

26 free clinical-Spanish scenarios you can work tonight

Take-home companion to the playable /practice/ page. 246 turns. ~141 minutes.

"Every shift you use a 7-year-old as an interpreter is a shift you chart data you didn't quite hear. This is the rehearsal."

Each scenario is one patient encounter, annotated the way an MD or experienced RN would annotate it for a colleague.

What this is

Twenty-six full patient encounters spanning ED intake, chest-pain triage, pre-procedure allergy review, kidney-stone discharge, telephone triage, pediatric exam, medication reconciliation, psych safety screening, OB triage, post-op opioid counseling, bedside BE-FAST stroke screening with a bilingual family member, urgent-care saw-laceration repair with Workers' Comp consent, an ED hypoglycemia emergency in a family-brought-in altered diabetic with the 15-15 rule delivered to the daughter, an ED opioid-overdose reversal with a brother-at-bedside — Narcan, precipitated-withdrawal framing, pressed-fentanyl pill identification, and a same-day buprenorphine warm hand-off — an adult moderate asthma exacerbation where the iceberg under three ED visits this spring is inhaler technique, not disease severity: a cadenced six-step spacer demo in numbered Spanish plus controller-vs-rescue taught by canister color (la azul de rescate, la gris de prevención) with 'aunque se sienta bien' as the adherence rule, a pediatric febrile seizure brought in by a terrified mother who put a spoon in the child's mouth during the event — naming 'convulsión febril' and distinguishing it from epilepsia, redirecting 'mal de ojo' without mocking the frame, and teaching a four-rule home rescue protocol (de lado, nada en la boca, cuente los minutos, cinco-minutos-911) with the load-bearing myth correction that lowering fever does NOT prevent another febrile seizure, a geriatric fall in an 82-year-old Spanish-speaking woman where the reported mechanical fall turns out mid-history to be a syncopal collapse — the library's first elder-patient encounter and first advance-directive conversation in Spanish, framed as three reversible questions (resucitación, ventilator-duration limit, poder notarial médico) rather than the useless '¿tiene directivas por adelantado?', and the library's first procedural-consent scenario — CT-with-IV-contrast in a 52-year-old Spanish-speaking woman who volunteers 'alérgica al camarón' on the gurney as the IV tray appears, where the scenario distinguishes the debunked shellfish-allergy myth from the contrast-allergy question

Important

Language training only. Not medical interpretation. Always follow your facility's policies for qualified interpreters when a clinical decision depends on accurate communication.

Reviewed by clinical staff. Spanish leans Mexican — dialect notes flag where Puerto Rican / Cuban / Central American Spanish differ in a way that matters in a clinical encounter.

v1.0 — 2026-04-22 · clinicalingo.com

CONTENTS

The 26 scenarios

All twenty-six are playable now at clinicalingo.com/practice/.

1	Abdominal pain — triage intake <i>ED intake</i>	4 min · 8 turns
2	Pain assessment — chest pain <i>ED pain assessment</i>	4 min · 8 turns
3	Allergies & home medications <i>Med reconciliation</i>	5 min · 9 turns
4	Discharge — return precautions <i>Discharge instructions</i>	4 min · 8 turns
5	Telephone triage — child with fever <i>Pediatric telephone triage</i>	5 min · 9 turns
6	Pediatric exam — toddler with belly pain <i>Pediatric exam</i>	5 min · 9 turns
7	Med reconciliation — diabetes and anticoagulants <i>Med reconciliation</i>	5 min · 9 turns
8	Safety screening — suicide risk assessment <i>Psych / safety screening</i>	5 min · 9 turns
9	OB triage — bleeding in early pregnancy <i>OB / women's health triage</i>	4 min · 9 turns
10	Discharge — post-op opioid counseling <i>Discharge instructions</i>	5 min · 9 turns
11	Stroke screening — BE-FAST at the bedside <i>ED neuro triage</i>	5 min · 9 turns
12	Laceration repair — saw wound, Workers' Comp consent <i>Urgent care / wound care</i>	6 min · 10 turns
13	Hypoglycemia emergency — altered diabetic brought in by	

-
- 14 Opioid overdose — Narcan reversal with witness at bedside** 6 min · 10 turns
ED toxicology emergency
-
- 15 Asthma exacerbation — albuterol-not-working is really spacer-never-taught** 6 min · 10 turns
ED respiratory
-
- 16 Pediatric febrile seizure — terrified parent, 18-month-old post-ictal** 6 min · 10 turns
ED pediatric emergency
-
- 17 Geriatric fall — syncope uncovered + advance-directive conversation before hip surgery** 6 min · 10 turns
ED geriatric / pre-op
-
- 18 CT with IV contrast — informed consent, allergy screen, and contrast-sensation pre-description** 6 min · 10 turns
ED / urgent-care procedural consent
-
- 19 Lumbar puncture for suspected meningitis — informed consent, paralysis-fear anatomy reassurance, and "presión, no dolor" sensation pre-description** 6 min · 10 turns
ED procedural consent / neurology
-
- 20 Cardiac catheterization with possible PCI — informed consent, "no le vamos a abrir el pecho" anatomy reassurance, and combined diagnostic + intervention consent** 6 min · 10 turns
ED procedural consent / cardiology
-
- 21 Postpartum hemorrhage tele-triage — 3am call, Spanish-speaking husband, day-6 postpartum bleeding heavily** 6 min · 10 turns
OB / tele-triage
-
- 22 Central-line placement consent — septic 64F whose husband died of a line infection eight years ago** 6 min · 10 turns
ED procedural consent / sepsis
-
- 23 Foley catheter consent — 73M with acute urinary retention from BPH, son at bedside, dignity refusal opens the conversation** 6 min · 10 turns
6 min · 10 turns

-
- 24** **NG-tube placement consent — 58F with partial SBO from post-hysterectomy adhesions, daughter-in-law at bedside, "por la nariz no" refusal opens the conversation** 6 min · 10 turns
ED procedural consent / surgery
-
- 25** **Brown-paper-bag med-rec — 67M T2DM, comadre-sourced glibenclamida overlap with metformin (BG 38 last Monday), daily diclofenaco for foot pain, weekly comadre-administered "complejo B" injection, an unmarked "pastilla del primo para los nervios" — first hour of new-patient PCP intake** 6 min · 10 turns
Primary care · medication reconciliation
-
- 26** **Herbal-supplement med-rec — 58F widow on lisinopril + HCTZ with K+ 3.1 + Cr 1.5 + three orthostatic spells last week, comadre-prepared nopal-canela / jamaica / diente-de-león / vinagre-de-manzana + cross-border ginkgo from primo's vitamina shop in Guadalajara — first hour of a 4-month follow-up visit** 6 min · 10 turns
Primary care · medication reconciliation
-

Abdominal pain — triage intake

4 min · 8 turns

CONTEXT

A 38-year-old woman walks into your triage bay, holding her right side. Right upper quadrant tenderness is what you're trying to rule in or out before you move her to a room and call for imaging.

CLINICAL GOAL

Localize the pain, quantify it, establish onset, confirm no known allergies before the MA sets up an IV.

DIALOGUE

PATIENT · 38F, WALK-IN **Me duele el estómago. Desde anoche.**

My stomach hurts. Since last night.

YOU

#2

Ask where exactly it hurts.

¿Dónde exactamente le duele?

PATIENT

#3

Aquí, en el lado derecho. Me duele más cuando respiro.

Here, on the right side. It hurts more when I breathe.

YOU

#4

Ask her to rate the pain from 0 to 10.

¿Del cero al diez, qué tan fuerte es el dolor?

PATIENT

#5

Como un ocho. A veces nueve cuando me muevo.

About an eight. Sometimes nine when I move.

YOU

#6

Ask if she has vomited or had a fever.

¿Ha vomitado o ha tenido fiebre?

PATIENT

#7

Vomité dos veces anoche. Fiebre no sé, no tengo termómetro en casa.

I vomited twice last night. Fever, I don't know — I don't have a thermometer at home.

YOU

#8

Ask if she is allergic to any medicines.

¿Es alérgica a alguna medicina?

WHAT TO NOTICE

- 'Me duele más cuando respiro' (worse with breathing) is a red flag you want to surface to the provider — diaphragmatic irritation, possible Murphy's sign patient.
- 'No tengo termómetro en casa' is common. Don't document 'denies fever' — document 'unable to quantify'.

ABDOMINAL PAIN — TRIAGE INTAKE — CONTINUED

- Allergy question before IV access is the chart-order habit. Practicing it in Spanish is the whole point of the scenario.

DIALECT NOTES

- 'Me duele' (it hurts me) is the universal construction. Avoid 'Yo tengo dolor' — technically correct, stilted, not how patients talk.
- 'Estómago' covers the whole abdomen colloquially — don't correct it to 'abdomen' unless you're charting.
- Numbers: '0 al 10' is spoken 'cero al diez.' Saying 'de cero a diez' also works; neither is wrong.

Pain assessment — chest pain

4 min · 8 turns

CONTEXT

A 54-year-old man in for chest pain. You're working the assessment with the mnemonic you already know in English — OPQRST — but the patient speaks only Spanish. Goal: a chartable pain description before the ECG machine rolls in.

CLINICAL GOAL

Elicit onset, provocation, quality, radiation, severity, and timing — in Spanish, in under 3 minutes.

DIALOGUE

**PATIENT · 54M,
BROUGHT IN BY
WIFE**
#1

Me duele el pecho. No me había pasado antes.

My chest hurts. It hasn't happened to me before.

YOU
#2

Ask when it started and what he was doing.

¿Cuándo empezó y qué estaba haciendo?

PATIENT
#3

Hace una hora. Estaba subiendo las escaleras de la casa con las bolsas del súper.

An hour ago. I was going up the stairs at home with the grocery bags.

YOU
#4

Ask how the pain feels — pressure, burning, or sharp.

¿Cómo se siente el dolor? ¿Como opresión, ardor, o una punzada?

PATIENT
#5

Como una opresión. Como si me apretaran aquí en medio.

Like pressure. Like something's squeezing me right here in the middle.

YOU
#6

Ask if the pain goes anywhere — arm, jaw, back.

¿El dolor se corre a algún lado? ¿Al brazo, la mandíbula, la espalda?

PATIENT
#7

Se me va al brazo izquierdo. Y un poco al cuello.

It goes into my left arm. And a bit into my neck.

YOU
#8

Tell him you're going to do an ECG right now and ask him to stay lying down.

Le voy a hacer un electro ahora mismo. Quédese acostado, por favor.

WHAT TO NOTICE

- 'Opresión' + exertional onset + left-arm radiation = don't wait on this one. This scenario is designed to rehearse the question sequence so you get the answers fast.

PAIN ASSESSMENT — CHEST PAIN — CONTINUED

- 'Electro' is the colloquial short form of 'electrocardiograma.' Both are fine; 'electro' is what the patient hears every day.
- 'Quédese acostado' (stay lying down) uses the formal 'usted' imperative. In a triage bay, formal is the right register even with younger patients.

DIALECT NOTES

- 'Se corre' (it runs/spreads) for radiation is widely understood; 'se irradia' is more medical but patients use 'se corre' or 'se va hacia' (goes toward) most often.
- 'Opresión' = pressure/tightness. The classic cardiac-quality word; worth knowing cold.
- 'Ardor' = burning. 'Punzada' = sharp/stabbing. 'Dolor sordo' = dull ache.

Allergies & home medications

5 min · 9 turns

CONTEXT

A 62-year-old woman admitted for cellulitis on her forearm. You're doing med reconciliation before antibiotics go up. The home-med list the family wrote down on a napkin has drug names in Spanish, some spelled phonetically. Goal: a chartable allergy + current-medication list.

CLINICAL GOAL

Confirm drug allergies with reaction detail, capture home meds (prescription + OTC + supplements), document last dose.

