Cancer is one of the most feared diseases in the world. The fear of this disease contributes to the grief experienced after the diagnosis. The patient, family members, caregivers, and physicians experience this grief, which has many dimensions and can be extremely complicated. Grief is expressed differently by different cultures, and faith can help in dealing with grief, but no one can escape the emotional, psychological, and spiritual pain associated with the grief individuals feel when they suffer a loss. For this reason, it is best to have a holistic approach when caring for those who are grieving to more effectively meet their needs and to bring hope and healing into a very painful experience. Two case presentations illustrate the application of the hospice approach to grieving patients and the complexity of their grief.

Vignettes are used to describe the holistic approach afforded to patients with cancer and the emotional and spiritual aspects associated with the grieving process these patients and their family members endure after receiving a diagnosis of cancer. Physicians can play a vital role in bringing hope and healing to patients with cancer if these physicians understand the factors that can influence and contribute to a person’s grief. Understanding these factors can also aid physicians as they deal with their own grief as caregivers of patients with cancer.

Cancer
The following anecdotal case presentation describes the holistic approach in caring for a patient in the terminal stage of cancer. Although this patient and others described here are real, the names used to refer to them are not their real ones to protect their identity.

Case Scenario 1
Martin, a 70-year-old male patient, was brought onto the hospice service with a diagnosis of end-stage lung cancer. During my first visit with Martin, I found him to be extremely angry and verbally abusive to those who came in to care for him. He was so offensive to the nurses and their aids that he even brought one of them to tears. I sat with Martin only briefly during this first visit, and when he became verbally insulting towards me, I politely told him that I would come back to visit him another day if that was all right with him. He agreed to let me return to see him with the words “Do whatever the h__ __ you want.”

After leaving Martin’s room, I went to visit the nurse’s aid who was still crying. The aid explained to me that Martin is always that way with her and on this day, it just got to the point where she just could no longer take his name-calling. She felt her job as a nurse’s aid was hard enough, but to deal with a patient who was constantly saying hurtful and degrading things to her was “the straw that broke the camel’s back.” She did not want to take care of Martin anymore, and she was going to ask her supervisor if she could be transferred to another floor. I understood why. Martin was the angriest, meanest patient I had ever encountered as a hospice chaplain, and he was definitely a patient who challenged my ability to remain completely nonjudgmental, something we are taught and required to do as chaplains.

After talking with the nurse’s aid, I decided to speak with some other staff members who took care of Martin. It was not long before I noticed a pattern. No one liked Martin. None of the staff wanted to take care of him, and they were not even concerned that he was dying. There was one nurse who had compassion for Martin because she said there was a vulnerability about him that reminded her of an uncle who had recently passed away. My support that day was mostly to the staff as I listened to their feelings of anger, rage, and resentment toward this dying man. I spent time after that reflecting on Martin, his anger, and what may be contributing to his emotional state. I also reflected on my time with the staff that reluctantly took care of Martin—caregivers who did not want to provide care in this particular case.

During my next visit with Martin, I stayed longer even though his attacks were aimed directly at me. I sat there and let him attack me verbally, saying whatever he wanted for as long as he wanted. In between verbal attacks, he pressed his call button for help, but no one responded to his call until I went out to get them. When the nurse’s aids came in, they were as brief as possible. It was clear they wanted to do what was necessary for him and exit as soon as possible.

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After Martin quieted down and stopped his verbal attacks toward me, I asked if those aids had done something that caused him to act in this insulting manner. “Yes,” Martin said. “Those b---- s won’t take me out for a smoke.” Before dealing with the bigger issue here, (not that I even knew what it was at this point), I decided to try to address his immediate wish to go out for a smoke and offered to take him. He wanted to go, but it was time for his breathing treatment, which he desperately needed. I explained to Martin that the hospice certified nursing assistant (CNA) would take him out for a smoke whenever he wanted because one of her roles—and our roles as hospice workers—is to do things with him and for him that would bring joy to his life. I assured Martin that I would let his hospice CNA know about his desire to go outside for a smoke and that the entire hospice team would do whatever we could to make this happen for him every time we visited. Regular visits by the hospice nurse, CNA, social worker, and chaplain would ensure many opportunities for a smoke. I asked Martin if there was anything else he wanted, and he said, “No, I just want to smoke.”

