Narrative Medicine **July 13, 2025**

Dear Residents,

I've had a week off, but I am still thinking about some of the patients on our team at Parkland. The approach I initially learned to patient care was ensconced in the biomedical model of medicine. A symptom was what the patient complained about (right lower quadrant pain), the sign was what was elicited by the physical exam (rebound tenderness in the right lower quadrant) and the pathology was revealed by the ensuing laparotomy (acute appendicitis). This triad of symptom - sign - pathology formed the basis of biomedical medicine. Lurking in the background was the concept of medically unexplained symptoms. Michel Foucault, in The Birth of the Clinic, explores the *Medical Gaze*, where physicians began to view patients as objects to be examined, rather than individuals with subjective experiences. Till today, we construct our notes with *Subjective* and *Objective* headings, intimating that while we will acknowledge the *Subjective*, we may well dismissive some or all of it if we cannot validate it with the *Objective* (physical findings, lab tests or with imaging). We have also discovered diseases that don't have antecedent symptoms (hypertension, diabetes, hyperlipidemia, etc.) which also upend the classical triad - we have to convince patients that they have a disease but no apparent symptoms, yet they ought to follow our advice. No wonder that adherence rates are quite low.

Over time, we have begun to recognize that subjective symptoms are important to address and validate (pain being the main one). We have also recognized that there are many reasons for health care seeking behavior and that physicians exercise an outsized role in society in withholding or conferring the "sick role". Talcott Parsons explores this idea of illness as social deviance. He sees physicians as gatekeepers of the sick role which results in a strong doctor-patient hierarchy that is still present to this day even as concepts such as patient-centered care and shared decision making have permitted patients to gain more agency in their own care. A more recent movement has emerged, termed narrative medicine, which takes our approach one step closer to the patient's story as being instrumental to understanding their illness and as an approach to healing.

Our team had three memorable patients where we explored their narratives, some more completely than others. The first was a young woman, aged 25, who was abused as a child, began drinking alcohol at age 11 and then progressed to drugs. She had developed advanced heart failure with an estimated ejection fraction of 15%. An AICD was being considered. She arrived at the ED with her boyfriend with chest pain - she ruled out. We interviewed her - she seemed irritated at having to answer questions all over again. We noted that the potassium was modestly low along with the magnesium. The QT was ever so slightly prolonged. We offered IV potassium and magnesium which she declined because of a prior experience of an intolerable burning sensation in the veins. We agreed to oral replacement. She was holding on to

whatever dignity she could. Fifteen minutes later she had a cardiac arrest. There was a suspicion of torsade de pointes. It was a brief but troubling encounter with a vulnerable patient who had a very premature vital organ failure.

The second patient, we learned was an accomplished cook, who descended down the economic ladder because of alcohol use disorder and was evicted from his shelter because after being sober for weeks, he "made an error of judgment" and snuck some alcohol. Upon discovery of this violation, he was asked to leave. Dejected, he presented to the ED. He was admitted because of weight loss, cough and mild fever. We diagnosed acute exacerbation of chronic bronchitis. Three days of azithromycin fixed that. The weight loss turned out to be from food insecurity. We let him go without a fully safe discharge - he was to present at the same shelter and hope that they would let him back in.

The last patient had paraplegia from a tethered cord, a 10+ year history of homelessness, alcohol use disorder. He had had approximately 300 hospitalization days over the last 13 years. if each of those days cost $2000, then the total amount spent on his care was $6,000,000. Imagine even some of that being utilized for the social services he could have received. We admitted and readmitted him three times in 2 weeks for recurrent cellulitis. His was also a story of economic descent, estrangement from family and essentially nowhere to turn to.

These narratives are important as we seek to fully understand both why someone got to this point in the first place and what their path to recovery (if any) will be. A pure biomedical model of disease, while critically important in understanding pathophysiology, will fail our patients unless we fully learn who they are and what's important to them.

I will soon be heading back to Dallas. See you soon!

Dino Kazi