DIALOGUE

<p>YOU #1</p>	<p><i>Ask if she is allergic to any medication.</i> ¿Es alérgica a alguna medicina?</p>
<p>PATIENT · 62F, ADMITTED FOR CELLULITIS #2</p>	<p>Sí, a la penicilina. Me sacó ronchas hace muchos años. <i>Yes, to penicillin. It gave me a rash many years ago.</i></p>
<p>YOU #3</p>	<p><i>Ask what the reaction was — rash only, or also trouble breathing.</i> ¿Solo le salieron ronchas, o también le costó respirar?</p>
<p>PATIENT #4</p>	<p>Solo ronchas. No me faltó el aire. <i>Just a rash. I didn't have trouble breathing.</i></p>
<p>YOU #5</p>	<p><i>Ask what medicines she takes at home.</i> ¿Qué medicinas toma en casa?</p>
<p>PATIENT #6</p>	<p>Una pastilla para la presión, una para el azúcar, y a veces aspirina para el dolor. <i>One pill for blood pressure, one for blood sugar, and sometimes aspirin for pain.</i></p>
<p>YOU #7</p>	<p><i>Ask if she also takes herbal remedies, teas, or vitamins.</i> ¿También toma remedios de hierbas, tés, o vitaminas?</p>
<p>PATIENT #8</p>	<p>Té de manzanilla por las noches. Y un jarabe de mi comadre para la tos, pero ya no. <i>Chamomile tea at night. And a cough syrup from my friend, but not anymore.</i></p>

YOU

#9

Ask when she took her last dose of the blood-pressure pill.

¿A qué hora tomó la última pastilla de la presión?

WHAT TO NOTICE

- 'Me sacó ronchas' + 'no me faltó el aire' is a chartable non-anaphylactic allergy — clinically important distinction when a beta-lactam might actually be the right antibiotic.
- 'Una pastilla para la presión' is how most patients describe their meds. The specific drug name usually lives on the bottle at home or in the pharmacy record. Ask follow-up: 'Trajo las pastillas?' (Did you bring the pills?).
- 'Jarabe de mi comadre' is a shared-med disclosure you do NOT want to miss. Not accusatory — ask. It surfaces OTC codeine products, expired antibiotics, and herbal teas that interact with warfarin.

DIALECT NOTES

- 'Pastillas' = pills (any kind). 'Medicina' = medicine. 'Remedio' = a remedy, including home/herbal (be alert — may mean a non-Rx).
- 'Aseguranza' (Spanglish for insurance) vs. 'seguro médico' (formal) — both appear; patients on the US-Mexico border use 'aseguranza' daily.
- 'Me sacó ronchas' (it gave me a rash) is the idiom. 'Me dio alergia' (it gave me an allergy) is also fine. 'Anafilaxia' is known but often they describe it: 'se me cerró la garganta' (my throat closed).

Discharge — return precautions

4 min · 8 turns

CONTEXT

A 29-year-old man being discharged after four hours in the ED for a kidney stone. Pain is controlled, he's urinating, provider signed off. Your job: get him out the door with instructions he'll actually follow and red flags he'll act on.

CLINICAL GOAL

Hand off discharge meds, explain return precautions in terms that get him back to the ED for real red flags (not for fear), and confirm follow-up.

DIALOGUE

<p>YOU #1</p>	<p><i>Tell him he's going home today and you have instructions for him.</i> Se va a casa hoy. Tengo las instrucciones para usted.</p>
<p>PATIENT · 29M, KIDNEY STONE #2</p>	<p>Qué bueno. ¿Y qué tomo para el dolor? <i>Good. And what do I take for the pain?</i></p>
<p>YOU #3</p>	<p><i>Tell him ibuprofen every 8 hours with food, and to drink a lot of water.</i> Ibuprofeno cada ocho horas con comida, y tome mucha agua.</p>
<p>PATIENT #4</p>	<p>¿Cuándo tengo que regresar? <i>When do I have to come back?</i></p>
<p>YOU #5</p>	<p><i>Say: come back if you have fever over 38°C, blood in your urine, or the pain comes back strong.</i> Regrese si tiene fiebre de más de 38 grados, sangre en la orina, o si el dolor regresa fuerte.</p>
<p>PATIENT #6</p>	<p>¿Y si vomito? Porque ya vomité dos veces aquí. <i>And if I vomit? Because I already vomited twice here.</i></p>
<p>YOU #7</p>	<p><i>Tell him if he can't keep water down for 6 hours, come back.</i> Si no puede retener agua por seis horas, regrese.</p>
<p>YOU #8</p>	<p><i>Tell him to make a follow-up appointment with his primary-care doctor this week.</i> Haga una cita con su doctor de familia esta semana.</p>

WHAT TO NOTICE

DISCHARGE — RETURN PRECAUTIONS — CONTINUED

- Celsius over Fahrenheit matters. A patient hearing 'fiebre de 100' won't know whether that's Fahrenheit or a bad cold. '38 grados' is unambiguous.
- 'Si no puede retener agua' (if you can't keep water down) is the functional version of 'intractable nausea' — that's what goes on the return-precautions sheet.
- 'Haga una cita' (formal imperative) is the right register for discharge. 'Tiene que hacer una cita' also works but sounds more like a requirement than a recommendation; choose based on how mandatory the follow-up is.

DIALECT NOTES

- 'Regresar' / 'volver' (to come back) both work. 'Regrese' (formal imperative) is what you want on discharge papers.
- 'Fiebre' = fever. Specify the temperature: 'más de 38 grados' (over 38°C = 100.4°F). Use Celsius — most Spanish-speaking patients are thermometer-fluent in C, not F.
- 'Sangre en la orina' = blood in the urine. Don't say 'orina roja' — it's too vague. 'Sangre' is the word.
- 'Cita' = appointment. 'Médico de cabecera' / 'doctor de familia' = primary care.

Telephone triage — child with fever

5 min · 9 turns

CONTEXT

You're covering the evening triage line at a community clinic. A mother calls, worried about her 3-year-old's fever. Your goal: decide with her whether this is a home-care, clinic-tomorrow, or go-to-ED call — in Spanish, on the phone, without being able to see the child.

CLINICAL GOAL

Establish fever duration and height, rule out red flags (hydration, breathing, behavior), give a clear disposition.

DIALOGUE

**CALLER ·
MOTHER OF 3YO**

Mi hijito tiene calentura desde ayer. No me quiere comer.

My little one has had a fever since yesterday. He won't eat for me.

YOU
#2

Ask how high the fever is and if she took it with a thermometer.

¿Qué tan alta es la fiebre? ¿La midió con el termómetro?

CALLER
#3

Sí, hace una hora tenía 39.2. Le di Tylenol infantil.

Yes, an hour ago it was 39.2. I gave him children's Tylenol.

YOU
#4

Ask if he's drinking liquids and if he's wet his diaper or peed today.

¿Está tomando líquidos? ¿Ha mojado el pañal o hecho pipí hoy?

CALLER
#5

Toma poquita agua. El pañal lo mojó en la mañana, pero nada desde entonces.

He's drinking a little water. He wet his diaper this morning, but nothing since then.

YOU
#6

Ask if he's breathing fast, or if his breathing seems difficult.

¿Está respirando rápido, o se le dificulta respirar?

CALLER
#7

No, respira normal. Pero está muy cansadito. No juega.

No, he's breathing normally. But he's very tired. He's not playing.

YOU
#8

Tell her to bring him to the clinic this evening — not tomorrow. Fever plus not peeing in many hours needs to be seen today.

Tráigalo a la clínica esta tarde, no mañana. Fiebre y que no haga pipí en muchas horas se tiene que ver hoy.

YOU
#9

Tell her if his breathing changes or he becomes very sleepy, call 911.

Si cambia su respiración o se pone muy dormido, llame al nueve, uno, uno.

TELEPHONE TRIAGE — CHILD WITH FEVER — CONTINUED

WHAT TO NOTICE

- Dehydration red flags (no wet diaper in many hours) + reduced activity in a 3-year-old is the call you want to *pull forward*, not the call you want to punt to tomorrow. The disposition language ('esta tarde, no mañana') is designed to be unambiguous even over a bad line.
- Digit-by-digit 911 (nueve, uno, uno) is the single most common Spanish triage error — 'novecientos once' is 911 as a number, not the emergency line. Patients will dial 911 as digits; your instruction has to match.
- 'Muy cansadito' / 'no juega' is the Spanish equivalent of the 'altered behavior' red flag pediatrics wants. If the mom volunteers this, escalate.

DIALECT NOTES

- Diminutives with children are the norm. 'Su niño' is fine; 'su niñoito' is warmer. 'Mi hijito' (my little one) is what the mother will say.
- 'Calentura' is the colloquial, often-used word for fever — especially from non-medical family members. 'Fiebre' is more formal. Both are correct.
- Emergency call: '911' is said digit by digit — 'nueve, uno, uno' — never 'novecientos once'.
- 'Panza' (belly) is more natural than 'abdomen' with pediatric patients and their parents.

Pediatric exam — toddler with belly pain

5 min · 9 turns

CONTEXT

A 4-year-old girl, Ana, brought to your clinic by her mother for belly pain since last night. You're examining in the room; mom is on the stool next to the exam table. The register has to switch on you mid-encounter — warm diminutives with Ana, formal usted with the mother — and you need to avoid the Anglo habit of speaking at the child through the parent as if the child isn't there.

CLINICAL GOAL

Localize pain (periumbilical vs. RLQ), get last bowel movement and oral intake, perform a hop test, decide whether this goes to imaging or stays a clinic-observation visit.

DIALOGUE

MOTHER · PARENT OF 4YO ANA #1	Le duele la pancita desde anoche. Hoy vomitó dos veces y no quiere comer. <i>Her belly's been hurting since last night. She threw up twice today and won't eat.</i>
YOU #2	<i>Ask the mother how old Ana is and if she's drinking any liquids.</i> ¿Cuántos años tiene Ana? ¿Está tomando líquidos?
MOTHER #3	Cuatro años. Tomó un poquito de jugo esta mañana, pero también lo vomitó. <i>Four years old. She had a little juice this morning, but she threw that up too.</i>
YOU !' ANA (DIRECT) #4	<i>Speak directly to Ana, warmly. Ask her to show you where her belly hurts — with her finger.</i> Ana, mi amor, ¿me puedes enseñar con el dedo dónde te duele la pancita?
CHILD · ANA, 4YO #5	Aquí. Y a veces también aquí abajo. <i>Here. And sometimes down here too.</i>
YOU !' MOTHER #6	<i>Ask the mother when Ana last had a bowel movement and if it was normal.</i> ¿Cuándo fue la última vez que hizo popó? ¿Estaba normal?
MOTHER #7	Ayer en la mañana. Nada desde entonces. Era más durita de lo normal. <i>Yesterday morning. Nothing since. It was harder than usual.</i>
YOU !' ANA #8	<i>Ask Ana to try a little jump for you — say it's a game. You want to see if jumping makes it hurt.</i> Ana, vamos a hacer un jueguito. ¿Puedes dar un brinquito aquí, para mí?
CHILD · ANA #9	No quiero. Me duele cuando brinco. <i>I don't want to. It hurts when I jump.</i>

PEDIATRIC EXAM — TODDLER WITH BELLY PAIN — CONTINUED

WHAT TO NOTICE

- Pain-on-hop (positive hop test) + migration from periumbilical to RLQ + not-passing-stool is a classic appendicitis setup in a 4-year-old. Don't clear this from clinic without imaging or a surgical consult call — your workflow dictates which, but this is not a 'come back tomorrow' child.
- Switching registers mid-encounter is the real skill. 'Mi amor' with Ana, 'señora' or 'usted' with the mother, on every turn. Consistency across the register boundary is what earns you both patients' trust.
- Framing the hop test as 'un jueguito' (a little game) and asking permission ('¿puedes?') lowers the refusal rate vs. a direct command. A 4-year-old who refuses to jump still tells you something clinically — document the refusal and the stated reason, both.

DIALECT NOTES

- 'Pancita' (little belly) with kids is warmer than 'estómago'. 'Panza' is fine with parents too. 'Abdomen' is chart-language; patients rarely say it.
- 'Popó' is the pediatric word for bowel movement — every Mexican and Central American family uses it with small children. 'Hace del baño' also works. 'Defecar' is clinical and cold.
- 'Mi amor' / 'mi cielo' from a female clinician to a small child is warm, not flirtatious. A male clinician can use 'campeón' (champ) or the child's first name. Read the room — if the mom bristles, drop to the child's name only.
- 'Brincar' (to jump) is the pediatric-friendly verb for the hop test — 'un brinquito' (a little jump) is softer than 'salta'.
- 'Mija'/'mijo' (contraction of 'mi hija'/'mi hijo') is what the mother will call her child and sometimes you; it's a term of endearment, not possession. Don't be startled.

