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Migrations

By Esther Lee

for R.

I watch him slowly walk the hospital hallways each morning, his slippers dragging the floor. I can't help but wonder if he feels abandoned and lonely, so far from home. His medical history is fascinating and complicated enough to keep any student occupied, but the connection comes from a mutual sense of global displacement. A 34 year old migrant worker from Thailand, he has been in Israel as long as I. I came to study medicine through an American program. He is here to find high-income work worth the distance, to support three children back home. We can't communicate; he doesn't know Hebrew or English, and I don't know Thai. Now he is marooned in the hospital with infective endocarditis, status post valve replacement on IV antibiotic therapy. I'm reminded of him each time I meet patients who look like blurry mirror reflections of me.

I knew more about his renal function, latest cardiac imaging and his delicate electrolyte balance than the details that defined him. The Thai friend who spoke Hebrew at the ER and interpreted did not come up to the ward with him. The usual questions about family history, social history, lifestyle and habits, past medical history and even history of presenting illness produced a shamefully thin file. Language difficulty. Even though we didn't know the specifics of his life, let alone the arc of his present illness, it bothered me to know that we were treating him anyways. But what else could we do? For doctors, inaction is death. Watch and wait, or expectant management, sounded too close to passive disinterest. My previous preceptor prescribed Vitamin C, if not only for the patient's superstition, but to assuage some of her helplessness. But in all fairness, infective endocarditis after a valve replacement was pure medicine. We knew how to balance fluids and keep the drug levels in his blood from reaching toxic levels. And so that's what we did.

As a third year medical student released into the wards for the first time I was confronted with many unknowns. Yes, I knew how to exist on the wards as part of a medical team. But how do I care for patients without using medicine? How do I talk and connect with the amalgamation of cultures and languages of this young immigrant nation? In this hospital, Ethiopian immigrants, Bedouin families, children of the former Soviet Union and fourth-generation Israelis gathered together under Medicine's care and joined me in an elaborate tango of questions and answers to produce diagnoses. We are taught to lead the dance each time, control the pace and maintain tension, release empathy at the right moments. Even with my intermediate medical Hebrew, I interview patients and commanded an authority vested in my white coat. Still I find myself floundering in not only the language and culture of Israeli medicine, but also the nuances of healing through a doctor-patient partnership.

One day I asked him in English how he was doing and he replied in Korean. I'm immediately transported back to my birth country. For a split second I'm not in the Middle East, I'm somewhere South, someplace deeply familiar. *Him deul uh*, literally means, this takes strength. Translated in common use: I'm tired. I tried to visit him every morning between blood draws and morning rounds, hoping to catch my mother tongue from him again. Maybe this would be our common language. This could form the doctor-patient relationship I've heard about and wanted to explore since arriving on the wards.

I realized that *him deul uh* was the only phrase he knew. Still, he let me perch on his bed for our 10 second conversation (in English) almost every day. Perhaps he sensed a kinship with me as Asian minorities in our host country. Maybe he was just complying to the white coat and acted in a role. I had no words to ask. I hoped that somehow reading his file and keeping up with his cardiac and renal function, X-rays and echocardiograms would help me understand his disease—now decompensated endocarditis, resistant to treatment and impending heart failure—and by proxy, the patient. Did his family know that he'd been hospitalized for over a month now? Will the farm let him return to the same job after this?

By week five, his black hair had turned ashy gray. Asians have a propensity for early greying, usually induced by stress or just genetics. His was a sad newspaper grey, like the daily papers accumulating in the doctors' lounge. By this time he had stopped hanging by his bed. I saw him out on the porch with his chair facing the helicopter pad. He stayed outside as much as possible, watching the helicopters fly in and out. Once he signaled "no" when I approached him for the morning blood draw. I wrote "Patient Refusal" on the order and tried to not to let it bother me.

We kept him for four more weeks. We were unsure that he would continue antibiotics on the farm, so we kept him here, even though he was by all external appearances recovering and only needed expectant management. After his time was up, we let him go.

After the holidays, I came back to do morning blood draws and was surprised to see his name. What happened? Surely after such an extended stay he had used up his lifetime quota of being sick? A fast, irregularly-irregular EKG proved the reason for palpitation. Atrial fibrillation, most probably due to pericardial effusion, bad valve replacement—the resident drilled off to me as she pointed me to his room. The sac surrounding his heart that normally held a few teaspoons of fluid to ensure smooth contractions had collected too much fluid, too quickly, and was squeezing his heart to death. My mind raced with possible causes alongside the medical updates. He came to the ER last night because he felt his heart beating and couldn't breathe. I entered to draw his blood and noticed the change immediately. He was barely awake, lying on his back in the dark, with the monitors insistently beeping their red numbers. Tachycardia and hypotension. V2 waves were moving too fast, speeding past the red lights. He didn't greet me, but lay there, his left arm over the covers, as if, an offering. Though I could see and successfully poke his familiar cubital veins, blood didn't rush into the vials as usual. All his veins were collapsing; it was an impossible task. One of the attendings rushed in while I was cleaning up. *He's not going to make it like this, he needs immediate cardioversion! Transport to cardiac ICU, now!* I'm ordered to go to morning report instead. I sit through it, barely registering new chest pains, abdominal pains, and constipation, shocked at the sudden downhill narrative. I felt

inadequate sitting there but I knew well enough that I was probably inadequate sitting next to his bed, watching him. When I return to his bed after duties, he isn't there.

After a few days, I finally have time to go visit him. Ward responsibilities had now become familiar and comfortable existing on the ward. Somehow, I had found my place on the wards. The Russian nurses start smiling at me in the morning—doobray ootro!—and the Arab residents begin teaching me common ward lingo. I find a cardiologist in the dimly lit cardiac ICU on the first floor and ask what happened to the Thai patient. They brought his heart from atrial fibrillation into a stable rhythm. *Push, everyone clear, administer shock!* Perhaps the replaced tricuspid valve had malfunctioned, triggering a dangerous arrhythmia. As usual, I stand next to his bed, holding onto the metal railing. He looks better and smiles in recognition when I cautiously open the curtain to see him. I stand there, in my stiff white coat and stuffed pockets, wishing we could communicate. He raises his calloused hand in greeting. If we could talk, we'd converse like old friends. Put words to the peppery hair, our mirror imagery in the desert, the reality of our global wandering. A nurse walks in and gives him a pill. She forgets the water and he asks me for some. Well, he doesn't ask me - but by now, we've practiced our hand-and-face language. If only this was a game of Charades - if this was all role-playing. Me, the doctor and you, the make believe patient acting out a case: unstable arrhythmia patient. I'd know what to do and say this time. Language and culture may be an obstacle, but not a barrier to connection. I'd know how to be with a patient now.

I signal to him that I have to go. He tells me, *him deul uh*, and I know I don't have to say, I know, because we both know already. I wave and draw the curtain behind me.

Esther (Young Ju) Lee was born in Seoul, but considers the Philippines one of her many global homes. She is currently a third year medical student at Ben-Gurion University of the Negev, the Medical School for International Health, in Israel. An avid reader and a writer at heart, she incorporates reflective writing to help her maintain clarity in her studies and adjust to her emerging doctor role. She is also published in The Journal of General Internal Medicine, The Living Hand (2016), and in a collection of third culture kid narratives (The Worlds Within: An anthology of TCK art and writing; Summertime Publishing, 2014). She is eager to continue combining her interests in cultural humility and narrative medicine as a physician.

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