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## Plain English

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The night before my first rotation, my best friend toasted my ascent through a Zoom screen: “Here’s to you. Tomorrow, you stop speaking like a normal human being.” We had met studying abroad in Florence, two English majors charmed by the twisty *largo* and *allegretto* of Italian poetry.

I loved writing because it demanded I risk my own skin: writing was sieved through subjectivity, steeped in the personal. I could not remove self from the equation the way that a calculator or formula delivers the same result, every time. But medical school wasn’t so much about storytelling as it was about recitation. There was no artifact of self to be found in our multiple-choice answers on exams; even simulated patient encounters began to sound scripted, shared. “*I’m sorry to hear that.*” “*That must be hard for you.*”

The language of the classroom insulates you from medicine’s tangible reality: the rash becomes a needle, becomes a tube, becomes a barcode, becomes digitized numbers on a screen with a down-trending arrow. I entered clerkships ready to be bewildered by the body, to feel words in the flesh. Yet even here, words wallpapered everything. Under fat bricks of acronyms, patient stories disintegrated into incoherent, fragmentary rubble, word salad.

This ultimately prepared me not for the patient, but for the performance—the dreaded patient presentation: standing before a team of jaded professionals expecting me to speak eloquently, sell a story, defend a thesis, and predict the future. All while maintaining eye contact. Not in all my time in the humanities had I struggled so much to make myself intelligible.

The ideal clinical note, I was finding, narrowed the gap between what was seen and what was known, the subjective detail and the objective finding, the case and the category. Smoothing out these idiosyncratic wrinkles gave you something easier to work with, a narrative that might more easily mold to a template found in a textbook or article. Such a template would give you direction to treat and manage, give you guidance.

And yet, to me, personhood and language remained inextricable. Feeling excluded from a lexicon was, in some ways, akin to feeling your sense of belonging threatened. In the inner circle there persisted even deeper pockets of language. “Received a tracheostomy” became “trached”; “non-contrast CT” became “non-con,” delightfully lazy on the jaw. “Crumping” (somehow) meant that the patient was rapidly declining. We erected a palace of jargon to pedestal our understanding, then rejoiced in razing it all down.

Sometimes, I heard my residents referring to their patients as “unreliable narrators,” or “poor historians.” *But they still lived in their bodies*, I thought. They inhabited their words, as confused or digressive as they may be. How could I expect patients to shelve the self, while I existed in all my

clumsy articulation and disjointed knowledge? If the patient was an unreliable narrator, what exactly did that make me?

From day one, Helen\* refused to be read. She'd been admitted to the hospital for no less than three major intracerebral hemorrhages in the last month. No one could explain their etiology. Now they were suspecting vasculitis. She rarely acknowledged me, answering my absurd mental status checks in a clipped, deadpan tone that suggested *I* was unwell. A row of staples stood stiff as a mohawk on her head, shaved freshly bald for the cranioplasty, and had the odd effect of making her seem rough yet childlike, almost juvenile. She burrowed deeper into the blanket when I entered the room, eyes glaring balefully, screwing shut when I parted the curtains.

“Close those.”

Helen had a history of hospital-induced delirium. “It’s important for patients with delirium,” I explained, “to let in as much sunlight as possible, to help regulate sleep-wake cycles!” I tried to inject pep into my tone to mask how I really sounded: like someone reading from a textbook.

“Well, I also get migraines, and sunlight doesn’t help that.”

I lingered there, fabric still clutched in my fingers, weighing the risk. What was more dangerous: migraines or delirium? I realized how ridiculous it looked to keep the curtains open despite knowing about her pain, and whisked them shut.

“We’ve come to do a lumbar puncture. Are you familiar with the procedure?”

She twisted in bed so her back was to me. “Don’t want to know the details. Just do what you gotta do.”

As far as routine procedures go, lumbar punctures are unnerving. Seeing Helen’s face drawn tight, forcibly wiped of all emotion as she curled up into “the tiniest ball possible” (our instructions), made me cringe from how vulnerable I knew she must feel, how visibly she strived to keep it hidden.

I had spent that first week trying to embody the language I spoke, resisting my classroom instinct, constantly reminding myself: *feel this*. But right then, I held the needle and willed my mind to disaggregate from the pure horror of what my hands could do: stick a needle between the knobs of someone’s spine and drag out the fluid that cushioned their brain. The world narrowed to just that moment: the puncture of skin, the drag of dura on needle, the hiss of *ow*, the *click* of bone, my reflexive wince.

When it was done, she turned to look at me. “Want to hear something stupid?” I nodded.

“That was scarier than the brain surgery.”

In the following days, I returned to Helen’s room with renewed resolve: if I couldn’t yet move among patients with the internal confidence of a real doctor, I could at least bend my body to its mannerisms. I painstakingly asked every question, tested every reflex, tried to anticipate her needs before she voiced them.

One day, watching me do these things—picking up the socks strewn on the floor, double-checking her medication, gently sponging the

dark glaze of iodine from her sutures—she said, “You really *are* a student, aren’t you.” Her voice was not unkind.

I will likely always feel like a learner, but this doesn’t have to be alienating. I try to inhabit the moment, to dwell inside of an individual encounter instead of standing back at a distance. Often, this means approaching patients as myself and granting them, in turn, the grace of being messy, deconstructed, humans.

It took me days after discharging Helen to realize while chart reviewing that she had been a nurse: a fellow healthcare worker. It’s the details, the ones that defy diagnosis and classification, that deserve attention—not to reveal similarity to ourselves, but because in spite of it, difference persists. Unknowability persists, which is why we care.

The words in the medical chart have everything and nothing to do with what I see. It’s the disconnect that wakes me up. I want to protect that distance—to leave room for the spark to catch.

\*All patient names and identifying information have been changed to uphold privacy.

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