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Family Medicine

NARRATIVE ESSAY

The Grammar of Grief

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The insulin pump hummed softly beside the bed.

Morning rounds had begun when we entered the ward. The 14-year-old boy in the corner room looked better than he had two nights earlier, when he arrived barely conscious with diabetic ketoacidosis. Then, his breathing had been deep and laboured, his frame exhausted by dehydration and acidosis. Now the monitors were quieter. His eyes followed us.

"Ketones are clearing," my resident said, "pH is improving. Electrolytes are stabilizing."

I nodded, "We'll transition to subcutaneous insulin tonight."

His mother exhaled, one hand gripping her sari. His father stood near the window, silent.

"He's doing well," I said. "DKA is serious, but treatable."

At the time, those words came easily. I believed in protocols—that if we acted correctly, medicine would restore order.

Later, when the parents stepped out, my resident told me what had happened. It had been the boy's birthday. He had felt tired and resisted insulin. Surrounded by friends, he had pleaded for cake, promising to take insulin later. He never did. By night, vomiting began. By morning, there was abdominal pain, laboured breathing, and a rushed admission with blood glucose above 400 mg/dL.

That afternoon, when the parents came to meet me, I remember the irritation rising. "Diabetes does not forgive lapses like this," I told his mother. "You should have been more careful."

Her eyes filled, though she said nothing. I believed I was emphasizing vigilance. Years later, I still remember how those words sounded.

None of us expected what followed. By evening, he developed fever and hypotension. Sepsis progressed rapidly. Over the next 48 hours, confidence gave way to escalating interventions—antibiotics, vasopressors, and ventilatory support. His mother whispered prayers beside him. He died on the fourth day.

Afterward, the ICU became quiet. Monitors were switched off. Forms were signed. The boy's mother stood in silence, as though no words could reach her. Slowly, her grief turned inward, settling into self-accusation. Around her, relatives gave voice to what she had begun to believe.

"How could she be so careless?"

"She gave him the cake."

"How could she forget the insulin?"

No one raised their voice. They did not need to. The explanation had already been supplied—by me. They left soon after, carrying death certificates and a silence heavier than tears. What became of them, I never knew. Medicine demands we move on.

For a long time, I defended myself with facts. What I had said was medically correct. But I had offered more than information; I had offered interpretation. In one sentence, I had reduced a complex tragedy to a single lapse. Without intending to, I had made blame easier to find.

Years later, I saw her again.

On a crowded bus, a woman stood and offered me her seat. "Doctor, please sit." I thanked her before recognizing her face. It was the boy's mother. She spoke of ordinary things: a shop job, a rented room, her daughter now in college. Her husband had left her; the house had been sold. She said it without bitterness. Then she paused. "Sometimes

these things are beyond us. I don't look for blame anymore. It only burns the living." I did not know whether to apologize or remain silent. "You were kind to him," she said.

"Kind." The word unsettled me more than accusation. When her stop arrived, I finally managed, "I'm sorry."

"It's all right, doctor. You gave us hope," she said softly as she disappeared into the evening crowd.

Long after the bus moved on, I remained seated, watching city lights slide across rain-streaked windows. For years, I had remembered that admission as a lesson in physiology and outcome. I had searched for the same clarity we often seek in medicine: a cause, a sequence, a careful explanation. But that conversation quietly shifted the centre of the memory. What endured was not simply the illness or its treatment. It was the story that had formed around it—and the part my own words had played.

Medical training teaches us the consequences of precise decisions—how carefully insulin must be prescribed, how meticulously electrolytes must be corrected. We speak far less about the consequences of precise words. A statement offered with confidence may outlive the clinical details that prompted it, becoming part of a family's understanding of what happened—and whom to blame.

That chance encounter on the bus left me with reflections I still carry. I thought about the limits of certainty in a profession where outcomes do not always follow expectations. I thought about the generosity of a mother who remembered hope when I remembered my own failure of tenderness. I wondered how easily our explanations, even when correct, become part of the narratives families carry after loss.

I once assumed that honesty and compassion naturally arrived together. I now understand that they must be consciously held together. Truth without kindness may become a burden; kindness without truth may feel incomplete. Our responsibility is not to choose between them, but to allow each to guide the other. When families ask whether things will be all right, I still offer hope—but leave room for uncertainty, for complexity, and for the understanding that suffering rarely belongs to a single moment or decision.

Families may not remember every diagnosis or treatment. They remember how we helped them carry the story afterward.

That evening, as I stepped off the bus, the city smelled faintly of rain; temple bells rang in the distance. I thought of the boy's mother disappearing into the crowd, carrying a grace I had not expected but had been offered. And I understood that the lasting consequences of medicine are not always found in survival curves or discharge summaries. Sometimes they persist quietly within the stories families tell themselves long after we are gone. Sometimes, without intending to, we help write those stories.

Our treatment ends, but our words linger. *Verba manent* ("words remain")—both our privilege and our penance.