Before my second visit ended, I asked Martin if I could see him again and, unable to speak this time because of his breathing treatment, he simply shook his head to indicate “yes.” I thanked him for allowing me to come back again and told him I would look forward to our next visit.

On my third visit with Martin, he seemed like a different man. He was less verbal, abusive, and agitated, and more relaxed, but not exactly pleasant. However, he did not look at me as he had on my two previous interactions when he rolled his eyes and turned his face away from me as if to say, “Oh, it’s you again.” I sat down and began to talk with him; slowly Martin’s deeper issues unfolded. After our 4-hour conversation, his emotional and spiritual issues were much clearer to me. Martin was grieving, and there were many aspects to his grief, but they were all related to one thing—his diagnosis of end-stage lung cancer.

Fear of Cancer and What Its Diagnosis Portends
Cancer is the most feared disease worldwide according to Biddle and Torosian, as noted in their book Spirit to Heal. Even in the 21st century, “cancer” is viewed as a four letter word often referred to as the “C” word; it can stir up thoughts of death. Cancer is more than a diagnosis. It comprises painful treatments like radiation and chemotherapy, laboratory studies involving blood draws, hair loss, metastasis, remission, and recurrence—and the “when,” which no one can predict. In the meantime, cancer patients and their families struggle to live a somewhat meaningful life.

Patients with a cancer diagnosis suffer physically, emotionally, and spiritually. Some distress begins almost immediately after hearing the diagnosis. Not only the patient but also the family members suffer. It is not uncommon for patients and their families to undergo anticipatory grief: the anguish in expectation of what is about to come or what could possibly develop in the next few days, weeks, months, or maybe even years as they battle this disease. Cancer is a disease for which even the most brilliant scientists have yet to find a cure. Cancer is daunting. The word itself can make even the most positive thinker think negative thoughts.

Cancer can be frightening even for persons of faith. I once knew a very religious young woman who would not even utter the “C” word for fear that she would speak it into existence. Her cancer was already present, but unfortunately, she was in such denial about it for so long that by the time she was ready to face reality and acknowledge her diagnosis, it was too late.

The cancer had spread throughout her body, and she died a few weeks later. Some religious people feel, as this young woman did, that if they just pray about their cancer, one day their physicians will say that the cancer has mysteriously and miraculously disappeared. The fact is some patients have been cured, or healed, from cancer, but some have not. We do not know why. I believe most people with a cancer diagnosis hope and pray that they will be one of the lucky ones who are cured, one of the blessed ones who are healed, or at the very least, one whose cancer goes into permanent remission.

Cancer is so frightening that even the possibility of it can cause a person to take drastic measures, as the woman in the following case vignette did.

Case Scenario 2
Sarah, a 51-year-old attractive and physically fit woman, recently opted to undergo a double mastectomy because there was a possibility that cancer could develop in the future. For 4 years, she had mammograms on which physicians found lesions that they referred to as being “suspicious” abnormalities. Biopsies of these lesions indicated that they were benign and remained noncancerous, but each time Sarah had a mammogram, the lesions had changed. They kept developing and taking on a different shape, always in the same region of the same breast. And each time she had a biopsy and removal of the lesions, they recurred different and larger.

Sarah describes this 4-year experience and time in her life as painful, full of anxiety, fear, and grief as she anticipated all the things that could possibly begin to happen to her. Sarah began to think about the future without her in it. She even wondered who her husband would remarry after she died. In other words, this vibrant young woman, with benign but abnormal cells in one of her breasts was thinking about death. During this time of pain, fear, and anxiety, Sarah also felt powerless until one day she realized that she was not helpless.

