HEALING ARTS: MATERIA MEDICA

The Code Switch

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“Mrs. Miller? Your husband just lost his pulse.” I say these words frantically. On the other end of the telephone line is a woman I have never met, whose husband is dying in a room down the hallway. I speak many languages, but this time, I do not hear what I am saying.

In addition to learning English and my mother tongue, I have also learned the rules of my mother’s tongue. She is an Indian American in an English-speaking society who effortlessly strings together hybrid sentences. Code switching, as this is formally known, is sometimes seen as a deficiency in either language, and her sentences can sound like gibberish to the untrained ear. But to me, it is a sign of being fluent in multiple worlds.

In my early years of doctoring, I have become fluent in another blended language: medical jargon. Jargon makes its way into my written histories and oral presentations and allows me to communicate effectively with my colleagues. It has become part of my identity as a resident and as a physician.

On morning rounds, for example, I can talk to an attending cardiologist about our patient with ischemic cardiomyopathy with an EF of 33%. My attending appreciates my brevity and this descriptor is sufficient for her. But the patient himself would not understand this, despite his vivid memories of his three heart attacks and now debilitating shortness of breath.

With my increasing fluency in medical jargon, I sometimes forget the meanings of words of my first language. For instance, when I say a patient “claims” something or “complains of” something else, I am forgetting that these are adversarial terms—terms that a layperson might associate with a courtroom instead of a clinic room.

In my line of work, the laypeople notably are my patients, who I am speaking of and who do not speak or understand my specialized language. I now have to pause to communicate with them appropriately. It is this pause—which is second

nature for a fluent code switcher like my mom—that is sometimes awkward for me. I completely botched it just last week with Mrs. Miller.

It is 3 am on the medical wards and a nurse on her hourly rounds finds her patient unresponsive. The hospital’s alarm sounds overhead, and its quiet, dim hallways are suddenly filled with sleepy, disheveled residents and their pounding shoes and flying papers. I enter to find a nurse pumping on the patient’s chest, another resident shouting orders from the foot of his bed, and still ten other people crowding the door of his room, waiting for their cues to help. Someone has to notify his emergency contact, I think, so I run out of the room to the phone at the end of the hallway.

“Mrs. Miller? Your husband just lost his pulse.” A man is dying in his hospital bed and my own heart is racing in my chest. “The team is trying to resuscitate him. You have to come to the hospital as soon as possible.” I continue breathlessly.

Behind me, there is a room full of people rallying against all odds to save a man’s life. The stakes are high and there are no pauses as I warn his family about his imminent death. And here, I stumble.

I forget that a 3 am phone call from the hospital would be so frightening for Mrs. Miller that words like “pulse” and “resuscitate”—words which she might recognize on the display of her exercise treadmill or on the board of her community’s swimming pool—would hold no meaning for her in the middle of the night. I forget if she even realized who was calling her and I forget to ask if she understood my message.

The frenzy continues inside the room, but after 25 min of compressions, the code is over. I have to call Mrs. Miller again.

“Mrs. Miller, I’m very sorry. Our resuscitation efforts were not successful.” She repeats my words to her daughter, rhythmically, mechanically. She tells me calmly, matter-of-factly, that they are in the car, on their way to the hospital.

I pause to imagine Mrs. Miller coming to her husband’s hospital room, expecting him to laugh at all this commotion and apologize for startling her in the middle of the night. She would kiss him on the forehead and then patiently await his retelling of the night’s events. But instead, she will walk in to the room to see her husband’s lifeless body. She will notice his nurse’s best efforts to clean up the dried blood from around his mouth and the leftover plastic wrappers of syringes and tubes littering the floor. She will search frantically for his doctor and demand to know why her husband was suddenly dead. I

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imagine this miscommunication and—at long last—I realize she has missed my message entirely.

I am suddenly aware I am not as skilled as my mother, who not only uses her two languages expertly but also seamlessly switches based on who should be listening. For Mrs. Miller, a woman whose husband had just died inside his hospital room, I had been speaking gibberish. I pause and think about my next words to her. I must clearly communicate the tragedy that has transpired inside her husband's hospital room.

"Mrs. Miller? Your husband has passed away." There is quiet on the other end of the line.

"Mrs. Miller. He is dead."

I hear tears. Finally, she understands.

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