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Primary care providers' bereavement care practices: Recommendations for research directions

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Abstract

Objective—Bereaved patients are often seen in primary care settings. While most do not require formal support, physicians may be called upon to provide support to some bereaved, particularly those with bereavement-related mental health disorders like complicated grief and bereavement-related depression. Research evidence on physician bereavement care is scant. We make recommendations for future research in this area.

Design—Literature review, focusing on studies conducted between 1996 and 2013 in the United States. Searches of Medline and PsychInfo, along with hand searches of reference sections, was conducted.

Results—The limited existing research indicates substantial gaps in the research literature, especially in the areas of primary care physician skill and capacity, patient-level outcomes, and the quality of research methodology. No U.S. studies have focused specifically on care for bereavement-related mental health disorders. We provide recommendations about how to improve research about primary care bereavement care.

Conclusions—The primary care sector offers ample opportunities for research on bereavement care. With greater research efforts, there may be improvements to quality of bereavement care in primary care, in general, and also to the accurate detection and appropriate referral for bereavement-related mental health conditions.

Keywords

bereavement; primary care; review; research recommendations; mental health; complicated grief; bereavement-related depression

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Introduction

The death of a loved one is a universal part of human life, and is especially frequent among adults aged 65 and older (Federal Interagency Forum on Aging Related Statistics, 2008). Over 70% of older adults in one study experienced the death of a close loved one in an 18 month observation period (Williams, *et al.*, 2007). Bereavement has been found to increase the risk for poor physical outcomes in older adults, including weight loss, decreased nutritional intake, immune system impairment, increased illness rates (Stroebe, *et al.*, 2007) and mortality risk (Manzoli, *et al.*, 2007).

For most bereaved older adults, the intensity of acute grief lessens within a year after the death (Bonanno, *et al.*, 2005). Most are able to return to pre-loss functioning (Chentsova Dutton and Zisook, 2005) and require only minimal support for their grief. However, a significant minority of bereaved older adults experience chronic, impairing reactions to their loss which can be characterized as mental health disorders (American Psychiatric Association, 2013; Stroebe *et al.*, 2007).

Primary care physicians are often called upon to support bereaved older adults. A recent prospective study of adults living with loved ones who died of cancer were more likely to visit their primary care provider (Adjusted IRR (95%CI), 1.06 (1.06–1.07) both before and after the death (King, *et al.*, 2013). Studies also indicate that between 30 to 50% of bereaved older adults seek support for grief from their primary care physicians (Bergman and Haley, 2009; Bergman, *et al.*, 2010; Billings and Kolton, 1999), and do so more commonly than from religious leaders, support groups, or mental health professionals (Bergman *et al.*, 2010).

Yet though primary care physicians are well-positioned to support bereaved older adults, little is known on this topic in the United States. Two previously published reviews on bereavement care were conducted in the United Kingdom (U.K.) and focused primarily on studies there (Nagraj and Barclay, 2011; Woof and Carter, 1997a, b). Given differences between health-care systems in the U.S. and in the U.K., as well as recent changes in primary care practice, more research of U.S. physician practices is warranted. The current paper describes the limited existing data on practices in the U.S., and discusses how these preliminary findings suggest future research. Recommendations for research on primary care bereavement care in the U.S. are outlined. We pay particular attention to recommendations for research on those with bereavement-related mental health disorders.

Bereavement Related Mental Health Disorders

Among the most common bereavement-related mental health disorders are Major Depressive Disorder (MDD; or depression) and complicated grief (CG) (Stroebe *et al.*, 2007). Diagnostic criteria for post-bereavement depression have just undergone a significant change, as the recently released 5th edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM-5) (American Psychiatric Association, 2013) allows diagnosis of depression within two weeks of a death. The previous DSM edition required that depression not be diagnosed until two months after a death (American

Psychiatric Association, 1994). This change will likely increase the number of bereaved older adults who will be diagnosed with and treated for depression. Studies have found that rates of depression are highest during the first month post-bereavement (29-35%) (Clayton, 1979; Clayton, *et al.*, 1972) and then decline to about 14% at 25 months (Zisook and Shuchter, 1993).

Complicated grief disorder is a condition first recognized by Horowitz and Prigerson and colleagues in the 1990s (Horowitz, *et al.*, 1997; Prigerson, *et al.*, 1995a). Professional understanding of condition has suffered from lack of consensus regarding its theoretical conceptualization and use of imprecise terminology (Rando, 2013). The terms given to the condition has altered over the years, including traumatic grief, complicated grief, and prolonged grief. There has been considerable debate over what specific criteria should be included (O'Connor and Breen, 2014; Rando, 2013).