Sarah reached out to one of her friends who was battling cancer. She listened as the woman discussed painful sores in her mouth as a result of chemotherapy, and how friends stopped visiting because they did not know what to say. She talked about how lonely and isolated this made her feel at a time in her life when she needed her friends the most. After listening to her friend’s experience, Sarah realized that she still had choices. She no longer feared what the physician would tell her after her next mammogram. She realized that she did not have to continue reacting to what was happening to her, but that she could become proactive and make some decisions for herself—and she did.

Sarah’s decision to have a double mastectomy came after testing positive for the breast cancer gene. This decision would be less painful, both emotionally and spiritually in the long run. Sarah no longer lived with the constant fear and anxiety, year after year, awaiting her mammography results.

What Patients With Cancer Feel
Fear, anxiety, loneliness, and isolation are common feelings for patients with cancer. Other emotional and spiritually
related feelings are also associated with the disease. Patients with breast and prostate cancer talk about how this affects their self-esteem and sexuality. Does a man find his wife attractive and feminine after she has had a double mastectomy? More important, does this woman find herself attractive and does she still feel herself to be as feminine? Does the man with prostate cancer worry about whether he will be able to physically satisfy his partner? If he cannot, will his partner accept him and all the other things he has to offer in the relationship, or will she abandon him?

Patients with lung cancer who smoke feel shame and regret because they sometimes think that they are responsible for their diagnosis. At times, their caregivers and healthcare professionals may even suggest that they are partly to blame for their unfortunate predicament; when this happens, it can lead to feelings of isolation and loneliness as they begin to grieve.

Grief

Grief is a reaction to loss. People grieve the many losses they experience in everyday life, those associated with growing old, resulting from an illness, and occurring as the result of death. Persons in nursing homes become more dependent on others to care for them, and they eventually begin to grieve losing their independence and autonomy. Patients with specific diseases and their family members begin to grieve losses associated with the medical condition. Patients with diabetes may grieve the loss of limbs, of being ambulatory, and consequently, of freedom. The loved ones of patients with dementia grieve two losses: losing the relationship before the patient dies, and then losing the patient after the patient has died.

Hospice patients whose physicians have given them a prognosis of 6 months or less to live sometimes grieve their own life and all the experiences and relationships that were meaningful to them throughout their existence. Life, death, and grief are the three things that all people have in common. All are born, all must die, and in between birth and death, all will experience some type of grief.

Even though dying and grief are a part of life, individuals as a society are still uncomfortable dealing with death and with those who are grieving as a result of their loss. Therefore, one either avoids persons who are grieving all together, thereby causing the grieving person to feel isolated, or one says inappropriate things because of not knowing what to say.

The way people respond to another person’s grief can hurt and hinder or help and heal the grieving person as he or she experiences and works through the grief. It is also important for those who care for the grieving to be sensitive and refrain from using common clichés (Figure 1) that are inappropriate and diminish a person’s loss by attempting to explain away their difficult reality with overly simple solutions.

Grief affects people emotionally, mentally, behaviorally, spiritually, and physically. The grieving process itself affects each person differently.

Stages of Grief

In her book On Death and Dying, Elisabeth Kübler-Ross, MD, identified five stages that a dying patient experiences when informed of a terminal prognosis; the stages she identified and explained as follows:

- **Denial** (“This isn’t happening to me!”)—Denial is a stage where people try to believe that the cancer diagnosis is not happening to them or their family. One may feel numb or in a state of shock. Denial is a protective emotion when a life event is too overwhelming to deal with all at once.
- **Anger** (at God, self, or others; “Why is this happening to me?”)—Anger is a stage in which you understand the cancer diagnosis but are very upset and angry that it has happened to you, a friend, or family member. One of the best ways of dealing with bursts of anger is to exercise or participate in another type of physical activity. Talking with family and friends, other people who have cancer, and the hospital staff may also be helpful. Those with cancer also need to be able to express their anger either verbally or by writing in a journal.
- **Bargaining** (“I promise I’ll be a better person if....”)—Questioning God, asking “Why me?” and “What did I do to deserve this?” are common questions in this stage. It is normal for persons with cancer to make bargains with themselves or God, hoping that this will make the cancer diagnosis go away. Guilt is a primary emotion during this stage. Searching for something that one personally did, which could have contributed to the cancer, is all part of bargaining. People tell themselves or God that they promise not to do something they previously did (such as arguing with family members), or to start doing something they have not done (such as going to church regularly) in exchange for their recovery.
- **Depression** (“I don’t care anymore.”)—This is a stage in which the diagnosis of cancer can no longer be denied, and those

**Figure 1.** Some common clichés that are inappropriate responses to persons who are grieving. (Source: Zinner ES, Featherstone S. The Center for Loss and Grief Therapy. Available at http://kara-grief.org/EventDocs/HOLIDAY%20SURVIVORSHIP%20SKILLS.doc. Accessed November 29, 2007.)
involved may feel a profound sense of sadness. This is normal. It can be accompanied by physical changes such as trouble sleeping or excessive sleeping, changes in appetite, difficulty with concentrating on simple daily activities, or feeling a constant fear that someone else in the family will have cancer diagnosed. It is important for patients to discuss depression with a healthcare professional such as a social worker, or counselor, or meet with a support group to help cope with such feelings.

Acceptance ("I'm ready for whatever comes.")—Acceptance is a stage at which patients have now believed their cancer diagnosis and is at a point where this terminal condition has been incorporated as part of their life. They have made an adjustment to their illness. This does not mean that they will never feel other emotions, but usually patients and their family members are better able to manage their lives overall on reaching this stage. Going through the grieving process is the best way to cope with a cancer diagnosis. When patients give themselves and their family permission to grieve, they will then be able to cope.

These stages of grief are helpful in defining some of the feelings a person may experience as a result of a loss. However, in my practice as a hospice chaplain giving bereavement support to family members after their loved one has died, I have observed that everyone does not necessarily go through all of these stages nor have all of these feelings. These feelings also do not necessarily come in any particular order, and the length of any particular “stage” or feeling for the grieving person is as unique as the person himself or herself. My experience with people who are grieving suggests that (1) there are many symptoms, feelings, and responses that people can possibly have as a result of a loss; and (2) there are many factors that contribute to and influence their grief.

Factors Contributing to and Influencing Grief

Just as all individuals are uniquely different, their grief is also distinctive. The following factors contribute to how individuals will grieve and how they are affected by their loss.

The nature of the relationship with the person who died—How attached was one to the person who died? Did one have any unresolved conflicts or unfinished business with that person? Was that person a major part of the other individual’s support system or someone that the grieving person turned to for strength and comfort?

Circumstances surrounding the death—Did that person die tragically, from something that could have possibly been prevented, or was the deceased elderly and dying of natural causes after living a long fulfilling life?

Circumstances surrounding the grieving person’s support system—Does the grieving person have the support needed to help during this time of grief, or is the support limited?

The griever’s unique personality—How does the grieving person normally respond to a crisis? Does that person seek the help of others, or tend to withdraw? Does the griever talk about personal feelings easily, or keep them in?

The unique personality of the person who died—Was that personality one that made the griever want to be around the deceased, or was it more of a burden to be with the deceased?

One’s own cultural background—For example, Germans are stereotypically viewed as being more stoic and Italians, tending to be more expressive regarding their feelings.

One’s religious or spiritual background—What is the grieving person’s personal belief about death? Does that person believe there is a better place to which people go after death? Does he or she turn to a higher power for strength and comfort? And, does prayer help this person during the challenging times?

Other crises or stresses in one’s life—Has the grieving person had other recent losses or crises in his or her life? Or, are the details of this loss causing other personal problems (ie, financial, etc)?

