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Family Medicine

NARRATIVE ESSAY

From the Waiting Room: Lessons on Grief

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"The family wants everything done, but the patient does not want to be vent and PEG dependent for life. They need a goals-of-care discussion." I nodded during morning sign-out, my first day on the palliative medicine consult service.

Although I only had three patients, I felt pressed for time, knowing each would entail long, emotionally-charged conversations. I didn't yet realize that most of my days would be spent not in patient rooms, but in waiting rooms, a place where medicine pauses while families live with uncertainty.

I entered the ICU waiting room just as my patient's wife sat down. Families were clustered quietly throughout, sunlight streaming in through windows overlooking the medical center. They took turns visiting loved ones, as if grief had visiting hours. The air felt thick with pockets of sadness unevenly distributed between vinyl chairs and coffee cups. My attending introduced us, explained our purpose: to honor her husband's autonomy and offer assistive technologies so he could fully communicate his wishes. There in the waiting room filled with hope, love, grief, and loneliness, I felt a stillness settle over us. As she listened, her face shifted with recognition, understanding the decision she was being asked to make: to uphold vows made in sickness and in health, to choose autonomy over the instinct to preserve life at all costs. It would be a decision that would consciously shape every minute of the rest of her life.

"We've been married since the '70s, when we were kids," she said softly, looking down at her worn Bible.

Despite my medical training, I did not know what to say other than I would return that afternoon. I wanted to sit, grieve, and wait with her, but I had other consults. As I left, I watched anticipatory grief gather around her like a fog. It was nine in the morning on a warm January, and my heart was already breaking.

When I returned, we met the family at the patient's bedside as they voiced the decision to move to hospice. In a single day, I witnessed them move from wanting life-saving measures to realizing and accepting that those were not his wishes—painfully learning that what *can* be done is not always what *should* be done. I wondered how many people I would guide during my career to the start of their grief journey. He died that evening.

Months earlier, I was in waiting rooms of my own.

When my maternal grandmother lay dying across the world, home became a waiting room: waiting for updates by phone, for flights to safely transport my parents, to grieve properly. The week before Christmas, the nursing home became another waiting room: waiting by my paternal grandmother for the infection to win, for death to come. Days later, my cousins stood vigil at my great aunt's bedside, entering their own rooms of grief. Then, abruptly, my mind became the worst waiting room of all when I learned of my cousin's suicide: waiting for answers that will never come, for guilt to subside, and for shock to wear off.

Over the holidays, these rooms offered space to wait and grieve, but they collapsed into one another, with no time to exit one before entering the next. Though each room was different, they all required the same impossible task of waiting for a future I did not want. A week later on my palliative rotation, walking into that ICU waiting room felt suffocating in its familiarity. I was surprised that despite my recent losses, I could not find words of shared pain or comfort.

I often think back to that encounter and my patient's wife sitting alone with her Bible, on the brink of a life-altering decision. I remember how I wanted to help, yet feeling unprepared to do so. I realized that occupying my own waiting rooms had not fully taught

me how to accompany someone else through theirs. Instead, I had used clinical efficiency as an excuse to leave.

As our population ages and medical advances extend life, clinicians will increasingly navigate end-of-life care and bereavement. Waiting rooms will literally and metaphorically multiply: a liminal space that holds grief, medicine, time, and uncertainty. Yet despite grief's presence in medicine, formal training in it remains sparse. Medical education teaches us how to treat, but far less often how to sit beside patients and families when there is no feasible intervention. It requires communication skills that can be difficult to develop through clinical experience alone, even with a fellowship.

Grief education is uniquely challenging because empathy, presence, and tolerance of uncertainty cannot be fully taught through lectures or objectively assessed. Instead, these skills can be cultivated through observations of skilled clinicians, structured reflections, and supervised conversations with patients and families. Medicine often teaches us that once the note is signed and consult complete, we have left the waiting room. Our patients and their families do not have that luxury. Grief does not follow timelines, despite our tendency to treat it as if it should. By embedding grief education throughout medical training rather than reserving it for isolated experiences, we can better prepare clinicians to accompany patients and families through some of medicine's most difficult moments.

The waiting room is an uncomfortable space, a grieving space we carry with us even once we leave, revisiting it willingly and unwillingly, without warning or schedule. But it is also a classroom. If we are to honor our patients fully – their autonomy and humanity – we must do more than master the physical exam and medication adjustments. We cannot eliminate the waiting room, but we can learn to remain in it a little longer. And when it is our own turn to wait, perhaps we will remember the clinicians who chose not to leave us in the room alone.