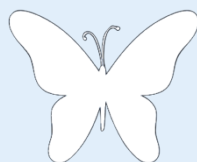


**Medicine is My Third  
Language  
and  
Narrative is My Fourth**

**Chapter 1**

**The Forgotten Text**

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The first year of medicine was one of fascination and wonder (☹ - ☹). The school tossed us a long list: stethoscope (Yeaay! ), white coat (why short though (¬o¬) ), tuning fork (whaa? (☹ \_ ☹) ), pen light...I expected endurance training with blood, human organs and astonishing CPR techniques. For some odd reason, my conception was between a slaughterhouse and the fancy TV shows where *everything* is solved with CPR... (-.-;) Who could blame me? I was over the moon with the Cardiology Stethoscope and the coat \ (^o^ )/. I remembered my kindergarten homeroom teacher. It was “profession day” and the school wanted kids in professional costumes (the joy (¬.¬)). I remember saying proudly, “I want to be a doctor!” and also the pity glance the teacher threw at me “Don’t you want something more fun, like a firefighter?” But what in the world ☹.☹, when are professions supposed to be fun, that is why they are called jobs and not hobbies ^\ \_ ☹ \_ ☹ \_/ ^...and so far so good, I have not found medicine to be a misery either (closest antonym of *fun* I could find).

In fact, a profession should not be measured by a “Scale of Fun”. Sure, you may enjoy what you do and be satisfied with your development (— ☹ —). However, I hardly find it *fun* when you have to say to your patient “I am sorry Mr. Z, but you won’t recover functionality below the waist. We are here to help you to cope with your new lifestyle”. I dare to guess, that it is not *fun* to rescue a severely burned child and hear the screams of pain of the little one while getting them out of their burning house...

Now returning to my first-year eudaimonic<sup>a</sup> state. It was during the very first weeks of my first year in medical school: “The first thing you will learn is how to write”. (Weren’t the required 12 Spanish and 12 English credits enough? (- -;)). So, we went the next couple of hours memorizing how to do a CC (chief complaint), HPI (history of present illness), PMHx (past medical history), SHx (social history) and ROS (review of systems). I wanted a refund! (; \_ \_ ) Twenty-four credits in language: poetry, epic poems, novels, short story...I even made a book, *Amatán*<sup>b</sup>, during my second year for a social science course \(\^xO^x)/ . But I have never seen such narratives in my life, unknown to me, medical narrative became in the following years my third language (◦●◡●◦).

Montgomery describes the medical narrative as a medical plot with the purpose of understanding a diagnosis<sup>1</sup>. I remember, how my medical narrative was shaped through the three years of medicine. My patient notes included *everything*, most of it classified as “junk” information to determine the diagnosis or course of treatment(¬\_¬). “Patient’s dog died yesterday; her mood is sad”. And the resident would point out that it was unnecessary information due that the chief complaint was knee trauma after falling

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<sup>a</sup> Eudaimonic: From eudaimonia which means Happiness or flourishing. For Aristotle, eudaimonia is “the highest good and the end of its own sake”<sup>5</sup>.

<sup>b</sup> *Amatán* is a one-print edition with the purpose of defining “yourself” within the cultural, historical and ancestry context. The course aimed to have an application of self-analysis along with social science techniques such as interviews and literature research.

from the bicycle (¯^¯). I remember being more than 30 minutes with a patient, asking about everything (checking the long list) ...preparing for case presentation.

“Good case presentation, but why go into so much detail for sexual history? The patient’s complaint was a sprained ankle” ...(>ε) All of that is part of the learning process.

In the first year, the students must learn the array of questions. In other words, the list must be known by heart, and the students must be comfortable asking questions that I would not even dream of asking in a social get-together with friends (. \_ . ). This is known as the comprehensive patient notes (AKA ask everything). Second year aims for the Focus History and Physical Exam. The challenge is with more constrained time, gather the necessary information for a diagnosis and treatment plan. Therefore, you need to know the extensive list by heart (■~∪~■), but also how to apply it on a case by case basis. The ultimate challenge is the USMLE Step 2CS (\*^\*). Gather the information (history and physical exam), provide counseling (i.e. stop smoking, please \(-o-)/), give your three educated guesses (the diagnosis) and a workup plan. Of course, answer any challenging questions and be sure to build rapport, all of that in 15 minutes or less. Then you have 10 minutes to convey all the encounter’s information in the patient’s note.

Interesting indeed...adding the unique medical narrative's structure along with the medical jargon, medicine become pretty much a language on its own (☹☹). A very formal and structural language, almost achieving 100% objectiveness. Yet, the patient's story is missing, as stated by Anthony Moore<sup>2</sup>. A clear example I can think of is with my bioethics master's degree director, Dr. Travis Rieder and his book *In Pain*. Probably, I could recreate a medical narrative that will be, more or less, similar to the original note. It would start with something such as *Case of a 33 years old male that presents to the ER after an MVA with a degloving injury with open fracture of his left foot...* However, if you read at least the first five chapters, there is much more narrative conveyed from the patient's perspective.