Biological sex—Being male or female may influence how a person grieves and how other people respond to that person’s grief. Sometimes, boys have been taught not to cry and to be more restrained with their emotions.

The ritual or funeral experience—Was the grieving person able to attend the funeral? Was it meaningful in honoring the loved one’s life? Did the grieving person live too far away to attend? How did the loved one look in the casket?

Disease-Related Factors That Influence How We Grieve

One factor that Wolcott does not list in his book Understanding Grief but which also influences how people grieve. For example, the loved ones of patients with dementia often begin to grieve the loss of...
the relationship long before the patient has died, because in many cases, the patient no longer recognizes them. Loved ones of the patient with AIDS might experience disenfranchised grief, ie, that which is not publicly recognized and acknowledged because of the stigma attached to the disease itself. Grief of the patient with cancer and his or her loved ones is also unique.

After reflecting for many days and nights about my 4-hour conversation with Martin during our third visit, I assessed that he was grieving. His verbally abusive language and behavior were symptoms of his grief. His grief had many dimensions to it and was complicated. Martin had been smoking for 50 of his 70 years of life, and now was on the hospice service dying of end-stage lung cancer.

His family had emotionally and physically neglected him, the staff at the nursing home had emotionally deserted him and remained as physically separated as they could be considering they still had to provide some care, and even I, the hospice chaplain, had abandoned him on our first visit. When Martin became verbally abusive to me, I ended our short visit by politely telling him that I would come back to visit him another day if that was all right with him. I am to this day grateful that he gave me a second chance to care for him, and I was determined not to ruin this second chance. Life does not always provide second chances.

Martin had been abandoned by almost everyone in his life. His family was angry with him for smoking most of his life, because they believed that his smoking contributed to his getting lung cancer. And, since they thought it was Martin’s fault, they punished him by limiting their visits to him. This abandonment by his family left Martin angry, hurt, rejected, and isolated. The nursing home staff thought that it would be irresponsible to allow Martin to continue to smoke since it was smoking, they believed, that put him in the “terminal” shape he was in. What they did not think about, though, was that keeping him from smoking was not going to help him get better. His lung cancer was not going to go away at this stage if he stopped smoking. All the staff did was take away one of the last few things that brought Martin joy at this difficult time in his life—the ability to go outside every once in a while for a smoke. Taking this ability away from Martin made him angry, bitter, resentful, and irritable. It also reminded him every day how dependent he was on others because he could not go outside unless they allowed him to do so. He vented this anger, bitterness, resentment, and irritability through his verbally abusive language and behavior toward his caregivers.

When I, as the hospice chaplain, left Martin after only a few moments during our first visit, he probably felt abandoned not only by me, but also by God, because he was abandoned by one who was “supposed” to be a representative of God. When I, a representative of a loving and accepting higher power, deserted Martin, it may have made him feel unworthy, unloved, unwanted, and devalued; he may have reasoned that if one of God’s representatives did not want to be with him, something must be horrifyingly wrong with him.

Martin not only was experiencing grief as a result of his family, the nursing

Figure 2. Some emotions and feelings experienced during the grieving process. (Adapted from a handout; source unknown.)

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home staff, and my actions, but he was also experiencing personal grief related to his disease. He suffered from feelings of guilt, regret, and shame because, as he confided to me on that third day, “my family hates my guts and they should because I did this to myself.” Martin was angry with himself because deep down, he felt responsible for his terminal cancer diagnosis. Because he believed that it was his fault that he had lung cancer, he also felt that he deserved to die and was not worthy of being loved; consequently, he pushed away everyone who tried to care for him. I saw this as a coping mechanism. Martin could no longer be abandoned if he rejected everyone before they had an opportunity to abandon him.