Yet despite debate over what exact symptoms a diagnosis should entail, there is agreement that a distinct grief-related mental health disorder exists, and that key symptoms include: persistent yearning/longing for the deceased; feeling disbelief over the loss, bitterness or anger related to the loss; and feeling that life is empty without the deceased (American Psychiatric Association, 2013; Prigerson, *et al.*, 2009; Shear, *et al.*, 2011; Zisook, *et al.*, 2012).

A recent population-based survey found that about 7% of those who experienced a major bereavement develop complicated grief (Kersting, *et al.*, 2011). A range of factor analytic studies have indicated that prolonged grief is distinct from anxiety and depression in bereaved samples (Prigerson *et al.*, 1995a; Prigerson and Jacobs, 2001a). The primary symptoms of CG have also been documented across different cultures (Fujisawa, *et al.*, 2010; Ghaffari-Nejad, *et al.*, 2007). Criteria for CG are now included in Section III ("Disorders Requiring Further Study) in the DSM-5 (American Psychiatric Association, 2013). Complicated grief is referred to in the DSM-5 as "complex persistent bereavement-related disorder." To help distinguish it from more typical acute grief, CG is not diagnosed until a year after a death (American Psychiatric Association, 2013).

Primary Care Providers and Bereavement-Related Mental Health Disorders

Primary care physicians may also be well-situated to link patients with bereavement-related mental health disorders to appropriate sources of care. One study found that among community-dwelling widowed older adults, 46% of those with CG and 50% of those with depression discussed grief with their doctors (Ghesquiere, *et al.*, 2013). Both depression and complicated grief are associated with a number of negative outcomes, even beyond the increased health and mortality risks found after bereavement (Ott, 2003; Silverman, *et al.*, 2000; Unutzer, *et al.*, 2000). For example, one study found that older adults with CG were 10 times more likely to have high blood pressure than bereaved older adults without CG. Thus, CG or bereavement-related depression may have different and potentially more intensive needs for examination by primary care providers.

Methods

We reviewed relevant literature on bereavement in primary care, focusing on U.S. literature. We conducted a search of Medline and PsychInfo databases from January 1, 1996 to March 15, 2014. Search terms used were: “grief” “bereavement” “complicated grief” “traumatic grief” “prolonged grief” “bereavement-related depression” “depression” “mourning” AND “primary care” “family medicine” “family physician” “family practitioner” “family practice” “general practice” “general practitioner.” Additional papers were identified by reviewing reference lists. The review was not intended to be systematic or exhaustive. Rather, we sought to identify general trends.

Results

We reviewed and identified a number of gaps in the primary care bereavement care literature, which can be categorized in the following areas: (1) primary care physician skill and capacity, (2) patient-level outcomes, and (3) quality of research methodology. While many of these recommendations are drawn from previous literature (Charlton and Dolman, 1995; Cruse Bereavement Care, 2001; O’Connor and Breen, 2014; Pasnau, *et al.*, 1987; Stephen, *et al.*, 2009; Wass, 2004; Wimpenny, *et al.*, 2006; Woof and Carter, 1997b), no previous paper has outlined research recommendations in detail.

Area 1. Primary Care Physician Skill and Capacity

Primary care physician training—Most studies on primary care physicians’ bereavement education and training have been conducted in the U.K. and Canada (Barclay, *et al.*, 1997; Downe-Wamboldt and Tamlyn, 1997; Doyle, 1997; Low, *et al.*, 2006; Saunderson and Ridsdale, 1999; Stephen *et al.*, 2009). In the U.S., Dickinson conducted several large surveys in 1975, 1985, and 1995, and 2002, collecting data from deans and other administrators at 113 medical schools in the United States. These surveys indicate that, in general, the frequency of education about death and bereavement care has improved over time. Medical schools without any formal death education decreased from 13% in 1975 to 2% in 1995. Most schools offered occasional lectures and short courses on death and bereavement, up from 80% in 1975 to 90% in 1995. However, full course offerings on death and bereavement remain infrequent: in 1975, 7% of schools offered a full course-of-unknown or poor quality, while 18% did so in 2002. Moreover, when asked in a 1995 survey 50% of the medical schools had no plans to offer or expand death education citing reasons including time constraints, lack of need, and limited faculty resources (Dickinson, 1976; Dickinson and Mermann, 1996). These findings were replicated by Wass (2004), and subsequently Lemkau *et al.* (2000), who found that 25%-39% of physicians received some education about grief during medical school.

