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A Case of Grief

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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. 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 lady in her 60s who attended with her husband, complaining of severe lower back pain who was very difficult to assess due to her pain level. Her husband was understandably concerned about the degree of pain she was in. After assessment and discussion with one of the GPs, we agreed 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 her 'normal' on account of her multiple sclerosis. At the physio assessment a few days later, the physio felt things were worse and some urgent bloods were ordered, unfortunately finding raised cancer and inflammatory markers. A CT scan of the lung found widespread cancer, a later CT of the head after some developing some acute confusion found brain metastases, and a week and a half after presenting to me, the patient sadly died in hospital.

While that was all impactful enough on me, it was the follow-up appointment with the husband who attended on the last triage slot of the evening two weeks later that I found completely altered my understanding of grief and the mourning of a loved one. The husband had asked to speak to a doctor just to talk about what had happened to his wife. The GP decided that it would be better if he came into the practice - strictly he probably should have been consulted with over the phone due to coronavirus restrictions - but he was asked what he would prefer and he 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 husband of the lady I had seen a few weeks earlier. He came in and sat down, head lowered, hands fiddling with the zip on his 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 he 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 her…” he whispered with great effort, “I don’t understand how this all happened.”

Over the next 45 minutes, he spoke about his wife, how much pain she had been in, the rapid deterioration he witnessed, the cancer being found, and cruelly how she had passed away after he had gone home to get some rest after being by her bedside all day in the hospital. He talked about how they had met, how much he missed her, how empty the house felt without her, and asking himself and us how he was meant to move forward with his life. He had a lot of questions for us, and for himself. Had we missed anything – had he missed anything? The GP really just listened for almost the whole consultation, speaking to him gently, reassuring him that this wasn’t his or anyone’s fault. She stated that this was an awful time for him and that what he was feeling was entirely normal and something we will all universally go through. She emphasised that while it wasn’t helpful at the moment, that things would get better over time.[3] He was really glad I was there – having shared a consultation with his wife and I – he thanked me emphatically even though I felt like I hadn’t really helped at all.

After some tears, frequent moments of silence and a lot of questions, he left having gotten a lot off his 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.

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 when patients are 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 have to 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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