Life & Times

A case of grief:

SAPC prize winner

As a student undertaking a Longitudinal Integrated Clerkship (LIC)[1] based in a GP practice in a rural community in the North of Scotland, I have been lucky to be given responsibility and my own clinic lists, with appropriate supervision.

Every day I conduct consultations that change my practice: the challenge of clinically applying the theory I have studied, controlling a consultation and efficiently exploring a patient's problems, empathising with and empowering them to play a part in their own care,[2] and, most difficult I feel, dealing with the vast amount of uncertainty that medicine, and particularly primary care, presents to both clinician and patient.

I initially consulted with a gentleman in his 60s who attended with his wife,* complaining of severe lower back pain. He was very difficult to assess because of his pain level. His wife was understandably concerned about the degree of pain. After assessment and discussion with one of the GPs, we agreed that some pain relief and a physio assessment in the next few days would be a practical plan. The patient had one red flag, some leg weakness and numbness, which was his 'normal' on account of an underlying chronic condition.

At the physio assessment a few days later, the physio felt that things were worse and some urgent bloods were ordered, unfortunately showing raised cancer and inflammatory markers.

A CT scan of the lung found widespread cancer. After developing acute confusion a later CT of the head found brain metastases, and a week and a half after presenting to me the patient sadly died in hospital.

AFTERMATH

While that was all impactful enough on me, it was the follow-up appointment with the wife who attended on the last triage slot of the evening 2 weeks later that I found completely altered my understanding of grief and the mourning of a loved one.

The wife had asked to speak to a doctor, just to talk about what had happened. The GP decided that it would be better if she came into the practice — strictly she probably should have been consulted with over the phone because of coronavirus restrictions — but she was asked what she would prefer and she opted to come in.

I sat in on the consultation. I had been helping with any examinations the triage doctor needed and I recognised that this was the spouse of the man I had seen a few weeks earlier. She came in and sat down, head lowered, hands fiddling with the zip on her jacket, trying to find what to say.

The GP sat, turned so that they were opposite each other with no desk between them. I was seated off to the side, an onlooker, but acknowledged by the patient with a kind nod when she entered the room.

The GP asked gently, *'How are you doing?'* and roughly 30 seconds passed (a long time in a conversation) before the patient spoke.

'I just really miss him ...' she whispered with great effort. *'I don't understand how this all happened.'*

Over the next 45 minutes, she spoke about her husband, how much pain he had been in, the rapid deterioration she witnessed, the cancer being found, and how he had cruelly passed away after she had gone home to get some rest after being by his bedside all day in the hospital.

She talked about how they had met, how much she missed him, how empty the house felt without him, and asking herself and us how she was meant to move forward with her life.

She had a lot of questions for us, and for herself. Had we missed anything? Had she missed anything? The GP really just listened for almost the whole consultation, speaking to her gently, reassuring her that this wasn't her or anyone's fault. The GP stated that this was an awful time for her and that what she was feeling was entirely normal and something we will all universally go through. They emphasised that, while it wasn't helpful at the moment, things would get better over time.[3]

She was really glad I was there — having shared a consultation with her husband and me — and she thanked me emphatically even though I felt like I hadn't really helped at all.

After some tears, frequent moments of

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silence, and a lot of questions, she left having got a lot off her chest.

'You just have to listen to people, be there for them as they go through things, and answer their questions as best you can', urged my GP as we discussed the case when the patient left.

MEETING PATIENTS WITH COMPASSION

Almost all family caregivers contact their GP with regards to grief, and this consultation really made me realise how important an aspect of my practice it will be in the future.[4] It has also made me reflect on the emphasis on undergraduate teaching around 'breaking bad news' to patients, but nothing taught about managing patients in the process of grieving further down the line.[5]

The skill required to manage a grieving patient is not one limited to general practice. Patients may grieve the loss of function from acute trauma through to chronic illness in all specialties of medicine — in addition to 'traditional' grief from loss of family or friends.[6]

There wasn't anything 'medical' in the consultation, but I came away from it with a real sense of purpose as to why this career is such a privilege. We look after patients so they can spend as much quality time as they are given with their loved ones, and their loved ones are the ones we care for after they are gone.

We as doctors are the constant, and we must meet patients with compassion at their most difficult times — because it is as much a part of the job as the knowledge and the science — and it is the part of us that patients will remember long after they leave our clinic room.

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*Personal, demographic, and medical details of these encounters have been altered to protect the anonymity of the patients.

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Editorial note
This is a slightly edited version of the winning 2021 medical student essay prize of the Society for Academic Primary Care. We congratulate Andrew on his win!

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REFERENCES

1. University of St Andrews. Scottish Graduate Entry Medicine (ScotGEM) MBChB 2022 entry. https://www.st-andrews.ac.uk/subjects/medicine/scotgem-mbchb/ (accessed 19 Aug 2021).
2. Scottish Government. Shared decision making in realistic medicine: what works. 2019. https://www.gov.scot/publications/works-support-promote-shared-decision-making-synthesis-recent-evidence/pages/1/ (accessed 19 Aug 2021).
3. Ghesquiere AR, Patel SR, Kaplan DB, Bruce ML. Primary care providers' bereavement care practices: recommendations for research directions. *Int J Geriatr Psychiatry* 2014; **29(12):** 1221–1229.
4. Nielsen MK, Christensen K, Neergaard MA, *et al.* Grief symptoms and primary care use: a prospective study of family caregivers. *BJGP Open* 2020; DOI: https://doi.org/10.3399/bjgpopen20X101063.
5. O'Connor M, Breen LJ. General practitioners' experiences of bereavement care and their educational support needs: a qualitative study. *BMC Med Ed* 2014; **14:** 59.
6. Sikstrom L, Saikaly R, Ferguson G, *et al.* Being there: a scoping review of grief support training in medical education. *PLoS One* 2019; **14(11):** e0224325.