Should we make physicians gather this information as well, and incorporate all of it in the patient's note? (´•\_•`) Not likely, the time constraints and the patient-physician ratio in the healthcare system (especially in a trauma unit) would not make such an endeavor feasible. Still, physicians *should be aware* that there is a story behind every patient (.' \_ .) . There is always a slipped comment where someone on the floor said "Oh, did you check the ~~one with~~ broken pelvis?" or "The migraine one is presenting with fever now". I cringed, still do. I felt, and pardon my comparison, (>ლ) like when I bicker with my siblings over the phone after buying chicken in our favorite fast food chain. "Yeah, I got two thighs, two drumstick, one breast...and obviously the

wings...sure I will stop by and get the barbecue sauce..." For some odd reason, there is no chicken (whole) but pieces of it (parts).

Before my MBE I would say something like "*Nonetheless, human beings are not chickens, and therefore, they should not be treated as pieces but as a whole*"  $\cong \odot \_ \odot \cong$  ...fortunately I got the chance to hit my face over the table (over and over again) during my Global Food Ethics Course given by Dr. Anne Barnhill (who is also my thesis mentor). The previous argument as it is, falls under the Peter Singer's *speciesism*<sup>c</sup>. The details are out of the scope, but the point is that animals should be ethically and morally considered; there is no default value just for being non-human.

I remember my rotations at the trauma bay, I even heard compelling stories where an arm arrived before the person... I think that after constant brutal exposure, physicians dissociate the disease with the person as a mechanism of defense; making it perhaps easier to cope with the situation ( $\smile \_ \smile$ ). Nonetheless, efforts should be made and go beyond treating the "severed arm" and recognize the personhood in our patients. I believe this would provide a better care. It is virtually impossible that the healthcare professionals gathered the information provided in five chapter of the book *In Pain*, without increasing mortality ( $\wedge \_ \wedge$ ;). However, physicians should be able to treat

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<sup>c</sup> Speciesism is a "prejudice or attitude of bias in favor of the interests of members of one's own species and against those of members of other species" (Singer, 2007) See Citation Appendix after Reference.

the patient and not patient's pieces; by recognizing that each one has a story behind them (~\_^).

Most of the physician's experience is acquired through the empirical training (r\_■\_■), rather than reading books. I have known the SPIKES<sup>d</sup> mnemonic since the second half of first year. However, it wasn't until my third year when I was exposed to Bad News Delivering by the residents and attending in a family meeting; or when I partially participated in telling my patient that the colon biopsy returned positive for adenocarcinoma under my resident supervision, that the SPIKES burned into my memory (>\_<). Which also proved to be problematic as will be seen in Part II. In the book *In Pain*, a pendulum analogy is contrasted with the opioid epidemic response-history; swinging between unstirred restriction to unhindered freedom<sup>3</sup>. I will borrow the pendulum analogy for a second, it is good to have guidelines, but I assure you that you don't want the conversation to go strictly, step-by-step, word-per-word...it is very robotic (☹\_☹). At the same time, you want to have a sense of uniformity in the profession, because too much creativity is an invitation to chaos as well.

Enough of Part II spoilers (n\_n). Narrative medicine provides a learning tool for students and clinicians regarding these personal experiences. If the narrative is attached to critical reflection, then the healthcare community can learn about struggles and

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<sup>d</sup> SPIKES (Setting, Perception, Invitation, Knowledge, Emotions, Strategy/Summary) is a six-step protocol for delivering bad news (Baile et.al, 2000) See Citation Appendix below Reference.

mistakes that may be faced in similar cases. So far, we have discussed two narratives: the medical note and the medical encounter through a patient's perspective.

The latter along with medical narrative promotes reflection regarding the humanitarian components expected from the profession such as: empathy and compassion<sup>4</sup>. Masterpieces such as *The Use of Force* by William Carlos Williams, *Brute* by Richard Selzer, among others, provide an insight in the physician-patient relationship that the expected medical note cannot convey: feelings, thoughts, attitudes, and beliefs that are not and cannot be shared through the structured medical communication.

Let's pause for brief moment. By no means I am suggesting that physicians' feelings, thoughts, attitudes, and beliefs should be fixed in the patient's note. Can you imagine seeing around 50 patients' consult, where some may have life-threatening situations (@\_@) and then you have to read through whether your colleague felt satisfaction, but then regretted it, by forcing a patient through a procedure, for all the 50 patients?! (>\_<) Burn out would be an understatement!!! (x\_x) However, as an educational tool, it has unconceivable value♥\_♥. After reading, Williams and Selzer's short stories and then working in a reflective critical analysis, guided by Dr. Jeremy Sugarman and Dr. Lakshmi Krishnan; I gathered experience that perhaps I would have not gathered throughout my entire career (i.e. the setting for an encounter, specialty, different population, etc.).



Still, I believe that another text could be added. Since my first year of medical school, I have been writing what I called “*Mini-Reflexiones*” (Mini-Reflections in Spanish) of the different encounters I had lived. I love to write (I have a few unpublished fictional short stories and two novels; and during the early teens a few fanfictions [*Yeah, I know, I am such a nerd*]). Therefore, I gave no thought of the mini-narrative beyond as an extension of my hobby, and an escape valve under the high-pressure environment. It wasn’t until my Bioethics Practicum mentor, Dr. Joseph Carrese, suggested that I worked in an ethical-medical narrative for my writing component. A reflective compilation from an MD/MBE student’s perspective, whose third-year clerkship occurred simultaneously to Hurricane María’s devastation. The Practicum’s proposal was submitted to the program and the project was accepted.

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