When I sat with Martin and allowed him to lash out at me in a verbally abusive way without judgment or retaliation by walking away, what I hope he heard me saying to him is: I care enough about you and respect you enough as a human being created by God to allow you to feel whatever you feel, say whatever you want to say, and be wherever you are emotionally and spiritually. When I offered to take Martin out for a smoke after realizing that was his desire, and I promised that the hospice team would do its best to take him out for a smoke at every visit, I hope he heard me saying to him that I realized he had already lost so much in his life that it would be cruel and unusual punishment to take away the one remaining thing that brought him joy—a smoke.

On my third visit with Martin (during the short span of 4 hours), I made a real connection with him. Once during a long period of silence, he asked me why I was still there with him, how come I had not left him like everyone else did? My response was simple, “Because you allow me to be here and I don’t take that for granted because you could throw me out.” When I spoke these words to Martin, I hope he heard me acknowledging his rights and autonomy as a valuable human being. He died about a week after my third visit. I am happy to say that our hospice team afforded him many opportunities to go out for a smoke before he took his last breath. As this case study demonstrates, a person’s grief can be complex and complicated with many layers and dimensions. For this reason, physicians and other healthcare workers need to be aware of many factors that may influence and contribute to grief so they can help the grieving patient and family members.

How Physicians Can Help Grieving Patients and Family Members:

Because of the delicate nature of the human psyche, it is important to understand that many factors contribute to and influence grief, and that they may form some of the resulting symptoms. Some aspects that physicians should be aware of to help those who are grieving include—but are not limited to—the following:

I Relate to the patient as an individual, not as a disease. Individuals are made up of mind, body, and spirit. Therefore, their grief will have many different dimensions as already noted. These elements may include emotional, mental, behavioral, physical, and spiritual symptoms; feelings, and responses to such a loss. Osteopathic physicians have a holistic approach to care and treat the whole person—mind, body, and spirit. They can best meet the patient’s needs by forming an interdisciplinary team involving those who are qualified to deal with each dimension of grief, which can sometimes be misdiagnosed as depression, and for which there may be a psychiatric consultation.

Consequently, patients with a misdiagnosis of grief may be given medication, which leads to a problematic situation. Any drugs prescribed may inhibit a person from expressing the normal feelings related to grief. Thus, medication might be given to some individuals who just needed to talk while working through their grief, and then, because of the medication, they may not be able to do so. Assessing and distinguishing grief from depression is complex, but differences exist to aid in the delineation.

II Understand how social and psychological factors influence the grieving person and the grieving process. In his book, Living with Life Threatening Illness. A Guide for Patients, Their Families, & Caregivers, Doka lists the following social and psychological factors that influence us as we grieve: social class, income, gender, race, ethnicity, culture, intellectual ability, knowledge, education, prior experience with disease, personality, coping skills, will to live, formal support from medical staff and other professionals, informal support from family, friends, and confidants, and concurrent crises. If we do not take these factors into consideration when we are dealing with those who are grieving, we will not be able to provide them with the support they need. As we saw in Martin’s case, many factors contributed to his behavior. However, since they were never taken into consideration, Martin was not able to receive the support he needed to deal with his real issues.

II Acknowledge the significance of religion and spirituality. Harold Koenig states that 96% of Americans believe in God, more than 90% pray, 70% are church members, and more than 40% have attended church, synagogue, or temple within the past 7 days. These statistics strongly suggest the important role that religion and/or spirituality has in the life of most people.

Spirituality (seeking connection through something or someone greater than yourself to find meaning and purpose in one’s life) may become even more important during times of crisis, such as a serious illness. A medical condition such as cancer may challenge personal beliefs and cause a great deal of distress. Patients may suffer a loss of faith and a feeling of hopelessness after being having a terminal illness diagnosed. Getting in touch with their spirituality may help patients cope more effectively with the psychological and emotional effects of cancer. Researchers have found a striking correlation between good spiritual health and good physical health. Spiritual well-being may improve the quality of life in patients by:

☐ reduction of anxiety, stress, depression, and discomfort
☐ helping them achieve a more positive outlook
☐ elevating their personal growth and self-awareness
☐ raising their hope and empowering them
☐ diminishing their feelings of isolation and loneliness

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square improving their sense of belonging and connection to others
square guiding them toward finding meaning in life and strengthening their will to live
square subduing fear of death
square raising a sense of inner peace
square increasing ability to cope with treatments for cancer.

