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Family Medicine

NARRATIVE ESSAY

Still Undiagnosed: When Health Care Remains a Privilege, Not a Right

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Her smile was big and bright when she stepped onto the bus. An hour later—head down, shoulders slumped, tears shed—she was a stranger to the woman who had walked into the clinic.

M. was a new patient at the mobile health clinic, a freestanding bus that provides free primary care to uninsured people, where I was completing my family medicine clerkship. M. was a 37-year-old Haitian female; Haitian-Creole was her only language. Thankfully, the attending physician, Dr T., was fluent in Haitian-Creole. For the next hour, I would witness the encounter as a curious onlooker, clinging to body language and sparse translations to piece together M.'s story.

I entered the exam room with Dr T. and watched the conversation unfold. Dr T. turned to me every so often and offered brief translations, breaking the fourth wall. Slowly, I found out that M. came in because of worsening abdominal pain, nausea, vomiting, an inability to tolerate food, and "something growing in my belly." Although these concerns promptly signaled red flags to us, M. continued to smile broadly.

Dr T. pushed forward with the interview. Although I could not understand the details, it was evident through Dr T.'s facial expressions that M's story grew more complex with every word. After a long back and forth, Dr T. looked at me; I sensed worry in her eyes. She briefly stated that M. was undocumented, recently crossing the borders from Haiti to Mexico to the United States. She deferred medical care until now, because health care was limited in Haiti. Moreover, M.'s health was a low priority compared to the host of other stressors she was enduring. Nonetheless, her symptoms continued to worsen, and her body persuaded her to seek medical attention.

Dr T. asked me to complete a physical exam while she translated for me, encouraging me to "discover what the body is telling us." We learn in medical school to observe body language and to look, listen, and palpate the body to diagnose underlying pathology. This practice is a third party in the exam room, providing invaluable insight into a patient's story.

I began with an abdominal exam, having M. lie down and raise her T-shirt. Until now, M.'s oversized clothing concealed her protruding abdomen. I palpated her stomach, noting the firm, uniform mass invading her lower quadrants and pelvis. I asked, "Are you pregnant?" waiting for Dr T. to translate.

However, that much M. understood. She laughed and said no.

Dr T. asked me what I thought was going on. I was confused. Completing only my second clerkship, I'd performed few abdominal exams, mostly on healthy standardized patients or classmates. But I wasn't alone; Dr T. admitted that she also wasn't sure what was going on. Dr T. asked M whether we could perform a pelvic exam to help distinguish the etiology of the mass. M agreed, and we left the room to let her undress.

As we waited, Dr T. told me more about M. She was pregnant twice while living in Haiti, suffering two early miscarriages. In both cases, M. passed the fetuses at home without medical attention. M was sexually active with one male partner, using PlanB sporadically. She also had never had a pap smear.

Taking in M.'s history, several thoughts raced through my mind. Health care inaccessibility in Haiti accounted for a myriad of issues, all relevant to her chief complaint: she'd never been to a doctor, never had a pap smear, and did not have reliable contraception. I felt disheartened to realize that despite M. now being in a country with far more health care resources compared to Haiti, I could not foresee M. receiving the care she deserved, given her uninsured and undocumented status. The blatant injustice angered me.

We returned to the exam room, and Dr T. asked me to perform the pelvic exam. I began to insert the speculum, but M's body immediately pushed it out. Dr T. then took over and said that she could see an irregular mass protruding from the cervix. She withdrew the speculum, helped M. to a seated position, and sat across from her.

I became a spectator once again as Dr T., speaking with concerned undertones, shared the exam findings. M. remained silent and began to make herself small, her shoulders slumping as she absorbed the weight of uncertainty, fear, and confusion that had abruptly crashed down on her. Eyes directed at the ground, she finicked with her exam gown, said a few words, and began to cry.

As Dr T. allowed M. to process the news, she turned to me and said, "M. said she wants to have children."

I shared her emotions viscerally. I grieved for the future M. envisioned for herself, which suddenly seemed jeopardized. I feared for M.'s health and the probable neglect she would face in our health care system. Typically, these history and exam findings would trigger a cascade of tests, imaging, and referrals to assess for urgent diagnoses such as cancer. However, for M., no such workup would occur. Without a job and insurance, M. couldn't afford testing or imaging, which, nevertheless, would be futile without access to specialized care.

M., an outsider to the US health care system, would remain undiagnosed.

We sat in silence, the grief in the room tangible. Dr T. lifted M.'s chin, holding M.'s face in her hands. In the resource-limited setting of our mobile clinic, Dr T. resorted to doctoring in its truest form: compassion as a source of healing. Although there was nothing to say that could take away her heartache, Dr T.'s comforting presence honored M.'s emotions, offering a unique solace that cannot be provided by diagnostics and treatments.

I think of M. frequently, because stories like hers motivate me to become a physician that cares for everyone and to resist a system that does not. As I progress through medical training and eventually become an agent of the health care system myself, I will embrace what I can provide that the formidable system cannot: my humanity.