Med reconciliation — diabetes and anticoagulants

5 min · 9 turns

CONTEXT

A 71-year-old man, Don Rafael, admitted for a lower-GI bleed. His home-med list on the triage sheet is incomplete — the ED noted 'patient on blood thinner, diabetes' with no specifics. You're doing med reconciliation at the bedside before anticoagulation reversal and insulin orders go in. Goal: exact warfarin dose and last taken, insulin regimen including sliding scale, and any NSAID disclosure the ED didn't ask for.

CLINICAL GOAL

Capture warfarin dose + last administration, basal insulin (brand + units), short-acting insulin sliding scale + last dose, fasting glucose this morning, and NSAID/ASA exposure that would worsen the GI bleed.

DIALOGUE

YOU
#1

Tell Don Rafael you're going to go through his home medicines one by one, and ask what he takes every day.

Don Rafael, vamos a repasar sus medicinas de casa, una por una. ¿Qué toma todos los días?

**PATIENT · 71M,
ADMITTED GI
BLEED**
#2

Tomo una pastilla para el azúcar y una para que la sangre esté delgada. Y me inyecto insulina en la noche.

I take a pill for my blood sugar and one to keep my blood thin. And I inject insulin at night.

YOU
#3

Ask the name and dose of the blood thinner, and when he took his last one.

¿Sabe el nombre y la dosis de la pastilla para la sangre? ¿Cuándo tomó la última?

PATIENT
#4

Warfarina, cinco miligramos. La tomé anoche antes de dormir, como siempre.

Warfarin, five milligrams. I took it last night before bed, like always.

YOU
#5

Ask which insulin he uses, how many units, and when.

¿Qué insulina usa, cuántas unidades, y a qué hora?

PATIENT
#6

Lantus, veinte unidades en la noche. Y en las comidas me pongo Humalog, según el número del azúcar. Es una escala.

Lantus, twenty units at night. And at meals I use Humalog, depending on my blood sugar number. It's a scale.

<p>YOU #7</p>	<p><i>Ask what his blood sugar read this morning and how many units he gave.</i></p> <p>¿Qué número marcó su azúcar esta mañana? ¿Cuántas unidades se puso?</p>
<p>PATIENT #8</p>	<p>Doscientos diez. Me puse seis unidades de Humalog, como me dijo el doctor.</p> <p><i>Two-ten. I gave myself six units of Humalog, like my doctor told me.</i></p>
<p>YOU #9</p>	<p><i>Ask carefully if he's taken ibuprofen, aspirin, or Motrin for any pain recently — even a few times.</i></p> <p>¿Ha tomado ibuprofeno, aspirina, o Motrin últimamente — aunque sea unas pocas veces?</p>

WHAT TO NOTICE

- The ibuprofen question is the one the ED often skips because the patient is 'only on warfarin.' NSAID + warfarin + GI bleed is exactly the interaction you're looking for; if he says yes, that changes the reversal urgency and the discharge plan for after.
- Glucose 210 + 6 units Humalog at breakfast means this patient runs on the high side of his scale and knows his own numbers. Document the sliding-scale rule verbatim ('six units for 201–250' or whatever he gives you) — do not assume a standard protocol.
- 'Warfarina, cinco miligramos' is specific enough to order reversal against. Always get the number and the time of last dose on the same line in the chart — 'warfarin 5 mg last night approximately 10 p.m.' — so INR reversal timing is unambiguous at handoff.

DIALECT NOTES

- Patients describe warfarin as 'la pastilla para la sangre' or 'para que la sangre esté delgada.' 'Anticoagulante' is understood but not what they'll volunteer. Always follow up with 'warfarina' or the brand name — patients recognize 'Coumadin' too.
- 'Me inyecto' (I inject myself) is the verb for self-injected insulin. 'Me pongo' (I put on myself) also works and is common.
- Insulin brand names are said in Spanish-accented English: 'Lantus' (LAAN-toos), 'Humalog' (oo-ma-LOG), 'Novolog' (no-vo-LOG). Patients nail these because the pharmacist says them out loud at pickup.
- Sliding scale: 'una escala' / 'depende del número del azúcar' / 'según cómo amanezca el azúcar' — patients describe it functionally ('more units if the number is higher') more often than by protocol name.
- Glucose numbers in mg/dL are typically read as three-digit whole numbers: 210 = 'doscientos diez,' not 'dos uno cero.' Exception: phone numbers and emergency lines (e.g. 911) go digit-by-digit.
- 'Ibuprofeno' (ee-boo-pro-FAY-no) and 'aspirina' are the words patients will recognize. 'Motrin' and 'Advil' land too — they're US OTC brands that crossed the border.

Safety screening — suicide risk assessment

5 min · 9 turns

CONTEXT

A 48-year-old man, Mr. Aguirre, brought to ED triage by his wife this evening. She told the clerk at the window that she found him crying in the bathroom and is worried he 'is going to do something.' You're the triage nurse. You have one chance to run the safety-screen questions in Spanish well enough that he tells you the truth — which means the register has to land right, the confidentiality frame has to be honest, and the ladder from passing thoughts !' plan !' access !' intent has to be walked step by step.

CLINICAL GOAL

Elicit presence/absence of ideation, differentiation of passing thoughts vs. a plan, means identified, access to those means, and intent to act — so the psych consult and safety-plan that follow have a real chartable assessment, not a yes/no tick.

CONTENT NOTE

Covers suicide-ideation screening. Language training only — the scenario rehearses the Spanish phrasing of a Columbia-SSRS-style safety interview. Disposition decisions follow your facility's protocol, not this scenario.

DIALOGUE

<p>YOU #1</p>	<p><i>Open with the honest confidentiality frame and permission to be straight with you.</i></p> <p>Señor Aguirre, le voy a hacer unas preguntas importantes. Lo que me diga se queda entre usted y su equipo médico. Le pido que me conteste con la verdad.</p>
<p>PATIENT · 48M, BROUGHT IN BY WIFE #2</p>	<p>Está bien. Es que... ya no puedo más. No sé qué estoy haciendo aquí.</p> <p><i>All right. It's just... I can't do this anymore. I don't know what I'm doing here.</i></p>
<p>YOU #3</p>	<p><i>Thank him for saying that, then ask — directly but gently — if he's had thoughts of hurting himself.</i></p> <p>Gracias por decirme eso. ¿Ha tenido pensamientos de hacerse daño?</p>
<p>PATIENT #4</p>	<p>A veces. Son ideas que pasan. No sé si son serias.</p> <p><i>Sometimes. They're thoughts that pass through. I don't know if they're serious.</i></p>
<p>YOU #5</p>	<p><i>Differentiate — ask if he's thought of a specific way, or a plan.</i></p> <p>Entiendo. ¿Ha pensado en una manera específica de hacerse daño? ¿Un plan?</p>

PATIENT #6 **He pensado en las pastillas de dormir de mi esposa. Pero no lo he hecho.**
I've thought about my wife's sleeping pills. But I haven't done it.

YOU #7 *Ask if he has access to those pills right now — where are they.*
¿Tiene acceso a esas pastillas ahora mismo? ¿Dónde están?

PATIENT #8 **Sí. Están en el botiquín del baño, en casa.**
Yes. They're in the medicine cabinet in the bathroom, at home.

YOU #9 *Thank him again, normalize that he's not alone, and tell him you're going to have the mental-health team come speak with him — he isn't going home like this tonight.*
Le agradezco mucho que me esté diciendo. Usted no está solo; esto le pasa a muchas personas. Voy a pedir que nuestro equipo de salud mental venga a hablar con usted. No se va a ir a casa así esta noche.

WHAT TO NOTICE

- Ideation + named means + access + 'pero no lo he hecho' is method-identified, access-positive, intent-ambiguous. Your facility's protocol dictates the next step (psych consult, hold, 1:1 observation, removal of means) — the scenario's job is to rehearse the Spanish so the protocol can start. Document the patient's words verbatim.
- 'Le agradezco que me esté diciendo' before disposition is clinically protective, not a pleasantry — it acknowledges the social risk the patient just took and correlates with better follow-up engagement in the literature. Don't skip it on the way to the next question.
- Have a plan for the wife's disclosure too. With the patient's permission (or on the authority of the safety plan your facility puts together), the sleeping pills need to go — 'vamos a pedirle a su esposa que saque las pastillas de casa' — and that conversation happens in Spanish in most of these families.

DIALECT NOTES

- 'Hacerse daño' (to harm oneself) is the normal, non-stigmatizing phrasing patients will engage with. 'Suicidarse' lands harder and can trigger shame-driven deflection ('no, yo no soy así').
- 'Ideas pasajeras' (passing thoughts) vs. 'un plan' (a plan) vs. 'la intención de hacerlo' (the intention to do it) — the clinical ladder maps cleanly onto Spanish. Use the ladder explicitly; don't skip rungs.
- Confidentiality framing: 'Lo que me diga se queda entre usted y su equipo médico' is the honest version. Never promise blanket secrecy — you have mandatory-reporting obligations in both languages, and a patient who later learns you implied otherwise will never trust the next clinician.
- 'Vergüenza' (shame) is a real and cultural braking factor, especially for older men and in families where depression is framed as 'echarle ganas' (just try harder) or a spiritual failing. Acknowledging the difficulty of the disclosure — 'le agradezco mucho que me esté diciendo' — is protective, not sentimental.
- 'Usted no está solo' (you are not alone) is a common, tested normalizing phrase. Use it after the disclosure, not before, so it doesn't land as empty reassurance.

OB triage — bleeding in early pregnancy

4 min · 9 turns

CONTEXT

A 28-year-old woman, Mrs. Rivera, walks into your urgent-care clinic on a Saturday morning with light vaginal bleeding that started overnight. She believes she's about 8 weeks pregnant; no prenatal visit yet. Goal: estimate gestational age from LMP, quantify the bleed by pad count, screen for associated pain and orthostatic symptoms, and decide if she stays here for an ultrasound or needs an ED transfer for a possible ectopic rule-out.

CLINICAL GOAL

Establish LMP !' estimated weeks, pad-count quantification of the bleed in a chartable way, pain localization and severity, orthostatic/volume-status red flags, clear disposition.

DIALOGUE

PATIENT · 28F,
WALK-IN

Creo que estoy embarazada y estoy sangrando desde anoche.

I think I'm pregnant and I've been bleeding since last night.

YOU

#2

Ask when her last period was, by date.

¿Cuándo fue su última regla? Si puede, la fecha.

PATIENT

#3

Como el quince de febrero. Calculo que tengo unas ocho semanas.

Around February 15. I figure I'm about eight weeks along.

YOU

#4

Ask if she's spotting or bleeding heavier — quantify by pad count.

¿Está manchando o está sangrando más fuerte? ¿Cuántas toallitas ha usado desde anoche?

PATIENT

#5

He usado tres toallitas desde la mañana. No son manchas, pero tampoco las lleno.

I've used three pads since this morning. It's not spotting, but they're not filled up either.

YOU

#6

Ask if she has pain — where, and how intense.

¿Tiene dolor? ¿En dónde, y qué tan fuerte?

PATIENT

#7

Un cólico aquí abajo, como cuando me baja la regla. Y a veces una punzada del lado derecho.

Cramping down here, like when my period comes. And sometimes a sharp stab on the right side.

YOU

#8

Ask if she's felt dizzy, faint, or like her vision blurred when she stood up.

¿Se ha sentido mareada, desmayada, o se le nubló la vista al pararse?