Content analysis of professional medical textbooks also indicates minimal attention to bereavement issues. A review of best-selling textbooks found that content on end-of life care and bereavement care was minimal or absent in almost 70% of textbooks in family and primary care medicine (Rabow, *et al.*, 2000). Instead, most learning in bereavement care appears to occur in practice. In a survey (Lemkau *et al.*, 2000) of 113 U.S. family physicians, 88% of respondents said that their learning about grief and bereavement was

based on interactions with patients, 63% from experiences with their family or social network, while only 55% said they learned about these topics in residency training and 39% said they learned in medical school. There is no data available on whether the information shared in any of these contexts is up-to-date or accurate.

There are preliminary indications that education is of interest to physicians. Leigh and colleagues (Leigh, *et al.*, 2006), in a survey of 1,365 directors of accredited residency training programs, found that 50% of family practitioners desired more training. Similarly, in their survey of physicians, Lemkau et al. (2000) found that most respondents expressed interest in continuing education on grief identification and treatment.

Researchers have also made recommendations for improving education, including making basic literacy regarding bereavement care an important component of physician educational programs (Wass, 2004). Post-medical school, education regarding bereavement might involve in-service trainings, or simply raising general awareness of bereavement related issues via written materials. Appropriate supervision and support may also be necessary for maintaining and enhancing bereavement care skills (Cruse Bereavement Care, 2001; Stephen *et al.*, 2009; Wimpenny *et al.*, 2006; Woof and Carter, 1997b).

However, there was no published empirical research on the efficacy of any of these recommendations in the U.S. There is also no existing research on the education and training of physicians specifically regarding CG or bereavement-related depression.

Bereavement care provision—Most studies on physician bereavement care have been conducted in the U.K., with the earliest studies by Cartwright (Cartwright, 1982). The only study on primary care physician practices in the U.S. surveyed 113 family physicians across the state of Ohio (Lemkau *et al.*, 2000).

Respondents reported that they could play an important role in identifying and treating grieving patients. Many reported that their bereaved patients were interested in discussing their grief, but physicians varied in how they identified and responded to bereaved patients. Some physicians routinely inquired about deaths during annual visits (43%) or routine follow-up appointments (22%), but most relied on outside information about the bereavement (88%). The most common behaviors were expressing condolences (reported by 89%), encouraging patients to talk to family and friends (84%), offering anticipatory guidance about the grieving process (83%) and encouraging the patient to express their feelings (81%), with only 66% arranging for more frequent appointments to track symptoms. In the survey, 87% of physicians said their own time constraints were a significant barrier to the treatment of grieving patients, and 28% said that patient time constraints were a major barrier.

Researchers and clinicians have made many suggestions for how to improve bereavement care. Immediately after the death, primary care offices could either make a condolence phone call or send a condolence letter (Charlton and Dolman, 1995). It has also been suggested that physicians schedule follow-up visits after the loss (e.g. at one month post-loss and near death anniversaries) to assess general physical and mental health, family

functioning, answer questions about the cause of death, describe the grief process, and provide referrals as necessary (Charlton and Dolman, 1995; Lee and Kessler, 1995; Lloyd Williams, 1995; Parkes, 1998; Wadland, *et al.*, 1988; Woof and Carter, 1997b). During these visits, physicians could encourage social support, learning new skills, and maintaining an active routine (Brown, *et al.*, 1996; Prigerson and Jacobs, 2001b; Prigerson, *et al.*, 1994).

It has also been suggested that physicians provide patients with informational pamphlets, with detail on common grief symptoms, locally available bereavement services, and recommended lay literature on bereavement (Blyth, 1990; Charlton and Dolman, 1995; Cruse Bereavement Care, 2001; Dyregrov, 2011; Parkes, 1998). Others have recommended that practices create a standardized death registry, which would record the death experience in the bereaved patient's chart the deceased's birth and date of death, and major anniversaries (Berlin, *et al.*, 1993; Charlton and Dolman, 1995).

More research is needed on whether any of these approaches are effective, and how best to overcome time constraints. Creating death registries seems to be feasible; Berlin *et al.* successfully implemented registries for several GPs in the U.K. (Berlin *et al.*, 1993; Charlton and Dolman, 1995; Cruse Bereavement Care, 2001; Woof and Carter, 1997b), but this has not been studied in the U.S.

