Doctor's Narrative

A language we built together: A physician assistant's reflection on a renal transplant

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Abstract

Background: Medicine relies on objective clinical data, but organ transplantation demands a deeper human connection. This narrative reflection explores the unique relationship built between a physician assistant (PA) and a patient undergoing a renal transplant.

Key words: Haemodialysis, Kidney; Narrative reflection

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I met Menaka in fragments before I met her as a person.

A hand tugging at a sleeve in the dialysis bay. A brief, urgent tapping on the bedrail. A sharp inhale that meant something had changed. Nurses would call her name louder, then realize, and look around for a family member. In the beginning, I did what everyone does when words don't land: I spoke anyway, slower, as if volume or rhythm might bridge the gap.

Menaka was twenty-six, but the chronicity of her illness made her feel older in the ways that mattered. End-stage kidney disease on hemodialysis, hypertension, hypothyroidism, seizures—those were the diagnoses in the file. The one that shaped every interaction was the one that never appeared in the lab results: she was born unable to hear, and she did not speak.

In our first weeks together, the most difficult part wasn't the medicine. It was the small questions that fill the spaces between procedures: Where is it hurting? Is the dizziness new? Did you understand what we just did? It felt wrong to reduce her experience to nods and shaken heads, to the crude language of "yes" and "no." Some days, her face tightened with a kind of polite surrender, and I hated the feeling that we were pulling her through care instead of walking alongside her.

So, we began with a notebook.

I wrote short sentences in large letters and drew crude sketches that I hoped would be universal: a cup for water, a bed for rest, a hand over the abdomen for pain. She would read, then look up at me as if to check whether I meant it. Often, she would answer by

pointing to a part of her body, or by pressing her fingers to her temple, or by tapping her chest twice—her own vocabulary, fluent and private.

The first time she laughed at something I wrote, it startled me. It wasn't a big laugh, just a quick brightness that crossed her face. I had drawn a needle that looked more like a sword, and she shook her head dramatically as if scolding me for my lack of artistic skill. That small moment did what months of polite exchanges could not: it made her real to me, not a problem to solve.

Over the next six months, Menaka returned repeatedly.

Sometimes it was infection. Sometimes breathlessness. Sometimes the vague unwellness that dialysis patients can name with one word and clinicians spend days translating into numbers. But the recurring theme was access. Her right upper limb arteriovenous fistula—her lifeline—thrombosed. She came in with the arm swollen and tender, her brows knit in a familiar mixture of fear and exhaustion. She sat on the edge of the bed and held her forearm the way people hold something precious when it's breaking.

Explaining access failure to someone who cannot hear you is a lesson in humility.

I tried diagrams. I drew a vessel like a tube, then a clot like a dark plug. I mimed blood flow with my hands, then stopped my fingers abruptly. I wrote "blocked" and watched her eyes fix on the word as if it had weight. She looked away, then back at me, and her hand moved in a quick, decisive gesture—one I had come to understand as her version of "again?" Not a question, exactly. A statement of fatigue.

That night, while the team discussed options—new access planning, temporary catheters, the usual path—Menaka stared at the ceiling, lips pressed into a straight line. When I held the notebook out, she took it and wrote slowly, carefully, in Tamil. Two words, then she underlined them twice: "எப்போ முடியும்?" (When will this end?)

It is emotionally hard, as a clinician, to be asked that question when your honest answer is a paragraph long.

Over time, I realised that my job wasn't only to translate our instructions into something she could understand. It was also to protect her from the loneliness that can come from being the only person in the room who cannot access the conversation.

Doctors would do rounds and speak to each other: "creatinine," "electrolytes," "access revision." Menaka would watch their mouths move and the expressions on their faces, trying to read meaning. Sometimes she would look at me, eyebrows raised, asking silently: Is it bad?

I began to slow the ward down for her.

After rounds, I would return, sit where she could see my face clearly, and rewrite the plan in plain language. Not the plan we tell ourselves, but the plan that matters to the person living in the bed: we will do a scan; we will check blood; we will change a tube; you may feel pain here; if you feel this, show me.