PATIENT

#9

Me mareé un poco cuando me paré esta mañana. Tuve que sentarme.*I got a little dizzy when I stood up this morning. I had to sit down.*

WHAT TO NOTICE

- Right-sided 'punzada' + 8 weeks from LMP + orthostatic symptoms is an ectopic rule-out, not a routine threatened-miscarriage workup. Quantitative beta-hCG + pelvic ultrasound today, not in the morning. If your clinic can't get imaging stat, this is a transfer, not an observation visit.
- Pad count is the chartable bleed quantifier clinicians under-use. 'Tres toallitas en seis horas, no llenas' maps to moderate bleed; 'una toallita cada hora o saturándose' maps to heavy. Document the number and the saturation, not 'moderate' alone.
- LMP in date form lets you verify gestational-age math at the bedside — February 15 ! April 22 is about 9 weeks, so her 8-week estimate is close. Flag the discrepancy on the ultrasound order so tech sizes to dates, not to patient-reported weeks.

DIALECT NOTES

- CRITICAL false cognate: 'embarazada' = pregnant. 'Embarazosa' = embarrassing. A clinician who means 'I'm embarrassed' and says 'estoy embarazada' has just told a waiting room she's pregnant. Never attempt this translation — use 'me apena' or 'qué pena' for embarrassment.
- 'Regla' (rule) is the everyday word for menstrual period across every Spanish-speaking country. 'Menstruación' is chart-language. 'Periodo' is a Spanglish crossover word that also works in the US.
- 'Toallitas' (pad, diminutive) — the quantifiable unit. Asking 'cuántas toallitas ha usado' gives you a chartable pad-count. 'Manchar' (to spot) is lighter, 'sangrar' (to bleed) is heavier — patients differentiate these naturally.
- Pain quality in the pelvis: 'cólico' (cramping) is the neutral word, maps well to menstrual-type cramps. 'Punzada' (sharp) is the one-sided stabbing that flags ectopic. 'Dolor sordo' (dull) means exactly what it sounds like.
- 'Mareada' (dizzy) vs. 'me desmayé' (I fainted) vs. 'se me nubló la vista' (my vision clouded) — the orthostatic ladder in Spanish. 'Mareada al pararme' is standing-up dizziness; document it as orthostatic.
- Dates are said with day-then-month in Mexican/Central-American Spanish: 'el quince de febrero' = February 15. Avoid 'February 15' word-for-word — it sounds Anglo and some patients will re-compute to check.

Discharge — post-op opioid counseling

5 min · 9 turns

CONTEXT

A 55-year-old woman, Mrs. Delgado, being discharged after a rotator-cuff repair. Discharge script: oxycodone-acetaminophen 5/325 every six hours PRN × 3 days, stool softener, naloxone rescue kit. She lives in a three-generation household — two kids in college home on spring break, grandchildren visiting weekends, shared bathroom cabinet. Goal: teach-back that she understands the acetaminophen ceiling, the no-sleep-aid / no-alcohol interaction, the controlled-substance storage and no-sharing rule, and why naloxone is in the bag even though she's never going to overdose.

CLINICAL GOAL

Confirm dose + frequency + PRN rule, acetaminophen-combined-dose understanding, sedative-interaction rule, locked storage and no-sharing, constipation prophylaxis, naloxone awareness.

DIALOGUE

YOU
#1

Tell her the plan: oxycodone with acetaminophen, 5/325 mg, every 6 hours only if she has strong pain, for up to 3 days. Ask if she has Tylenol at home.

Le voy a mandar oxicodona con acetaminofén, cinco miligramos, cada seis horas solo si tiene dolor fuerte, por tres días como máximo. ¿Tiene Tylenol en casa?

**PATIENT · 55F,
POST ROTATOR-
CUFF REPAIR**
#2

Sí, siempre tengo Tylenol en casa. ¿Puedo tomar el Tylenol con la oxicodona?

Yes, I always have Tylenol at home. Can I take Tylenol with the oxycodone?

YOU
#3

Explain that this pill already contains Tylenol. Combining them can damage the liver.

No. Esta pastilla ya tiene Tylenol adentro — es el mismo medicamento, acetaminofén. Si toma Tylenol encima, puede dañarse el hígado.

PATIENT
#4

Entiendo. Yo a veces tomo una pastillita para dormir en la noche. ¿Puedo seguir tomándola?

I understand. I sometimes take a little pill to sleep at night. Can I keep taking it?

YOU
#5

Tell her not to mix. Oxycodone with sleep aids or with alcohol can make her stop breathing.

No las mezcle. Oxicodona con pastillas para dormir o con alcohol puede hacer que deje de respirar.

PATIENT
#6

Ay, qué miedo. ¿Y dónde la guardo? Mis nietos vienen los fines de semana.

Oh, that's scary. And where should I keep it? My grandchildren come over on weekends.

DISCHARGE — POST-OP OPIOID COUNSELING — CONTINUED

YOU
#7

Tell her to keep it locked up — not in the shared bathroom cabinet. And never share it, not even with family.

Guárdela bajo llave, no en el botiquín del baño donde puedan encontrarla los nietos. Y no le dé esta medicina a nadie más, ni siquiera a familia.

YOU
#8

Tell her the oxycodone will cause constipation — take a gentle laxative like Miralax every day while she's on it.

La oxiconona casi siempre causa estreñimiento. Tome un laxante suave, como Miralax, todos los días mientras esté tomando la oxiconona.

YOU
#9

Explain the naloxone in the bag: it's a life-saving medicine if someone takes too much by mistake, or if she can't be woken up. If that happens, family calls 911.

En la bolsa también viene Narcán — naloxona. Es una medicina que salva vidas si alguien toma demasiado por error, o si usted no puede despertar. Si pasa eso, que la familia llame al nueve, uno, uno.

WHAT TO NOTICE

- Teach-back is the chartable skill here. 'Ya tiene Tylenol adentro' + 'no la mezcle con pastillas para dormir' + 'guardar bajo llave' are the three counseling points that most reliably fail in post-op pharmacy call-backs. Ask her to repeat at least the combined-dose rule before she leaves.
- The grandchildren-on-weekends detail is not a hypothetical — it's the single most common pediatric oxycodone-ingestion vector the ED sees. The 'para que los nietos no las encuentren' frame makes the storage rule stick because it's a reason the patient already cares about.
- Naloxone counseling in Spanish: frame it as 'smoke alarm, not accusation.' 'Por error' (by mistake) is the key phrase. A patient who hears 'in case you overdose' will refuse the kit; a patient who hears 'in case anyone in the house takes too much by mistake' takes it home.

DIALECT NOTES

- 'Adolorida' (in pain, feminine) is the adjective. 'Dolor fuerte' (strong pain) is what the script is for — specifying 'fuerte' is important because the standing order's PRN criterion is severity, and patients take meds on the basis of the word you use at discharge.
- 'Tylenol' is the universal brand in Spanish-speaking US households. 'Acetaminofén' is known but patients say Tylenol. The combined-dose hazard lands faster if you use both: 'esta pastilla ya tiene Tylenol adentro (acetaminofén).'
- 'Pastillas para dormir' = sleep aids, including OTC diphenhydramine (ZzzQuil, Benadryl-for-sleep) and prescription zolpidem. Patients don't differentiate; neither should your counseling.
- 'Guardar bajo llave' (keep locked up) is a real phrase. In a Spanish-speaking household with visiting grandchildren, framing it as 'para que los nietos no las encuentren' (so the grandkids don't find them) lands harder than abstract 'controlled substance.'

DISCHARGE — POST-OP OPIOID COUNSELING — CONTINUED

- 'Narcán' is the brand name patients recognize; 'naloxona' is the generic. Both are fine. Framing: 'es una medicina que salva vidas si alguien toma demasiado por error' — the 'por error' (by mistake) framing makes the kit feel like a smoke alarm, not an accusation.
- Emergency: '911' said digit-by-digit — 'nueve, uno, uno.' Never 'novecientos once.'
- 'Estreñimiento' = constipation. Universal word. 'Laxante suave' (gentle laxative) — Miralax is the one most patients recognize.

Stroke screening — BE-FAST at the bedside

5 min · 9 turns

CONTEXT

A 72-year-old man, Sr. Morales, brought in by his adult daughter. She walked into his room at 7 a.m. and found him unable to lift his right arm, speech slurred. You are the first clinician to see him. The clock on the tPA window starts at last-known-well, not at symptom-discovery — and the family is your only source for that timestamp. The patient can hear you; whether he can speak back is one of the things you are here to find out. Stroke-alert criteria trigger a CT angiogram and a neurologist call, so every minute you spend mis-asking the LKW question is a minute off the back of the 4.5-hour tPA eligibility clock.

CLINICAL GOAL

Establish last-known-well time from family, directly assess the patient's comprehension with a confirm-command, run BE-FAST face/arms/speech, screen for thunderclap headache, visual field, and unilateral numbness — all in Spanish, without a qualified interpreter in the room yet.

DIALOGUE

**DAUGHTER · AT
BEDSIDE**

Mi papá amaneció así. No puede mover el brazo derecho y no le entiendo lo que dice. Lo encontré como a las siete de la mañana.

My dad woke up this way. He can't move his right arm and I can't understand what he's saying. I found him around seven in the morning.

YOU
#2

Re-anchor to last-known-well. Tell the daughter that the time she found him is not the same as the last time he was normal — and ask when that was.

La hora en que lo encontró no es lo mismo que la última vez que estaba bien. ¿A qué hora lo vio bien por última vez? ¿Anoche cenó con él, hablaron, se fue a la cama a una hora que usted recuerde?

DAUGHTER
#3

Cenamos juntos, como a las ocho. Estaba bien. Después se fue a la cama, como a las diez. Ya no hablamos más.

We had dinner together, around eight. He was fine. Then he went to bed around ten. We didn't talk again after that.

YOU
#4

Turn to the patient. Ask if he can hear and understand you. Have him squeeze your hand with his unaffected side to confirm, since his speech may not be reliable.

Señor Morales, ¿me oye? ¿Me entiende lo que le digo? Si me entiende, apriéteme la mano con la mano izquierda, por favor.

**PATIENT · 72M,
RIGHT-SIDED
WEAKNESS**
#5

Sí... ehh... sí... le... entiendo... (squeezes left hand)

Yes... ehh... yes... I... understand... (squeezes left hand)

YOU
#6

Run BE-FAST: face, arms, speech. Ask him to smile, raise both arms as if he's flying, and repeat a test sentence.

Sonríame, por favor, enseñándome los dientes. Ahora levante los dos brazos como si fuera a volar. Y repita después de mí: 'El cielo es azul.'

PATIENT
#7

El... el cielo... ehh... (right arm drifts down, mouth droops on the right)

The... the sky... ehh... (right arm drifts down, mouth droops on the right)

YOU
#8

Screen for thunderclap headache, visual changes, and unilateral numbness. Use both 'entumecido' and 'dormido' to catch the dialect variation.

¿Le empezó un dolor de cabeza muy fuerte, de repente, como un golpe? ¿Se le borra la vista, o ve doble? ¿Siente el lado derecho entumecido, o como dormido?

PATIENT
#9

Dormido... no siento... la pierna... derecha... no me duele la cabeza.

Asleep (numb)... I can't feel... my right leg... my head doesn't hurt.

WHAT TO NOTICE

- The tPA window runs from last-known-well (LKW), not from when the family found the patient. 'Amaneció así' is the single most common way a family opens a stroke presentation, and it is NOT a timestamp — it's a discovery. Never let it stand as onset time. Re-anchor to the last verified-normal observation: last meal, last phone call, bedtime. Document LKW explicitly; a neurologist reading the chart will make tPA eligibility decisions on whatever time you wrote down.
- The patient in this scenario is Broca-pattern (expressive) aphasic: he comprehends, he can follow a hand-squeeze command, but he cannot generate fluent speech. Don't conclude 'patient non-verbal, no history obtainable' — he just answered your screening questions. 'Dormido' for numbness is a dialect variant you need to accept, not correct. Spanish-speaking families will tell you later that 'he knew exactly what was happening' — that is consistent with the aphasia pattern, not with altered mental status.
- BE-FAST in Spanish is a script with specific Spanish words, not a translation exercise. 'El cielo es azul' is the validated sentence-repetition test (not 'You can't teach an old dog new tricks' rendered into Spanish, which phonemically doesn't work). 'Sonríame enseñándome los dientes' tests the facial-droop sign without the 'sonría de verdad' ambiguity some patients bring. 'Como si fuera a volar' is the arms-up cue that translates cleanly — unlike 'hold your arms out,' which some patients interpret as hold-for-me and pronate early.
- The 'usted' register matters clinically in this encounter. In Spanish, a clinician addressing a 72-year-old patient as 'tú' can register as disrespect and erode the rapport you need in the next 30 minutes — when the neurologist calls and you have to explain tPA risks and consent through the daughter. The stroke-alert protocol will move fast; the relationship you establish in the BE-FAST minute is what buys you consent at minute 20.

