what kind of feelings GPs experience. Marshall and Smith describes six constellations of general patient characteristics that consistently evoke negative emotions in physicians: ‘somatizers’, ‘challengers’, ‘clingers’, ‘self-destructives’, ‘incommunicatives’ and ‘challenging medical conditions’. Loners, as portrayed by the GPs, had similar experiences.

Marshall states that GPs believe emotions should be suppressed or ignored in order to maintain clinical objectivity. The GPs we interviewed also tried to create emotional distance and level personal reactions that might stir in them. None of the GPs described the utilization of evoked emotions in their consultation, known as transference and counter-transference.

We asked ourselves why GPs experience loners as people who are demanding and who evoke feelings of, for example, frustration and insufficiency. Although these feelings will be caused by patients’ behaviour, as is in line with Marshall’s findings, the urge GPs experience to solve the loneliness might partly be responsible for this as well. As one GP said: ‘By informing someone on your loneliness, you automatically and probably unconsciously, put social pressure on the other’. Moreover, some GPs mirrored themselves to the loners: they feared what their own life will bring or were reminded of their own (previous) loneliness.

Recognizing your emotions during consultation is important for both patient and physician’s health. Marshall and Smith and Meier et al. support this thought and promote awareness of (negative) emotional reactions during consultation in order to alter potentially harmful behaviour in daily practice.

One way of doing so is by participating in Balint groups, in which GPs could be guided in developing both their skills regarding the physician–patient relationship as well as the handling of their own emotions during patient encounters. Patient centeredness plays in important role in this matter and is believed to enhance work satisfaction and decrease the risk of burnout. Also, in Balint groups, some minor psycho-therapeutic skills could be taught to GPs, which they can apply in their consultations with lonely people, if necessary.

**Strengths and limitations of this study**

This research offers insight in the phenomenon of loneliness in general practice and GPs’ view on this topic. An exploratory qualitative design was essential in order to discover this new field of research. All interviews were held by the same researcher and were coded by two researchers. Data analysis was performed by three researchers. We are aware of the fact that this topic could be sensitive to evoke socially desirable answers. We tried to rule this out as much as possible by creating an open atmosphere and emphasizing the importance of honesty. Although we tried to include as many male as female GPs, only three female GPs participated. We found no indication for gender bias though the sample could be too small to rule this out.

**Conclusions**

GPs find recognition of loneliness in patients relevant. But, how to tackle this problem, or whether this is a true component of a GP’s range of duties, turned out to be open to discussion and needs further attention. Also, our finding that the emotions lonely patients evoke are partly due to patients’ personality traits and coping mechanisms should be unravelled in depth in order to propose specific improvements regarding doctor–patient interaction. Further research should take into
account lonely patients’ experiences. Patients’ needs should be compared to this study's outcome in order to be able to fine-tune care for loners in general practice.

With respect to the impact that management of lonely people has, GPs should try to recognize the emotions lonely patients evoke and try to make sure these emotions do not harmfully influence the management of the patient, like being unfriendly or referring without an adequate reason. A helpful distinction could be made between transitory or chronic loneliness.

Continuous medical education during GPs’ careers and peer feedback meetings such as Balint groups could facilitate this act of reflection. Revealing and if possible transferring GPs’ emotions will lead to a more transparent and healthier relationship between doctor and patient and might prevent fatigue and burnout in GPs.

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Declaration

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