I learned to ask fewer questions and make more space for her answers.

Instead of "Are you in pain?" I would draw a simple line of faces from calm to crying and let her point. If her eyes narrowed and she jabbed at the far end, I believed her. If

she pressed two fingers to her abdomen and then made a small circular motion, I learned that meant "cramping." If she tapped her wrist rapidly, it meant "hurry"—not impatience, but fear. The fear that something was happening inside her body, and she couldn't say it fast enough.

Then, during one of those admissions—the kind that began as "planned for repeat access" and threatened to become "another month of waiting"—the cadaver call came.

In transplant units, those calls change the air in the room. People sit up. Phones appear. Decisions are made quickly. For most patients, the first part is spoken: "We have an offer." For Menaka, it had to be seen.

I walked to her bedside with the notebook and felt, unexpectedly, nervous. Not about the medicine. About the moment. How do you deliver the possibility of a new life to someone who cannot hear your voice? How do you ensure the message lands gently, without shattering?

I wrote: "Kidney available."

She stared at the sentence. Then she looked at me as if she was checking whether this was a mistake. I wrote again, slower, as if handwriting could carry reassurance: "Transplant possible today."

She read it, then her hands flew up in a burst of rapid signing—too fast for me to catch. Her face changed, the way the sky changes when cloud breaks. She grabbed her mother's hand, pressed it hard, and then looked back at me with wet eyes. Not crying, not yet—something held. Disbelief, maybe. Or the kind of cautious hope people learn after being disappointed too many times.

Consent is not a signature. Consent is understanding.

That day, my role became to make sure she knew what "transplant" meant in a way she could hold. I drew the shape of a kidney, then a line to a new place in the pelvis. I wrote "surgery," "tubes," "ICU," "pain," "medicine lifelong." After each word, I paused and watched her face. If her eyes softened, I continued. If her mouth tightened, I stopped and rewrote. When she finally nodded—firm, not polite—I felt a kind of relief that had nothing to do with creatinine.

The operation went well. In the ICU, she became again what she had been for months: a patient whose body spoke louder than her voice ever could.

Post-transplant ICU is a place of alarms and routines. It is also a place where patients often depend on words for comfort: "This is normal." "This will pass." Menaka couldn't hear any of that.

So, I made sure she could see what was happening.

Before interventions, I showed her what was coming. I wrote short warnings— "cold," "pinch," "turn"—and waited for her nod before proceeding. When her face tightened in pain, I didn't ask her to be brave. I placed the scale in front of her and let her show me exactly how much it hurt. When she pointed high, I treated it high.

There was a morning, In the ICU, when the urine bag filled faster than it had the day before. It wasn't dramatic—just a subtle, steady improvement. Menaka noticed before I

did. She pointed at the tubing, then at the bag, then looked at me with a question on her face that was almost childlike in its directness: Is this mine working?

I nodded and wrote, “Yes. Your new kidney is waking up.”

She read it twice. Then she placed her palm over her lower abdomen, exactly where the graft sat beneath the dressing, as if she was feeling for a heartbeat.

That gesture is the image I carry.

Not the lab values. Not the charts. A young woman, who had lived for months in a cycle of access failures and admissions, placing her hand over a new organ and acknowledging it—quietly, reverently—like someone greeting a stranger who had just become family.

I have cared for many patients. Some are remembered for their complexity, some for their outcomes. Menaka will be remembered for the language we built between us when standard language failed.

It taught me something simple: communication is not an accessory to care. It is care.

And it reminded me that hope, when it finally arrives, does not always come with sound. Sometimes it arrives as a hand pressed gently to a dressing, and a face that says, without words, “I am still here. And maybe now, I can begin again.”

Patient Consent

Written informed consent was obtained from the patient and her family for publication of this narrative and the accompanying clinical details. The patient's name has been changed to protect privacy.