DIALECT NOTES

- 'Amaneció así' (woke up this way) is the opener families give when they find a stroke patient in the morning. The tPA clock does NOT start at discovery — it starts at last-known-well. Never accept 'amaneció así' as the onset time; re-anchor with 'la última vez que lo vio bien.'

STROKE SCREENING — BE-FAST AT THE BEDSIDE — CONTINUED

- 'Entumecimiento' (numbness) is textbook Spanish; many Mexican-Spanish patients describe true numbness as 'se me durmió' (fell asleep) or 'adormecido.' Ask both — 'entumecido o como dormido' — or you'll get a false negative on a real hemiparesis.
- 'Mareo' collapses dizziness and nausea into one word. In a posterior-circulation stroke this matters: ask 'como si todo diera vueltas, o como ganas de vomitar' to separate vertigo from nausea.
- 'El cielo es azul' is the sentence-repetition test used in Spanish-language stroke screens (analogous to 'You can't teach an old dog new tricks' in English). It exercises phonemes that dysarthria degrades first. Don't translate the English test sentence; use the Spanish one.
- 'Apriete mi mano' (squeeze my hand) is the universal confirm-command for a patient whose speech is failing but comprehension may be intact — cleaner than 'levante el brazo' when one arm is already hemiparetic.
- Formal 'usted' throughout. A 72-year-old patient from a Mexican-heritage family will register 'tú' as disrespect, and you're already a stranger giving commands — don't add a second friction.
- Last-known-well anchors that work better than clock-time: '¿a qué hora se fue a la cama?' / '¿cuándo fue la última llamada?' / '¿cuándo cenó anoche?' Families rarely know the clock; they almost always know these.

Laceration repair — saw wound, Workers' Comp consent

6 min · 10 turns

CONTEXT

A 34-year-old construction worker walks into your urgent-care clinic with his right hand wrapped in a bloody T-shirt — an 8 cm transverse circular-saw laceration across the dorsum, cut on a job site about an hour ago. Bleeding is controlled but the wound is not yet irrigated. He has never had stitches and he is asking in the waiting room whether his employer will find out. Before the saline warms and the lidocaine goes in, you need a tendon-and-sensory function check, a tetanus-vaccination date, Workers' Comp employer info, informed consent for lidocaine plus closure method, and return precautions — all in Spanish. Six minutes from now his dominant hand will be numb and he will not be signing anything.

CLINICAL GOAL

Rule in tendon/nerve injury by direct function and sensation; establish tetanus vaccination status in years; obtain Workers' Comp employer info before the patient's dominant hand goes numb; set lidocaine expectations and offer puntos-vs-grapas closure choice (ruling out Dermabond for a dirty, deep saw wound); discharge with specific observable infection signs named in Spanish and a booked suture-removal follow-up.

DIALOGUE

PATIENT · 34M, WALK-IN, RIGHT HAND WRAPPED IN A BLOODY T-SHIRT

#2

Me corté la mano con una sierra, en el trabajo. Hace como una hora.

I cut my hand with a saw, at work. About an hour ago.

Before you touch the wound, rule in tendon and nerve function. Ask him to unwrap the T-shirt slowly, move each finger, and compare sensation side-to-side. Any 'I can't move that one' or 'this side feels dead' changes where the next 20 minutes go.

Déjeme ver, por favor. Quítese la camiseta de la mano despacio. ¿Puede mover cada dedo para mí, uno por uno? ¿Y siente los dedos igual que los del otro lado, o algún dedo está dormido?

PATIENT

#3

Los muevo todos, sí. Los siento igual que en la otra mano. Me arde nada más cuando la cierro fuerte.

I can move them all, yes. I feel them the same as my other hand. It only stings when I close it tight.

YOU

#4

Function is intact — good. Now, before lidocaine, you need tetanus status and Workers' Comp employer info. Both have to be on the chart before his dominant hand is numb and he can no longer sign forms. Ask for both in one breath so it reads as routine, not optional.

Muy bien. Antes de dormirle la herida necesito dos cosas para el expediente. Primero: ¿se acuerda de cuándo fue su última vacuna del tétano, la antitetánica? Y segundo: como esto pasó en el trabajo, necesito el nombre y el teléfono del patrón para el reporte de Workers' Comp.

PATIENT

#5

La antitetánica... ha de haber sido hace muchos años. No me acuerdo bien. Y sí, fue en el trabajo, pero... mi jefe, ¿se va a meter en problemas? ¿Es una demanda contra él?

The tetanus shot... it must have been many years ago. I don't remember exactly. And yes, it happened at work, but... my boss — is he going to get in trouble? Is this a lawsuit against him?

YOU

#6

Kill the lawsuit fear immediately — WC is insurance, not litigation, and the employer pays into it precisely for this. Then push past 'muchos años' to a real number: for a dirty saw wound, anything past 5 years gets a booster today.

No es una demanda. Workers' Comp es un seguro de trabajo — sirve para que a usted le cubran esta visita y el seguimiento, sin costo. No es un problema para su patrón; al contrario, el patrón paga ese seguro precisamente para cuando pasa algo así. Y sobre el tétano: ¿hace más de cinco años? ¿Más de diez? Con una cortada de sierra, si fue hace más de cinco, le ponemos una vacuna nueva hoy.

PATIENT

#7

Ah, bueno. Me siento mejor. Pues... como unos quince años, creo — desde que estaba en la secundaria.

Oh, okay. I feel better. Well... about fifteen years, I think — since I was in middle school.

YOU

#8

Confirm the tetanus plan, then set expectations for the lidocaine injection in concrete sensory terms (sting, then numb) and offer the closure choice. Rule out Dermabond up front — a deep saw wound with construction-dust contamination is the wrong wound for tissue adhesive, and you do not want the patient asking for it after you have committed to sutures.

Entonces le ponemos la antitetánica hoy. Para cerrarle la cortada, primero le pongo una inyección de anestesia al lado de la herida — le va a arder unos cinco o diez segundos, como un piquete fuerte, y después se le va a adormecer toda esta parte de la mano. Cuando ya esté dormida, le limpio la herida por dentro con agua, y después la cierro. Tengo dos opciones: puntos o grapas. El pegamento especial no nos sirve para una cortada tan profunda y con tierra del trabajo. ¿Cuál prefiere, puntos o grapas?

PATIENT

#9

Puntos, supongo. Nunca me han cosido. ¿Me va a quedar cicatriz?

Stitches, I guess. I've never been stitched up before. Am I going to have a scar?

YOU

#10

Give an honest answer on the scar, then deliver return-precautions with specific observable signs — 'si se siente mal' is worthless to a man who will work through a fever. Name each sign in Spanish and book the suture-removal appointment NOW, before his hand goes numb and he can no longer sign the follow-up slip.

Sí, le va a quedar cicatriz — en una cortada así es inevitable — pero se ve menos si sigue las indicaciones. La herida se mantiene limpia y seca; no la moje por cuarenta y ocho horas. Los puntos se los quitamos aquí mismo en diez días; antes de que se vaya le agendo la cita. Regrese inmediatamente a esta clínica si le da fiebre de más de cien punto cuatro grados Fahrenheit, si la herida se pone caliente o roja, si ve que el enrojecimiento crece, si le sale pus, si ve una línea roja subiendo por el brazo, o si de repente no puede mover un dedo o no lo siente. Cualquiera de esas señas — no espere, regrese.

WHAT TO NOTICE

- Tetanus eligibility runs on the calendar, not on 'sí, alguna vez.' A dirty saw wound in a patient whose last booster was 15 years ago is tetanus-prophylaxis territory — you do not get to skip the shot because the patient is tired of forms. Push past 'muchos años' to a real number (or absence of one) and document the year; a colleague reading the chart cannot infer from 'many years' whether this wound was prophylaxed or gambled on.
- Informed consent for lidocaine AND closure method must happen BEFORE the anesthetic needle — a patient with a numb dominant hand cannot sign, and a patient who heard 'voy a cerrarle la herida' without being offered puntos / grapas / (not) pegamento has not been offered a choice. Name the three options, eliminate the inappropriate one (Dermabond in a deep, dirty wound) on clinical grounds, and wait for a verbal pick before the vial comes out of the drawer.
- Workers' Comp conversations are the single biggest consent landmine in urgent-care Spanish. Spanish-speaking construction, restaurant, and housekeeping workers frequently fear retaliation, deportation referral, or loss of hours if they report an on-the-job injury. Reassure in their terms: WC pays for THIS visit and the follow-up, it is an insurance product the employer already pays into, it is not a lawsuit. Skip this reassurance and the patient can — and occasionally does — walk out AMA with a saw wound rather than risk the boss finding out.
- Return precautions must name specific observable signs in Spanish — not 'si se siente mal,' which a construction worker will ignore through a fever. Each sign gets a Spanish verb: fiebre de más de 100.4°F (38°C), la herida se pone caliente / roja, el enrojecimiento CRECE, le sale pus, una línea roja SUBE por el brazo (lymphangitis), pérdida súbita de movimiento o sensación en un dedo. A patient who was told 'watch for infection' in English reports 'watching' on follow-up — not observing the right things.
- Dermabond / tissue adhesive is not a choice for a deep, contaminated laceration — a circular-saw wound is both. Offer puntos or grapas and rule out pegamento on clinical grounds up front. Suture-removal timing goes in the same sentence as WHERE ('aquí mismo, en diez días') and the follow-up is booked before the patient leaves — a man who just consented to a numb hand and a tetanus shot is not in a state to navigate a scheduling portal later.

DIALECT NOTES

- 'Cortada' is the patient word for a laceration; 'herida' is the generic wound word. Mirror their vocabulary — a patient who said 'cortada' and hears you say 'lesión' will feel you are not listening.

LACERATION REPAIR — SAW WOUND, WORKERS' COMP CONSENT — CONTINUED

- 'Puntos' is universal for stitches; 'grapas' for staples; 'pegamento especial' for tissue adhesive (Dermabond). Do NOT call Dermabond 'pegamento médico' — patients laugh at that phrasing and it undercuts the clinical framing. 'Suturas' is chart-Spanish; patients use 'puntos.'
- 'Le va a arder' (it'll sting/burn) is the right lidocaine-injection warning. 'Le va a doler' is too vague; 'le va a picar' is too minor (patients hear 'itch'). The sensation IS a burn, for 5–10 seconds — say the word that matches the sensation.
- 'Piquete' (pinprick) is Mexican-Spanish for the needle-stick sensation; 'pinchazo' is more Iberian / Caribbean. Either is comprehensible; mirror the patient's word if they use one.
- 'Antitetánica' is the patient word for the tetanus shot; 'vacuna del tétano' is the chart word. Most construction and food-service workers know only one of the two — ask with both ('la vacuna del tétano, la antitetánica') so you do not get a false 'no.'
- 'Señas' (Mexican colloquial) and 'señales' (more formal) both mean 'signs' in the context of infection warnings. Return-precaution handouts should use 'señas y señales' to catch both; verbal teach-back can use either.
- Workers' Comp reassurance phrasing matters clinically — Spanish-speaking construction workers frequently conflate WC with a lawsuit against the employer, or fear retaliation / deportation. 'Seguro de trabajo — es para que a usted le cubran' lands; 'no es una demanda contra su patrón' lands. Do not say 'vamos a reportar a su jefe' — that one phrase can send the patient out AMA.