Physician attitudes towards grief—Some critics have argued that involving physicians in bereavement care may turn a normal life event into a pathological condition, and research suggests that physicians have this concern. For example, according to British researchers Woolf and Carter (1995), “grief can be considered a normal part of ageing...The more the medical profession become involved in bereavement, the more it takes on the connotations of a disease” (p. 690). Woolf and Carter further propose that having physicians involved in bereavement care could weaken patients' existing social support, and “on an individual level, it could also limit the person's emotional growth that can come from grief” (p. 690). These concerns appear in U.S. literature as well, with many researchers noting the potential for all grief to become pathologized (Hogan, *et al.*, 2003; Stroebe, *et al.*, 2001). However, advocates have countered that because conditions like CG is associated with heightened risk of negative outcomes, including suicidality and functional impairment, that such concerns are unfounded. Rather, diagnosis should lead to better identification, improved treatment, and greater social acknowledgement of symptoms (Bambauer and Prigerson, 2006; Parkes, 2002; Prigerson *et al.*, 2009). More detail is needed on how widespread such concerns are, and how/if they affect care provision. Detail is also needed on other potential attitudinal barriers to care.

Limited information on care for CG and bereavement related depression—Though researchers have made recommendations for how primary care physicians might care for those with bereavement-related mental health disorders, (e.g. (Prigerson and Jacobs, 2001b)), little is known about how primary care clinicians provide care in real world practice. For example, whether or not practices aimed at patients with typical acute grief differs with conditions like CG and bereavement-related depression remains unknown. Physicians do appear to consider concepts of abnormal bereavement when making decisions about referrals to mental health services, but do not measure or document bereavement-

related distress in any consistent way. Lemkau et al.'s study found that factors influencing concern about bereavement-related difficulties included low social support, the nature of the death (sudden death or suicide), and remaining in a period of intense grief for a long period (2000). Physicians rarely refer to specialty services for grief, however. Only 9% of physicians said that they generally refer grieving patients to mental health professionals (Lemkau *et al.*, 2000).

Potentially, physicians could be trained to conduct evidence-based assessments for depression (e.g. the PHQ-9) (Kroenke, *et al.*, 2001), and CG (e.g. the 5-item Brief Grief Scale and 19-item Inventory of Complicated Grief) (Prigerson, *et al.*, 1995b; Shear, *et al.*, 2006). Physicians could help link patients to bereavement or mental health specialists focusing on complicated grief or depression treatment (Shear, *et al.*, 2005; Zisook and Shuchter, 2001). Physicians can help manage bereavement-related depression with pharmacotherapy (particularly SSRIs), though the combination of pharmacotherapy and psychotherapy is most effective (Hensley, *et al.*, 2009; Zisook and Shuchter, 2001). However, no studies have examined the efficacy of physician training in screening, referral, or treatment for CG or depression in the U.S.

Recommendations for improving research on physician training in practice in bereavement care in the U.S. are outlined in Table 1.

Area 2. Data on Patient-level Outcomes

Lack of clarity over patient preferences—The limited data on patients' expectations of bereavement care come mostly from a mixture of qualitative and quantitative surveys conducted in the U.K. (Blyth, 1990; Daniels, 1994; Gunnell, 1990; Main, 2000), with only two U.S. studies identified. Dangler and colleagues (Dangler, *et al.*, 1996) administered a questionnaire survey to next of kin of deceased patients at a single suburban family practice. Nearly half of the respondents expected a telephone call shortly after the death, while about one third expected the physician to ask about their emotional well-being at their next visit. Most patients also indicated that any gesture of sympathy or show of concern from the physician was appreciated. However, this study did not examine whether care provided actually reduced grief symptoms.

Bright et al. obtained surveys from 137 bereaved parents in Kentucky (2009) including open ended items about what they would like physicians to know about interacting with bereaved parents. Parents often noted deficits in physician language, demeanor, and listening skills. For example, parents felt that physicians often used harsh and overly technical language when discussing their child's death with them, using in a cold, clinical tone. Parents also wished that physicians had provided more information on local resources, like support groups, and more follow-up care, with even a simple note or phone call perceived as helpful.

