Reflection

Grief and the medical referral

Helping ward registrars transition from denial to acceptance

What is the emergency registrar to do when a 69-year-old woman with dyspnoea and clear signs of congestive cardiac failure is hindered from admission under a cardiologist? Why is it that the cardiology registrar called to review the patient, after hemming and hawing about B-type natriuretic peptides and D-dimers, magically transforms the congestive cardiac failure into a respiratory problem and is suddenly on their way?

This is the unfortunate lot of the emergency doctor, played out in emergency departments (EDs) across the country every day. It is not restricted to patients with congestive cardiac failure, nor even to medical patients: how many women get shunted between specialties for their abdominal pain? The situation is now so prevalent that hospitals across New South Wales have dedicated admissions policies to deal with it. The Garling inquiry even touched on the issue in one of its recommendations.1

While this scenario is discussed frequently and at length by emergency physicians, the reasons for it are not clear. However, I put forward my own theory for testing. I believe it is a manifestation of the stages of the grief response as documented by Kübler-Ross in 1969,2 which arguably revolutionised the assessment and management of grief. The Kübler-Ross model was classically developed to deal with the dying patient. However, it has been applied to many other situations in medical practice and can be extrapolated to non-medical but nevertheless traumatic situations, such as crashing your car or having a patient referred to you from the ED.

Ward registrars invariably have a very structured existence. They have a certain number of patients in their care whom they have to review, in no discernible order, in the hours during which they are at work. A referral from the ED causes much distress as it can ruin an otherwise well structured day. They will have to exit their planned ward round and go to that most unstructured of well structured days. They will have to review a new patient, a potential admission, leading to an extra patient to help these poor souls transition to acceptance — of the patient, of their profession and of their life.

So the next time you refer a patient from the ED, remember that you have “broken bad news” to the ward registrar.

Kübler-Ross described five stages of grief: denial, anger, bargaining, depression and acceptance. These stages can be experienced in any order, with some stages being omitted altogether on occasion, and culminating in the final stage of acceptance. Interaction with ward registrars can invoke all of these stages. Anger is the most straightforward to witness: anger at being called in the first place or about being called to see a specific patient. Denial (that the patient has a diagnosis requiring their review) is the most predictable and can be expressed by the simple act of not answering their page. An inpatient registrar attempting to find a diagnosis outside their area of specialty is also a key symptom of denial. Depression is less evident, but depressive thoughts expressed out loud can be easily missed, with examples such as “I am so busy”, “I was on call over the weekend” and “I don’t have an intern today” being some of the more frequent manifestations of negativity, catastrophisation and helplessness. Bargaining is evidence of progress through the grief process — often some minor requests are made, such as asking for additional investigations to be performed, before agreeing to review the patient. Acceptance is evidenced by admission of the patient to the inpatient service.

A natural extension of this concept is pathological grief. This term is sometimes applied to those who are unable to work through their grief despite the passage of time.3 A common problem in pathological grief is getting stuck in one phase. Thus people may become trapped in denial, as our hapless cardiology registrar shows, never moving on from the position of refusing to accept the inevitable admission into their care. Another trap occurs when a person moves on to the next phase without having completed an earlier phase and so enters cyclic loops, such as between denial and anger, that repeat previous emotions and actions4 — a constant oscillation between “It’s not my problem” and “How dare you say it’s my problem?”

Unfortunate individuals stuck in this loop should not be derided behind their backs or be the subject of performance management meetings. They need to be managed in relation to their abnormal grief response. Clearly, having chosen a career that requires them to accept patients from the ED, a strategy must be identified to help these poor souls transition to acceptance — of the patient, of their profession and of their life.

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