Hypoglycemia emergency — altered diabetic brought in by daughter

6 min · 10 turns

CONTEXT

A 58-year-old Type-2 diabetic on a long-acting plus mealtime-insulin regimen is walked up to your triage bay by her adult daughter. She is diaphoretic, confused, clammy — textbook hypoglycemia. The tech is drawing a point-of-care glucose as she arrives. You have about sixty seconds before the number comes back to gather, in Spanish, what insulin she took this morning, when she took it, what and when she last ate, and whether she can still swallow safely. The daughter is the witness — the patient will almost certainly have anterograde amnesia for this visit, so the discharge teaching you give at the end of this encounter has to land on the daughter, not on the patient. Your plain-Spanish framing of 'suero con azúcar' vs. the chart-Spanish 'dextrosa' decides whether this family panics or follows along when the IV goes up.

CLINICAL GOAL

Differentiate severe hypoglycemia from hyperglycemia in a family-brought-in altered diabetic; establish insulin-type-and-timing and last-meal timeline from the family member before the POC glucose decides the treatment path; check swallow-safety in Spanish before choosing oral-glucose vs. IV-D10; deliver the teaching — recognition signs, the 15-15 rule, the 911 criteria, and the 'never take rapid insulin without eating the full plate' rule — to the daughter, who will be the witness when this recurs at home.

DIALOGUE

DAUGHTER · AT
TRIAGE, ARM
AROUND HER
MOTHER
#1

Ayúdenos, por favor. Es mi mamá. Es diabética. La encontré así hace como media hora — sudando mucho, temblaba, y no me contesta bien. Cree que es lunes, pero es viernes.

Please help us. It's my mom. She's diabetic. I found her like this about half an hour ago — sweating a lot, shaking, and she's not answering me right. She thinks it's Monday, but today is Friday.

YOU

#2

The tech is drawing a POC glucose as they walk up — you have ~60 seconds before the number comes back. Collect three things from the daughter in parallel: insulin TYPE (long / rapid / both), TIMING of the last dose (was it coupled to a meal?), and what + when the patient last ate. Ask all three in one compact block — you are not going to get a second uninterrupted minute once the glucose comes back and treatment starts.

Gracias por traerla rápido. Para ayudarla ahora mismo necesito tres cosas de usted. Primero: ¿qué insulina toma su mamá — la larga, la rápida, o las dos? Segundo: ¿cuándo fue la última vez que se la puso? Y tercero: ¿qué fue lo último que comió hoy, y a qué hora?

HYPOGLYCEMIA EMERGENCY — ALTERED DIABETIC BROUGHT IN BY DAUGHTER — CONTINUED

DAUGHTER

#3

Toma las dos. La larga se la pone en la noche, antes de dormir. La rápida se la pone antes de cada comida. Esta mañana se puso la rápida a las siete, antes del desayuno, pero yo creo que no comió casi nada — tenía náuseas. Y no sé si almorzó, doctora.

She takes both. The long-acting she injects at night, before bed. The fast-acting she injects before each meal. This morning she injected the fast-acting at seven, before breakfast, but I think she barely ate — she was nauseated. And I don't know if she had lunch, doctor.

YOU

#4

Classic presentation: rapid-acting insulin on board with no meal to absorb it. The POC glucose is about to come back low. Before you choose oral glucose vs. IV D10, you need a 30-second mental-status read AND a swallow-safety check — 'apta para vía oral' is the chart question; 'can this person drink juice without aspirating' is what it really asks. Address the patient directly (not the daughter this time) to test orientation, then offer a sip from the juice cup the tech is already holding.

Señora, soy la doctora. Dígame su nombre completo, por favor. ¿Sabe qué día es hoy? Mire — le voy a dar un sorbito de jugo. Pruebe, a ver si lo puede tragar bien, sin ahogarse.

PATIENT · MARÍA
LUISA, 58F,
DIAPHORETIC
AND CONFUSED
#5

Me... me llamo María Luisa Hernández. El día... no sé. ¿Es sábado? Me siento muy raro. Sí, sí puedo tragar.

I... my name is María Luisa Hernández. The day... I don't know. Is it Saturday? I feel very strange. Yes, yes I can swallow.

YOU

#6

POC glucose just came back at 38. She's oriented-to-self but not day, and she can swallow. Two paths: (1) oral glucose 15 g now + recheck in 15 min, or (2) IV D10 if mental status deteriorates or she drops again after oral. Announce both paths in plain-Spanish to the daughter — 'suero con azúcar' is the correct bedside term — so no one panics when the IV goes up as a backup. Also tell the patient, in one sentence, what she's about to feel: warm in the arm, then clear-headed within a minute.

Señora, su azúcar está muy baja — está en 38. Necesitamos subirla ahora mismo. Primero le vamos a dar este jugo con azúcar — tómeselo todo, despacito. Si con el jugo no sube lo suficiente, le ponemos un suero con azúcar directamente en la vena — va a sentir el brazo calentito y se le va a aclarar la cabeza en menos de un minuto. Hija, no se asuste cuando veamos que hay que poner el suero; es lo mismo que el jugo, pero le entra más rápido.

PATIENT · FIVE
MINUTES LATER,
RECOVERED
#7

Ay, gracias, doctora... ya me siento mejor. ¿Qué pasó? No me acuerdo bien cómo llegué aquí.

Oh, thank you, doctor... I feel better now. What happened? I don't really remember how I got here.

HYPOGLYCEMIA EMERGENCY — ALTERED DIABETIC BROUGHT IN BY DAUGHTER — CONTINUED

YOU

#8

She's asking because anterograde amnesia is common in severe hypoglycemia — she will not remember this visit tomorrow. That tells you the discharge teaching has to land on the DAUGHTER, not her. Before you pivot to teaching, close the trigger loop in the patient's own words so the chart has a real timeline (insulin at 7 a.m., half-breakfast, no lunch) and ask for the brand name of the rapid-acting insulin now that rapport is back — 'la rápida' is what the daughter said; the chart needs a drug name.

Su azúcar estuvo muy baja — por eso no se puede acordar bien de lo que pasó. Tuvimos que darle azúcar. Dígame, la insulina rápida que se pone antes de las comidas, ¿cómo se llama — la Humalog, la Novolog, o la Apidra? ¿Y es verdad que esta mañana desayunó nada más la mitad del plato y no almorzó?

PATIENT

#9

Es la Humalog. Me pongo diez unidades antes de cada comida. Sí, hoy desayuné nada más la mitad del plato porque tenía mucha náusea, y después ya no me dio hambre a mediodía, y pues, me quedé acostada.

It's Humalog. I take ten units before each meal. Yes, today I only ate half my breakfast because I was very nauseated, and then I wasn't hungry at lunchtime, and so, I just stayed in bed.

YOU

#10

The daughter is the person who will be there next time. Five things must land on HER, in Spanish, in one tight block — the patient is listening but this is not her teaching. (a) The five signs of falling glucose by name: sudor frío, temblor, confusión, hambre súbita, habla rara. (b) The 15-15 rule taught in its exact cadence — 'la regla de quince-quince: quince gramos de azúcar, quince minutos, vuelva a medir.' Juice or regular soda — NOT diet. (c) The 911 criteria: can't swallow, won't wake up, seizing. (d) The NEVER rule — 10 units of Humalog is coupled to a FULL plate; a half-breakfast morning is a no-Humalog morning, call the diabetes clinic. (e) Buy a glucose meter and a tube of glucose gel at the farmacia. Deliver all five. Ask for questions — teach-back, not consent theater.

Hija, esto es muy importante — póngame atención, porque su mamá probablemente no se va a acordar bien de lo que le diga. Son cinco cosas. Primero, las señales de que el azúcar le está bajando a su mamá — son cinco: sudor frío, temblor, confusión, hambre de repente, y que hable raro o lento. Si usted le ve cualquiera de esas señales, le da de tomar un jugo, o un refresco con azúcar — no de dieta — y esperan quince minutos. Después le vuelve a medir el azúcar. Si sigue bajo, otro jugo. Eso se llama la regla de quince-quince: quince gramos de azúcar, quince minutos, vuelva a medir. Segundo: si su mamá no puede tragar, no se despierta, o está convulsionando — llame al 911 de inmediato, no espere. Tercero, y esta es la regla más importante: su mamá nunca debe ponerse la Humalog si no se va a comer el plato completo. Si algún día tiene náuseas y no va a poder comer, ese día NO se pone la Humalog — llama a la clínica para que le digan qué hacer. Cuarto: compren en la farmacia un medidor de azúcar y un tubo de gel de glucosa — cuestan poco y se lo pueden meter entre la mejilla y la encía si no puede tragar. Y quinto: antes de que se vayan, les doy todo esto por escrito en español. ¿Qué dudas tiene?

HYPOGLYCEMIA EMERGENCY — ALTERED DIABETIC BROUGHT IN BY DAUGHTER — CONTINUED

WHAT TO NOTICE

- The 'tomar' vs. 'ponerse' distinction for insulin is the single biggest false cognate in Spanish-language diabetic care. '¿Se tomó la insulina?' translates roughly to 'Did you drink the insulin?' — a patient who doesn't want to correct the clinician will shrug or nod politely, and the medication-reconciliation line goes into the chart wrong. Use '¿se puso la insulina?' or '¿se inyectó la insulina?' at every encounter, including phone triage, intake, med-rec, and discharge. Chart it the same way.
- In severe hypoglycemia, anterograde amnesia for the episode AND for the ED visit is common. A patient discharged alone from a severe hypoglycemic episode has been discharged without teaching — she will not remember what you said. If a family member is present, that is who you teach; name them in the chart as the educated party and deliver the recognition-and-treatment rules to them, in Spanish, in one tight block. If no family is present, phone teaching within 24 hours (via the diabetes clinic or primary care) is the correct follow-up, not a handout she won't recall receiving.
- The 15-15 rule taught in Spanish in its exact cadence — 'quince gramos de azúcar, espera quince minutos, vuelva a medir' — is actionable. 'Si se siente mal tome algo con azúcar' is forgettable. Give the rule a name ('la regla de quince-quince') so the family member can repeat it over the phone to a relative or write it on the fridge. Every teachable rule in the ED that needs to survive a stressed 3 a.m. moment gets a Spanish label.
- '¿Qué comió hoy?' is the question that finds the insulin-meal timing error that caused the hypoglycemia. '¿Comió?' returns a reflex 'sí.' Specifics — half a plate, no lunch, only coffee — surface the actual cause. The follow-on NEVER rule ('nunca se ponga la insulina rápida sin comer el plato completo') is a single Spanish sentence and it prevents the next episode more reliably than a medication-list review or a referral-to-diabetes-education note.
- Plain-Spanish vs. chart-Spanish at the bedside is a trust and speed decision. 'Le vamos a dar un suero con azúcar en la vena' is how a scared daughter can follow what's about to happen as you start the IV; 'dextrosa al 10%' is how you document it. Using chart-Spanish at the bedside when plain-Spanish exists is a rapport cost with no clinical payoff — reserve the chemistry names for the H&P.

DIALECT NOTES

- 'Ponerse' (to inject) is the Spanish verb for insulin, NOT 'tomar' (to take / to drink). '¿Se tomó la insulina?' literally asks 'Did you drink the insulin?' and will get a blank stare or a polite reflex 'sí' from a patient who doesn't want to correct the clinician. Use '¿se puso la insulina?' or '¿se inyectó la insulina?' every time, and chart it the same way.
- Patients and families almost never use brand names first — they use functional names: 'la larga' / 'la de la noche' for long-acting (Lantus, Basaglar, Toujeo) and 'la rápida' / 'la de las comidas' for rapid-acting (Humalog, Novolog, Apidra). Ask by function FIRST to establish timing; then ask for the brand name once rapport is set. A 'do you take Humalog, Novolog, or Apidra?' opener to a stressed family member often returns 'no sé' — functional framing gets the full answer.
- 'Azúcar baja' / 'azúcar alta' is patient-Spanish for hypo- / hyperglycemia. 'Hipoglucemia' / 'hiperglucemia' is chart-Spanish and many patients will not recognize it cold. At the bedside with a scared family, 'su mamá tiene el azúcar muy bajo — en 38' lands immediately; in the chart, hypoglycemia (glucose 38) is what goes in the note. Both are correct for their audience.