Potentially, bereaved patients may be encouraged to be involved in their care through the use of new technologies. For example, patient coaching, use of prompt lists containing commonly asked questions, and computer programs have been found to increase patient participation during (Brown, *et al.*, 1999). Decision aids may also assist in any decision

making about care (Mauksch, *et al.*, 2001). No studies have tested the application of any of these methods to bereavement care in primary care, however.

Stigma associated with bereavement care—While no studies have specifically examined stigma in bereaved primary care patients evidence from general bereaved samples indicate that those who are concerned with being labeled with a psychiatric diagnosis are significantly less likely to seek professional help for their symptoms (Bambauer and Prigerson, 2006). Studies have found that grieving people tend to find it difficult to ask for help, even from close family members (Owens, *et al.*, 2005), and this may be especially true for those with complicated grief and depression (Ghesquiere, 2013). There is also a tendency for family members to dismiss these symptoms, underestimate the severity of the distress, and tell those with bereavement-related mental health disorders that “they should be over it by now.”(Ghesquiere, 2013; Owens *et al.*, 2005) Stigma may especially be a challenge for older generations, who were raised in a time when using mental health care was often seen as a sign of weakness (Corrigan, 2004; Johnson, *et al.*, 2009; Perlick, *et al.*, 2001; Sirey, *et al.*, 2001).

Public information campaigns and protocols implemented in primary care have both shown some efficacy in increasing treatment utilization and decreasing stigma for depression (Chung, *et al.*, 2006; Sirey, 2013; Sirey, *et al.*, 2005), could be modified for bereavement-related mental health disorders. To keep stigma from being enhanced by family members, information about common grief symptoms and community resources can be shared both with the patient and their loved ones (Blyth, 1990; Parkes, 1998). However, no existing studies have examined whether these efforts are effective for primary care patients in the U.S.

Recommendations for improving research on patient-level outcomes in bereavement care in primary care are outlined in Table 2.

Area 3. Quality of Research Methodology

Limited generalizability of existing research—Our understanding of bereavement in primary care in the U.S. is limited by several factors (Genevro, *et al.*, 2004). Most studies have been based on self-report questionnaires. These data may be biased by physicians who over-report care provided to present themselves in a positive light, and patients who are not be comfortable giving negative feedback about physician practices even when they are actually dissatisfied. Another major limitation of this research is that only a handful of studies were conducted in the U.S. Moreover, very few of these studies were conducted within the past 15 years. There may have been important changes to primary care practices since these older studies were conducted, such as increased demands on practitioner time, increased practice size, and greater attention to primary care models of depression care. These findings have limited generalizability to current primary care practices in the U.S.

Lack of data on bereavement interventions in primary care—No U.S. studies appear to have examined the effectiveness of implementing care for CG or depression in primary care. Two studies on this topic were conducted outside of the U.S. and provide some suggestions of how training might be implemented, with one testing the efficacy of

informational pamphlets and brief training on primary care physicians in Denmark (Guldin, *et al.*, 2013), and the other, conducted in Spain, randomly assigning family physicians to either receive training in bereavement care or to no training (Garcia, *et al.*, 2013). No significant changes were found in patient grief symptoms in either study, however. U.S. studies on the efficacy of interventions are needed.

Recommendations for improving the quality of research on bereavement care in primary care are outlined in Table 3.

Conclusions

Several convergent trends underscore the need for research on care for bereavement in primary care practice in the U.S. First, the mental health of older Americans has been identified as a priority by the Healthy People 2010 objectives (U.S. Department of Health and Human Services, 2010), the 2005 White House Conference on Aging (U.S. Department of Health and Human Services, 2006), and the 1999 Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999). Second, the high prevalence of bereavement among older adults (Federal Interagency Forum on Aging Related Statistics, 2008), the related risk/vulnerability of developing grief-related mental health problems (Prigerson *et al.*, 1995a), and the tendency for primary care to be the main site of delivery of care for older Americans (Mold, *et al.*, 2002) (including for those with complicated grief and depression (Ghesquiere *et al.*, 2013)) all point to the importance of educating primary care professionals in bereavement care. Third, the U.S. health care system varies from that of the countries in which bereavement care has been extensively studied; however this does not preclude the U.S. medical culture from adapting models of collaborative care for primary care (i.e. IMPACT; TeamCARE) (Unutzer, *et al.*, 2002; Von Korff, *et al.*, 2011) which meet the aim of health reform. Lastly, given the anticipated influx of individuals in need of health care after health reform in late 2013, primary care professionals may be increasingly called upon to address mental health care needs of Americans.

