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Entry Points

By A. Scott Pearson

When I speak of the concept of Narrative Medicine to clinicians, most indicate that this is a good idea. It sounds good, this connecting to the patient's story. Navigating from the theoretical to the practical, however, can be difficult. How does a healthcare provider connect with the patient's story, discover a diagnosis, formulate a treatment plan, and see the next patient in a timely manner?

What we need is an entry point into each patient's narrative, as so eloquently described by Sayantani DasGupta in "Narrative Humility." (*The Lancet*, vol. 371, 2008, pp. 980-981.) Recognizing what is important to the patient can become a recurring theme, a point where we enter their story each time we interact. These entry points may be offered by the patient during the initial discussion and thus requires us to be open and receptive to this aspect of their story which can serve to optimize their care and usher them into recovery. The importance of these narrative entries can be illustrated by two clinical encounters during which I realized that locating these entry points would be difficult or even impossible to achieve.

On trauma call, several years ago, I received a young male with high velocity gunshot wounds to his body, the result, I suspected, of a gang dispute gone bad. There were multiple entry points on his abdomen with some of the missiles passing through and exiting the back. We intubated him in the trauma room. His blood pressure was life-threateningly low, so we began rapid infusion of crystalloid fluid and blood. I thought he would die in the trauma room but he didn't. We rushed him stat to the operating room, squirted Betadine on his abdomen and chest, and opened him to find multiple intestinal injuries and a bleeding liver. At this point, we initiated a damage control laparotomy, removing the injured bowel but leaving the intestinal tract disconnected. We placed multiple packs into and around the damaged liver which continued to pour blood, so much so that the anesthesiologist could not infuse blood into the body fast enough and he went into cardiac arrest. With a pair of scissors, I zipped open the muscular diaphragm and entered the chest to expose the boy's lifeless, deflated heart. I began open cardiac massage. We continued this maneuver for several minutes, hoping that the rapid blood transfusions would restore enough circulating volume to restart his heart. Nurses scrambled for more packs of blood. It is three AM now and more personnel enter the OR to help. But when I looked beside me on the floor at the ever expanding pool of the boy's blood, I knew we would lose him. A few minutes later we stopped and pronounced him dead. I stepped back from the table and stood there and felt the senseless loss of life. I was exhausted, and angry, and hopeless all at once and wondered why I was doing all this. Reality returned in the form of my beeper the nurse handed to me. "It's the ER", she said. "They want you."

But I had another job to do. It was my responsibility to inform anyone who might be waiting of the boy's condition. Usually this would include family, parents perhaps, or friends. But this event had occurred so quickly, in the middle of the night. Perhaps no one was aware, and no one had arrived yet. The OR nurses informed me that indeed there was a group of

people waiting. Family, I assumed. This was going to be hard. I was tired and rushed and they deserved an explanation and time to absorb the tragic news I was about to deliver. I opened the door to find the waiting room full of young males, the same age as the boy. This is his gang, I thought, although I didn't know for sure, and didn't want to stereotype. They seemed restless, standing, pacing. I realized I knew absolutely nothing about this boy who had just died. I needed some entry point into his narrative, their narrative, any connection would have helped in what I was about to tell them. I started to explain how bad his injuries were, but one of them, the leader perhaps, interrupted. "He is alright, isn't he?" This seemed less question and more threat. I told him their friend was dead. The room descended into chaos, hitting, cursing. I realized how stupid I was to have entered that room alone. I stood to leave but they blocked the door. The leader got in my face and demanded that I bring their friend back to life. Minutes passed as I frantically tried to explain. But the only narrative I had was bad news. I was nothing to them. Security eventually heard the ruckus, busted in, and extracted me from the room.

Several nights later, I was called to evaluate an entire family who had been hit by another vehicle in their station wagon. Before entering the exam room, which contained the whole family, the nurse informed me there were many children involved, none wearing their seatbelts. Expecting the worst, I opened the door to see a large Hispanic family. Both mother and father were each holding the smaller children while five other children, playing on the floor, or in chairs, came to attention as I entered. I immediately realized I would have to examine each of them, including the parents, decide who was injured and what studies to order. None spoke English so I summoned a translator who would not arrive until I was nearly finished. I nodded at the parents, tried to ask about the accident, and then looked at the children. Each had one thing in common. They were all smiling. Big smiles, grins, like this was the most fun they had had all year. I leaned down to examine the smallest child in dad's lap, an adorable little girl who grabbed my stethoscope and would not let go while the older children giggled and stared. This child appeared uninjured as did the little boy in mom's lap. I did an exam, as was possible, on mom and dad while examining the lap children. Then on to the older children who appeared so excited at this prospect that they were nearly lining up for me to examine them.

While the father was telling me, I presume, of how their station wagon was hit and the unseat-belted children were tossed about the vehicle, I would examine the next, smiling, somewhat dirty, adorable child. The more I looked for injuries the more I found none. I loved this family. My dread of having to evaluate them turned into delight. I recruited the older children to hold the younger ones while I examined them. I feared that an emergency patient would come in, the nurses would call me out, and interrupt our great time. I had gained entry, although tentative, into their narrative: that of a family who cared for one another, their life traumatically interrupted by this event, who would pull through and emerge even stronger and perhaps, for at least the moment, would pull me along with them.

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