HYPOGLYCEMIA EMERGENCY — ALTERED DIABETIC BROUGHT IN BY DAUGHTER — CONTINUED

- 'Sudor frío' is the canonical Spanish phrase for clammy, cold diaphoresis — the kind that signals hypoglycemia. 'Sudando mucho' is vaguer and can describe a hot, sweaty patient (fever, heat-stroke). Use 'sudor frío' specifically in the recognition teaching so the witness has a concrete, memorable sign, not a generic one.
- 'Mareo' collapses dizziness and nausea in Spanish the way 'I feel sick' does in English. When you need to differentiate, ask '¿siente que se va a caer, o que va a vomitar?' (feel like you're going to fall, or going to vomit?) — one sentence of precision buys you a cleaner differential than any amount of follow-up to 'mareo.'
- '¿Qué comió hoy?' beats '¿comió?'. A yes/no question gets a reflex 'sí' from a polite patient or a hedging family member. A what-question forces specifics — half a plate, no lunch, only coffee — which is where the insulin-meal timing error lives. This rule applies any time medication-meal timing is on the differential, not only to hypoglycemia workups.
- 'Suero con azúcar' is plain-Spanish for a D10 or D50 dextrose infusion. 'Dextrosa al 50% por vía intravenosa' is accurate but makes a scared family look up the words. When you're about to put the IV up in front of a frightened daughter, 'le vamos a dar un suero con azúcar en la vena' is the truthful, landing phrase. Save 'dextrosa' for the chart.
- The 15-15 rule is taught in Spanish as 'la regla de quince-quince': 'quince gramos de azúcar, espera quince minutos, y vuelva a medir.' Teach it in exactly that cadence — numbered rules with names are repeatable over the phone and memorable at 3 a.m.; 'si se siente mal tome algo con azúcar' is not.

Opioid overdose — Narcan reversal with witness at bedside

6 min · 10 turns

CONTEXT

A 29-year-old construction worker is rushed into your triage bay by his older brother. The brother is talking fast — his brother took 'two pills for back pain' he bought on the street about fifteen minutes ago, went quiet on the couch, turned purple around the lips, and now breathes maybe once or twice a minute. You have thirty seconds to confirm the overdose picture, announce naloxone in Spanish so the brother doesn't panic when the reversal hits, and prep both of them for what actually happens in a Narcan reversal: the patient will wake up agitated, in precipitated withdrawal, wanting to leave. Your Spanish-language posture in the next five minutes — especially whether you can build enough trust for the brother to name the pill as blue with a '30' on it — decides whether this discharge lands a Narcan prescription and a same-day buprenorphine start, or whether the patient walks out of triage and re-overdoses in the parking lot while the naloxone wears off and the fentanyl stays on board.

CLINICAL GOAL

Rapid respiratory-status assessment in Spanish by numeric count, announce naloxone with plain-Spanish framing so the witness doesn't fight the reversal, re-establish rapport after the patient wakes in precipitated withdrawal, reveal with stigma-minimizing framing that the 'Percocet' was pressed fentanyl, and deliver discharge teaching to the brother-witness: a 4-step Narcan rescue protocol, the 'nunca use solo' rule, the observation period, a Narcan prescription, and a same-day buprenorphine warm hand-off — a combative patient in precipitated withdrawal will not absorb a lecture.

CONTENT NOTE

This scenario depicts opioid-overdose reversal and explicit discussion of illicit-pill contamination and immigration-related fears. The clinical-Spanish teaching goal is harm reduction and warm hand-off to medication for opioid use disorder, not a lecture about drug use — the debrief is explicit on this. Replace the stimulus pill ID with the locally prevalent counterfeit stamp if your region differs from the blue-M30 fentanyl-counterfeit pattern.

DIALOGUE

BROTHER · AT TRIAGE, HALF-CARRYING THE PATIENT

Doctora, ayúdenos, por favor. Es mi hermano. Se tomó dos pastillas para el dolor de la espalda hace como quince minutos — las compró en la calle. Se durmió en el sillón y ahora no me contesta. Mire — se puso morado aquí en los labios. Respira muy poquito, casi nada.

Doctor, please help us. It's my brother. He took two pills for his back pain about fifteen minutes ago — he bought them on the street. He fell asleep on the couch and now he won't answer me. Look — he's turned purple around the lips. He's barely breathing.

OPIOID OVERDOSE — NARCAN REVERSAL WITH WITNESS AT BEDSIDE —
CONTINUED

YOU

#2

Classic opioid-overdose picture: depressed respirations, perioral cyanosis, somnolent, ~15 min post-ingestion of a street pill. Your team is already pulling the bag-mask and the intranasal naloxone. Before you push, confirm the respiratory count OUT LOUD with the brother in Spanish — numeric, not narrative — so you both agree on the baseline and the brother is anchored to what the reversal is being measured against. Then announce naloxone in plain Spanish, name the brand AND the chemistry in one sentence, and prep the brother for the fact that his brother is about to wake up within a minute — so he doesn't interpret the rapid reversal as 'another drug' going in.

Señor, soy la doctora. Su hermano tiene una sobredosis. Vamos a contar juntos cuántas veces respira — mire el pecho. En un minuto, ¿cuántas veces lo vio respirar? ¿Una, dos? ... Bien, dos veces. Es muy poco, pero está respirando. Ahora mismo le voy a dar una medicina en la nariz que revierte la sobredosis — se llama Narcan, también le dicen naloxona. En menos de un minuto lo va a ver abrir los ojos y respirar normal. No se asuste cuando despierte — se lo voy a explicar en un momento.

PATIENT ·
MIGUEL, 29M,
PRECIPITATED
WITHDRAWAL
#3

¡Ay! ¡Ay, qué pasó! Me... me duele todo. ¿Dónde estoy? Suéltenme — me quiero ir. No, no llamen a la policía, por favor, doctora. No le hice nada a nadie.

Agh! Agh, what happened! I... everything hurts. Where am I? Let me go — I want to leave. No, don't call the police, please, doctor. I didn't do anything to anyone.

YOU

#4

Textbook precipitated withdrawal after intranasal naloxone: agitation, myalgia, sweating, the 'let me leave' reflex, and an immediate deportation-and-police fear that will shut down the history if you don't name it first. Do NOT restrain. Do NOT lecture about drug use — a combative patient in withdrawal who hears a sermon walks out and dies in the parking lot. Instead deliver three beats in one tight turn at eye level: (a) name the withdrawal symptoms in plain Spanish so he understands this sensation is the medicine working, not a reaction or 'getting sick'; (b) deliver the 'no police, no immigration' sentence BEFORE you ask for any pill information; (c) ask for pill color, shape, and number in a way that signals you already know the shape of the answer (blue round '30' is fentanyl; asking open-endedly for 'what was it' gets 'no sé').

Miguel, cálmese — está seguro, está en el hospital. Lo que siente ahora — el temblor, el dolor, el sudor, las ganas de vomitar — es la medicina que le acabamos de dar, que le revirtió la sobredosis. NO es algo malo, es la medicina haciendo su trabajo. Le va a durar una o dos horas y después se le pasa, se lo prometo. No le vamos a llamar a la policía ni a inmigración — aquí nos importa que no se nos muera esta noche, nada más. Ahora, con toda confianza: ¿cómo eran las pastillas? ¿De qué color — azules, blancas, amarillas? ¿Redondas? ¿Tenían algún número?

PATIENT

#5

Eran azules. Redondas. Con un treinta de un lado. Me las vendió un amigo, dice que son Percocet — para el dolor de la espalda. Yo trabajo en la construcción, me duele siempre, y no tengo seguro para ir al doctor. ¿Son malas, doctora?

They were blue. Round. With a thirty on one side. A friend sold them to me — he says they're Percocet — for back pain. I work in construction, my back always hurts, and I don't have insurance to see a doctor. Are they bad, doctor?

YOU

#6

Blue round M30: pressed fentanyl counterfeit — real Percocet is oval, white or yellow, NOT blue with a 30. You need to deliver three pieces in one calm turn: (a) those pills were not Percocet; they were contaminated with fentanyl — information, not blame. (b) The Narcan in his system wears off BEFORE the fentanyl does, which is why he stays here in observation at least two hours — if the fentanyl outlasts the Narcan he can stop breathing again without warning. (c) He is alive because his brother was there. Reframe the brother as the witness you're about to teach, not an awkward bystander — and ask for the patient's consent to teach the brother now, while he is awake but still in withdrawal and unlikely to absorb the teaching himself.

Escúcheme con calma, Miguel. Lo que compró NO era Percocet. Esas pastillas azules con el treinta, redondas, casi siempre tienen fentanilo — un medicamento muchísimo más fuerte que la oxicodona, y más fuerte que la heroína. El fentanilo es lo que le paró la respiración hoy. La medicina que le di, el Narcan, le quitó el efecto del fentanilo ahora — pero el Narcan dura menos tiempo que el fentanilo. Por eso usted se queda aquí en observación unas dos horas; si empieza a respirar mal otra vez le damos más Narcan. Usted tuvo mucha suerte — estuvo su hermano. Si hubiera estado solo, no estaríamos hablando ahora. Quiero enseñarle a su hermano qué hacer si esto vuelve a pasar — ¿está bien si lo aprende conmigo ahora mientras usted está aquí?

PATIENT

#7

Sí, doctora. Está bien. Que aprenda mi hermano, porque yo ahorita no puedo ni pensar bien.

Yes, doctor. That's fine. Let my brother learn, because right now I can't even think straight.

YOU

#8

Pivot to the brother. He is the person who will be there next time. Deliver the Narcan rescue protocol in FOUR numbered steps (naming the number makes it repeatable over the phone at 3 a.m. by a scared brother), then name the 'nunca use solo' rule explicitly — not as a suggestion, as a named rule. Include the counter-intuitive piece: when your brother wakes up from Narcan, he will be angry — like this. That is NOT the emergency. The no-breathing was the emergency. A brother who is not prepared for the reversal-agitation will panic and interpret it as 'I gave him the wrong thing.'

Señor, usted va a ser el que esté cuando esto vuelva a pasar, y lo que le voy a enseñar puede salvarle la vida a su hermano. Son cuatro pasos, póngame atención. Uno: si lo encuentra otra vez así — morado, no respira, no despierta — llame al 911 ANTES de cualquier otra cosa, aunque parezca que ya despertó. Dos: le voy a dar una receta del Narcan en spray, para que lo tengan en la casa. Es una dosis en un agujero de la nariz, aprieta hasta el fondo. En la farmacia se lo dan en paquete de dos porque a veces una dosis no alcanza. Tres: si no respira nada y usted sabe dar compresiones en el pecho, empiece — lo que les enseñaron en el trabajo. Cuatro: si a los tres minutos no responde, la segunda dosis en el otro agujero de la nariz. Importante — cuando su hermano despierte, puede despertar bravo, con dolor, como despertó aquí ahora. Eso NO es la emergencia. La emergencia era que no respiraba. Una regla más, la más importante: se llama 'nunca use solo.' Si su hermano va a tomar algo otra vez, que usted esté en la casa, aunque sea en el otro cuarto. La gente que usa sola es la que se muere.

BROTHER

#9

Sí, doctora, apunté todo. Una pregunta — ¿cómo le conseguimos el Narcan si no tenemos seguro? Y él me dice ahorita que quiere dejar esto, pero le duele la espalda de verdad — ¿hay alguna medicina aquí mismo que le quite las ganas, o nos va a tocar esperar semanas con un doctor afuera?

Yes, doctor, I wrote it all down. One question — how do we get the Narcan if we don't have insurance? And he's telling me right now that he wants to quit this, but his back really does hurt — is there some medicine right here that takes away the craving, or are we going to have to wait weeks with a doctor outside?

YOU

#10

Two killer follow-ons from the brother: cost-access for Narcan, and same-day MAT. Answer both concretely — 'ask your primary care' turns into 'never' for an uninsured Spanish-speaking worker. (a) Narcan spray is OTC in 2026 at most pharmacies and many county health departments stock it free for family members of someone with a history; write the Rx anyway because some pharmacies still want one and because documenting it helps if the discharge is audited. (b) Offer buprenorphine (Suboxone) started in the ED TODAY with a warm hand-off — name the clinic, name the day he'll be seen, name the phone number, and have the brother write it on paper. Close with a line specifically designed to land: this was not his fault, fentanyl is why this happened tonight, and the craving-medicine WORKS — it is keeping thousands of construction workers on the job this year. Offer the buprenorphine start now, not as a referral.