These findings suggest that research on the bereaved in the primary care setting is a missed opportunity. Given the existing limitations on primary care delivery, especially time constraints, it is unrealistic to expect primary care physicians to provide all the support needed the bereaved. Rather, research which helps improving the primary care physician's ability to recognize the needs of bereaved patients, personalize their care, and help connect patients existing community resources may have a critical impact on patients in need. Such research efforts could perhaps prevent or mitigate complicated grief and even bereavement-related depression. Thus, research that examines how to enhance physician education, including skill-building, training of primary care office support personnel, and increased collaboration with available community resources could help decrease the public health burden of these conditions.

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Key points

The very limited existing data indicates that both primary care physicians and patients view bereavement care as an important component of care. Research is needed on primary care physician skill and capacity, patient-level outcomes, and the quality of research methodology.

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Table 1

Recommendations for Improving Research on Primary Care Physician Skill and Capacity

Knowledge Gap	Research Recommendation
Primary care physician training	<ul style="list-style-type: none"> • Research on the content of medical school training courses on bereavement, particularly whether it is accurate and up-to-date. • Whether timing (during medical school, residency, or post-training) and modality (e.g. in-service training, written materials) of education on bereavement care impacts physician learning. • Whether supervision from mental health professionals and skilled physician supervisors affects quality of physician bereavement care.
Bereavement care provision	<ul style="list-style-type: none"> • Whether condolence phone calls or letters are associated with improvements in patient satisfaction or clinical outcomes. • Whether informational pamphlets are associated with improvements in patient satisfaction or clinical outcomes. • How often physicians schedule follow-up visits after a loss, the typical content of those visits, and whether such visits improve outcomes. • Whether standardized death registries can be implemented on a large scale, across practices nationally, and what barriers might arise in the implementation process.
Provider attitudes towards grief	<ul style="list-style-type: none"> • The influence of fear of medicalizing grief on bereavement care provision needs to be better understood. • Whether any other attitudinal barriers to bereavement care provision (e.g. concerns about cultural competence in discussing bereavement, general discomfort in discussing death and loss) are common in U.S. physicians • Education about treatment efficacy for bereavement-related mental health disorders may also improve physicians buy-in; the efficacy of such efforts could be tested.
Limited information on care for CG and bereavement related depression	<ul style="list-style-type: none"> • How often, and when, physicians screen for CG or depression after a loss. • How accurately primary care physicians detect CG and bereavement-related depression. • What screens are utilized, and whether they are evidence-based. • Whether physicians intervene differently with bereavement-related mental health disorders than they do typical grief. • How often physicians refer bereaved with CG or depression to other providers, vs. providing care themselves. • Whether treatment provided is primarily pharmacotherapy, psychotherapy, or some combination. • Whether external referrals or physician practices are evidence-based. • Studies could also examine how bereavement care provided within the health care system should best be linked to non-medical resources, such as peer support groups and other community resources.

Table 2

Recommendations for Research on Patient-Level Outcomes

Knowledge Gap	Research Recommendation
Lack of clarity over patient preferences	<ul style="list-style-type: none"> • Studies are needed to gather reliable information on patients' views, preferences and perceived needs. • Gather data on whether, and how, to incorporate patient preferences into treatment decisions. • Gather data on the effectiveness of new technologies (such as patient coaching, use of prompt lists containing commonly asked questions, computer programs, and decision aids) in providing bereavement support.
Stigma associated with bereavement care	<ul style="list-style-type: none"> • Public community information campaigns and primary care protocols to reduce stigma could be modified and tested for bereavement-related mental health disorders. • Whether physician behavior (e.g. language used) helps reduce stigma. • Whether family member educated reduces stigma.

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Table 3

Recommendations for Improving Quality of Research Methodology on Bereavement Care in Primary Care

Knowledge Gap	Research Recommendation
Limited generalizability of existing research	<ul style="list-style-type: none"> • A variety of rigorously designed studies could be conducted to gather data on bereavement care in primary care in the present day, including representative national cross-sectional surveys and longitudinal surveys.
Lack of data on bereavement interventions in primary care	<ul style="list-style-type: none"> • Multi-site randomized controlled trials (RCTs) could be conducted, perhaps with perhaps more intensive training than has been studied to date. RCTs could measure the results of physician training efforts on physician learning and behavior. • RCTs could also measure the impact of physician training on patient treatment engagement and symptom outcomes.

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