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Family Medicine

NARRATIVE ESSAY

# Grammars of the Clinical Encounter: A Universal Language of Care

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I first learned to listen with my eyes in São Gabriel da Cachoeira, where three languages are official and many more are spoken at home. My clinic sat at the edge of town, close to the forest. The catchment was considered vulnerable even within the municipality. Medicines arrived by boat, often after 7 to 10 days; referrals went to Manaus, and patients were sometimes lost to follow-up. In that place, I learned that care is a conversation with more than words and that clinicians must become adaptors of discourse.

One afternoon, an elderly couple arrived, accompanied by a nurse translating my words into Tukano. The man had been admitted 3 days earlier for pneumonia; now he sat on the edge of the hospital bed, shoulders curved inward, breathing shallow. He and his wife were quiet partners: he spoke first; she watched and corrected with a look. The nurse carried terms across languages, but the real translation was slower—gestures, pauses, what they chose not to say. In the hospital, elders were placed in beds. At home, they slept in hammocks. The nurse shared a local sign: recovery announces itself when a patient complains about the bed and asks for a hammock. We adjusted the plan around that signal—analgesia timed for evenings, a home visit to check whether the hammock had been hung again. The note in the chart read "improved pain control." What we actually saw was simpler: a hammock in use again.

That encounter taught me that every clinical meeting operates according to its own grammar—implicit rules about who speaks first, what silence means, which signs count as progress. These grammars are relational, not merely linguistic. They include the body's posture, the family's arrangement in the room, objects that carry meaning beyond their function. The hammock was not furniture; it was a diagnostic criterion, readable only by those willing to learn the local language of recovery.

Once I recognized this pattern, I saw it everywhere. A second encounter required a different grammar. A woman sought care after sexual violence. Here the grammar was silence: what could not be spoken aloud, what needed to be written, what required a trusted intermediary. We changed the usual sequence. We mapped a support network, identified someone she trusted to carry information between visits, and created a one-page plan in clear language, read aloud through a translator when needed. Medical decisions—prophylaxis, follow-up timing—stood alongside practical ones: who accompanies, how to reach the clinic, what to do if travel is required. Like the hammock, the plan became something she could return to—a tangible anchor in a landscape of uncertainty.

A third encounter widened the circle. A patient wished to see the *pajé* while continuing allopathic treatment. We could have competed for primacy; instead, we negotiated choreography. This grammar included ritual timing, fasting periods, and signs the *pajé* and family would recognize—signs invisible to laboratory panels. Rituals were scheduled on days without sedating medications; dose adjustments respected periods of fasting. We set a shared indicator both sides could read: appetite and sleep quality reported by the family, joining evening conversations without withdrawing early. Over weeks, the family reported steadier sleep and return to the circle. The patient asked, eventually, for his hammock—the same gesture that had marked recovery in the first encounter. Healing announced itself through return—to the hammock, to the evening circle, to the rhythms of home.

What, then, is a grammar of care? Not a checklist of cultural facts to memorize.[1] It is a disposition: the readiness to notice that communication operates through more

than words, that healing is recognized through locally meaningful signs, and that the clinician's task is not to impose a single language but to become fluent in translation between biomedical logic and the logics of home, ritual, and family. This aligns with pathways by which communication contributes to health: shared understanding, therapeutic alliance, and decision quality.[2]

These grammars are teachable. *Name the grammar:* agree who speaks first and which signs to monitor. *Summarize out loud:* end each visit with the plan in the community language and again for referrals. *Use situated metaphors:* explain risks with images that fit local life. *Negotiate choreography:* align timing with rituals and family availability. *Anchor referrals:* share a named contact and point of arrival, not only forms.

None of these skills require abandoning science. They require recognizing that science travels better when it learns the local roads.

Across settings and languages, patients and families read us. They observe whether we pause, whether we ask before assuming, whether we adjust. Our task is to make ourselves readable—to show that we are willing to learn their grammar even as we offer ours. When we adapt our discourse to the person and the place, we do not soften rigor; we widen the path through which care can travel.

Sometimes progress is captured in a lab value. Sometimes it is the moment a patient asks for a hammock. Both are data. Both are language. The clinician who learns to read both has begun to speak a universal grammar of care—not universal because it is the same everywhere, but because the disposition to listen, adjust, and translate is needed everywhere.

## DISCLAIMER

The views expressed in this essay are solely the author's and do not necessarily represent those of the University of Campinas or the local health service. An AI tool (ChatGPT) was used only for language clarity and copyediting; all ideas, case selection, analysis, and final decisions are the author's.

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## REFERENCES

1. Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLoS Med*. 2006;3(10):e294. doi:10.1371/journal.pmed.0030294
2. Street RL Jr, Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician–patient communication to health outcomes. *Patient Educ Couns*. 2009;74(3):295–301. doi:10.1016/j.pec.2008.11.015