How Physicians Can Best Help Themselves Through the Grieving Process

Physicians are the forgotten grievers. They are unique simply because they are physicians, the ones who daily have life after life entrusted in their care. Why do we forget the physician when talking about grief? And why do we not expect that they would experience grief as often as and as intense as anyone else?

In medical school, physicians are taught to save lives. In life, they are taught that is not always possible. In medical school, osteopathic physicians are taught to treat patients for illnesses and, when possible, provide a cure. In medical practice, they provide therapy to some patients whose disease cannot be cured. In medical school, they are taught to heal physically. In life, they directly learn that healing does not always occur physically but may take place emotionally and spiritually. That is the full story of life: everything born must eventually die.

When patients die, some physicians take it as a personal loss and feel that they failed to do something better or did something wrong. These feelings can become destructive as they search for answers to different questions, some of which have no comforting answers. “What could I have done differently?” “What could I have done better?” “What didn’t I learn in medical school?” “If only I had tried this alternative, maybe things would have turned out differently for this patient?” “Because I couldn’t save them, I have contributed to their death and their family’s pain and misfortune.” These beliefs can lead to feelings of inadequacy and failure.

Seeing how some physicians respond to the death of a patient has led me to believe that in many ways the medical schools may have let them down. Society has also failed physicians by projecting the notion that the power of life and death is in their frail and fragile human hands instead of in the hands of a transcendent creator. The healthcare profession has failed them by encouraging this unhealthy behavior. Patients and their family members continue this unfortunate process by placing more on physicians than is humanly possible for them to handle. For these reasons, physicians may often suffer substantial grief that often goes unnoticed.

Physicians may grieve their limitations. At some point in their career, physicians realize that they cannot save, help, or cure everyone even though some patients and families are expecting them to do so.

Physicians may grieve because of feelings of guilt. These feelings occur when physicians cannot accept their limitations as human beings, feelings that then lead them to the belief that they could have and should have done more. Questioning themselves and having feelings of guilt can lead to a mindset of inadequacy and isolation as they struggle to find meaning in a healing profession that cannot always heal.

Physicians can help themselves as they grieve when they can accept their true reality, not a false reality imposed on them by medical schools, society, the healthcare profession, and those patients and families who come to them for care. They can help themselves when they accept death as a natural part of life as opposed to something that they could not prevent.

Physicians can also help themselves by setting boundaries. These restrictions include preventing patient and family members from having expectations greater than is humanly possible to achieve.

Physicians can help themselves by accepting, appreciating, and embracing their limitations. When physicians recognize that they cannot do all and be all that people want them to do and be, they will reduce their burden by putting it where it belongs: on patients and their family members as individuals responsible for their own emotional and spiritual well-being as they cope with life’s ups and downs.

Physicians can help themselves by seeking and getting help from other professionals when they need it. It is unrealistic to think that physicians can go through their entire careers without ever seeking the support of a therapist, grief counselor, or related healthcare professional.

Comment

Grief, as painful and difficult as it is, is a gift. Grief helps people to grow and learn. It helps them to work through issues that may not have been worked through if they had not been forced to work through them. It teaches an important lesson about the realities of life, that life is filled with ups and downs, good times and bad times. This realization makes the down times a little more bearable because of the knowledge that it is all part of the cycle of life.

I have learned a great lesson during my time as a chaplain who also offers bereavement support: The best care is provided when it comes from an interdisciplinary team comprising healthcare and other professionals who are qualified to address each dimension of hurt a person will experience. As healthcare professionals caring for those in pain—physical, emotional, and spiritual—we are much more effective as a team than we could ever be alone.

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