Dos respuestas importantes, señor. Primero, el Narcan: aunque no tengan seguro, en la farmacia de aquí se lo dan sin receta — pero aún así le voy a dar una receta por escrito, por si acaso, y porque muchos condados lo regalan a familiares de alguien que ya tuvo una sobredosis. Segundo, la medicina para quitarle las ganas — sí, se puede, y sí, aquí mismo. Se llama buprenorfina, también le dicen Suboxone. Si su hermano quiere empezar hoy mismo, se la empezamos aquí antes de que se vaya, y mañana lo ve el doctor del programa — apunte este teléfono ahorita: el de la clínica de Medicina de Adicciones, abren a las ocho de la mañana, y le dan la cita el mismo día. Miguel, escúcheme — le voy a hablar claro. Lo de esta noche no fue su culpa; las pastillas de la calle en 2026 tienen fentanilo, y a muchos trabajadores de la construcción les ha pasado lo mismo. Esta medicina, la buprenorfina, les quita las ganas y les quita el dolor de la abstinencia — funciona. ¿Quiere que se la empecemos aquí mismo ahora?

WHAT TO NOTICE

- Respiratory-status assessment in Spanish must be numeric, not narrative, at triage — especially when you're about to push naloxone. 'Respira muy poquito' is a useless triage signal; 'respira una o dos veces por minuto' is the assessment that anchors the reversal. Counting out loud WITH the bystander ('¿una, dos, tres?') does two things at once: it confirms the rate, and it grounds a panicking witness to a number they own. Bystanders are fully capable of counting breaths when you ask them for a number instead of a story.
- Stigma-and-deportation framing is a clinical intervention, delivered FIRST. 'No le vamos a llamar a la policía ni a inmigración — aquí nos importa que no se nos muera esta noche' is the sentence that unlocks pill identification from a Spanish-speaking uninsured patient who woke up in withdrawal and is terrified. Without it, you get 'no sé' and a walk-out, and the next overdose in that household is charted by your colleague. Say it before you ask for the pill color, not after.
- Precipitated withdrawal will make the patient combative for 60–120 minutes after intranasal naloxone. Prep BOTH the patient and the witness for this in plain Spanish — 'va a sentirse muy mal: temblor, sudor frío, dolor, náuseas. Esto NO es una reacción mala; es la medicina haciendo su trabajo. Le va a durar una o dos horas y después se le pasa.' Naming the syndrome 'síndrome de abstinencia' is accurate but reads as accusation to a patient who doesn't yet trust you. Describe the symptoms in order first; name the syndrome only if asked. A patient who understands the sensation stays for the observation; a patient who doesn't walks.

OPIOID OVERDOSE — NARCAN REVERSAL WITH WITNESS AT BEDSIDE — CONTINUED

- Discharge teaching goes to the witness — same rule as stroke (#11) and hypoglycemia (#13). The patient who overdosed was minutes from death, is now agitated in precipitated withdrawal, and will not absorb a lecture. The brother will. Deliver the rescue protocol in four numbered steps with the 'nunca use solo' rule named explicitly, and include the counter-intuitive prep that the patient WILL wake angry — so the brother doesn't panic next time and think the Narcan 'made it worse.'
- Fentanyl-contamination framing ('estas pastillas azules del 30 casi siempre tienen fentanilo, aunque las vendan como Percocet') is the single most important piece of information in Spanish-language overdose care in 2026. The ICP doesn't know the street pill supply is contaminated; a 'drugs are bad' sermon loses to 'blue-pill-with-a-30 is fentanyl, not oxycodone, which is why your breathing stopped.' Teach the visual-identification rule; offer fentanyl test strips at discharge if the county health department stocks them. You are not trying to persuade him not to use; you are trying to make the next use survivable.
- Warm hand-off to buprenorphine in the ED — same day, same visit, specific clinic with a specific phone number the brother writes down — converts exponentially better than 'follow up with addiction medicine.' Uninsured Spanish-speaking patients have been told 'follow up' too many times without a callback to believe it abstract. Offer the buprenorphine start NOW, not as a future referral; if the department has an ED-initiated-buprenorphine pathway, this is its highest-yield indication. If not, escalate for one — it is the single most life-saving workflow change available to a US ED in 2026 for this ICP.

DIALECT NOTES

- 'Sobredosis' is the clinical Spanish term — patients and families at triage use euphemisms: 'se puso mal,' 'le dio algo,' 'se desmayó,' 'perdió el conocimiento.' Do NOT correct the euphemism to 'sobredosis' before rapport is set; it slows the history. Use the family's words back to them ('me dice que se puso mal hace quince minutos') and save the clinical term for the chart.
- Respiratory status in Spanish runs on observable counts, not narrative. 'Está respirando mal' is vague; 'está respirando una o dos veces por minuto' is the assessment. Ask the bystander 'en un minuto, ¿cuántas veces respira — una, dos, tres?' and accept a count. Bystanders are capable of counting; clinicians often under-use this and settle for 'respira muy poquito' when a number was there for the asking.
- 'Morado' is the canonical Spanish cyanotic-color word — lips, fingernails, around the mouth. 'Azul' also works and some Caribbean and Central-American patients prefer it. 'Pálido' is NOT the same thing: pálido is grey-white (shock, blood loss); morado is the blue-purple of hypoxia. Teach the witness this distinction: morado = respiratory emergency, pálido = different emergency, both !' call 911.
- 'Naloxona' is the chart term; 'Narcan' is the brand the public knows from posters, news, and pharmacy windows. Many Spanish-speaking patients recognize 'Narcan' faster than 'naloxona.' At the bedside, lead with Narcan and tie it to the chemistry name in one sentence — 'la medicina se llama naloxona, también le dicen Narcan' — so the brand they've heard links to the drug going in.
- Precipitated withdrawal in plain Spanish is best introduced by naming the symptoms in order, not by naming the syndrome. 'Va a sentirse muy mal — temblor, sudor frío, dolor en todo el cuerpo, náuseas, a veces vómito. Esto NO es una reacción mala; es la medicina haciendo su trabajo. Le va a durar una o dos horas y después se le pasa.' 'Síndrome de abstinencia' is the chart phrase; a patient who doesn't yet trust you hears it as accusation. Describe symptoms first; name the syndrome only if asked.

OPIOID OVERDOSE — NARCAN REVERSAL WITH WITNESS AT BEDSIDE — CONTINUED

- 'Fentanilo' (fen-ta-NEE-lo, stress on the penultimate syllable — NOT 'fentánil') is the word. In 2026, any Spanish-speaking patient buying pressed pills on the street is effectively buying fentanyl-contaminated product. The phrase that lands is 'esas pastillas azules del 30 casi siempre tienen fentanilo, aunque las vendan como Percocet.' Teach the contamination concept — 'contaminado con fentanilo' — not just the drug name; that is what is hiding in the non-prescription supply and what the teaching is meant to prevent next time.
- Stigma-and-deportation framing is a clinical intervention, not a social gesture. Spanish-speaking patients — especially uninsured workers — will often refuse to name a substance if they believe the ED will call police or ICE. The sentence 'No le vamos a llamar a la policía ni a inmigración — aquí nos importa que no se nos muera esta noche, nada más' unlocks the history. Say it first, before you ask what the pill was. Without it, you often get 'no sé' and a walk-out, and your next shift you will not know why he came back dead.
- 'Nunca use solo' ('never use alone') is the core Spanish-language harm-reduction phrase and the single most actionable piece of discharge teaching in an overdose encounter: if he uses again and a witness is present, a Narcan dose plus a 911 call is the difference between a callback and a funeral. Teach it by name — 'la regla de nunca use solo' — so a brother or cousin can repeat it. Paired with the rescue-protocol teaching, it is how the witness operationalizes what you just taught them.
- 'Buprenorfina' and 'Suboxone' are both recognized; lead with the brand the patient or family has heard on radio or from a neighbor, and include the generic name once. 'Quitarle las ganas' is the patient-Spanish for craving reduction — use it in the offer ('una medicina que le quita las ganas, se llama Suboxone, también le dicen buprenorfina') rather than 'para el trastorno por uso de opioides,' which reads as diagnostic label and loses the offer.

Asthma exacerbation — albuterol-not-working is really spacer-never-taught

6 min · 10 turns

CONTEXT

A 34-year-old Mexican-American woman — a seasonal landscaper — walks into your urgent-care / ED with her husband. She's tripodding at the registration desk, can't complete a sentence, audibly wheezing, visibly using accessory muscles. Vitals: SpO2 93% on room air, HR 118, RR 28, peak flow 40% of predicted. This is her third ED visit this spring for the same picture. She tells you through her husband that she uses her 'bombita azul' 'cuando me acuerdo' and has never been given a spacer. Your Spanish-language teaching in the next ten minutes — especially whether you can trigger a 'muéstreme cómo usa la bombita' demo, watch her technique, and convert this from another neb treatment into the first real inhaler teaching she's ever had — decides whether she has a fourth ED visit this month, or whether her home albuterol starts doing what it's supposed to do. The iceberg under three ED visits this spring is almost never disease severity; it is almost always a technique problem nobody has stopped to look at.

CLINICAL GOAL

Stabilize a moderate adult asthma exacerbation (nebulized albuterol + ipratropium, IM / PO steroids) while converting the visit into the first real technique teaching this patient has had: accessory-muscle assessment named in plain Spanish to anchor the exam for both patient and family witness, a 'muéstreme cómo usa la bombita' demo that surfaces the actual technique gap, a cadenced six-step spacer demonstration in Spanish that survives a stressed home moment, a controller-vs-rescue distinction taught by canister color ('la azul es de rescate; la gris es de prevención') instead of by chemical name, and 'aunque se sienta bien' framed as the adherence rule — so the home albuterol that was not working gets replaced by a spacer-delivered controller the husband can also monitor for accessory-muscle use as the home trigger to come back.

DIALOGUE

**PATIENT ·
TRIPODING AT
THE
REGISTRATION
DESK, CANNOT
COMPLETE A
SENTENCE**

Doctora... no puedo... respirar bien... me aprieta... el pecho... no me hace... la bombita...

Doctor... I can't... breathe right... my chest... is tight... my inhaler... isn't working...

ASTHMA EXACERBATION — ALBUTEROL-NOT-WORKING IS REALLY SPACER-NEVER-
TAUGHT — CONTINUED

YOU

#2

Moderate asthma exacerbation — audible wheezing, accessory-muscle use, patient can't finish a sentence, peak flow 40% predicted, SpO2 93%. Your team is pulling the nebulizer (albuterol + ipratropium) and the IV cart. Before you start, in one compact Spanish block name what you are seeing (so the husband can see it too — he's the home monitor), position her to open the airway, and announce the nebulizer treatment in plain Spanish. Accessory-muscle exam in Spanish is not chart-Spanish; name the visible body parts — neck muscles, skin sinking between ribs — so the family can use the same cue at home.

Señora, soy la doctora. La veo — está usando los músculos del cuello para respirar, y se le hunde la piel entre las costillas. Eso nos dice que está trabajando mucho para respirar. Vamos a empezar el tratamiento ahora mismo. Primero, siéntese bien derecha, inclinada hacia adelante, apoye los codos en las rodillas — así entra más aire. Le voy a poner una mascarilla con un nebulizador — es medicina en forma de vapor para abrir los pulmones. Respire por la boca, normal, no más fuerte. En diez minutos me va a contar la diferencia.

HUSBAND ·
STANDING
BESIDE HER,
FRUSTRATED

Doctora, es la tercera vez este mes que nos venimos para acá. Ya le cambiamos de bombita dos veces en la farmacia. Dice el doctor que es la misma medicina, pero a ella no le hace nada. Usa la bombita en la casa y no le quita el pito.

Doctor, this is the third time this month we've come in. We've already swapped her inhaler twice at the pharmacy. The doctor says it's the same medicine, but it does nothing for her. She uses the inhaler at home and it doesn't take the wheeze away.

YOU

#4

This is the teaching-unlock moment — three ED visits, two pharmacy swaps, same complaint. Before you chase another controller change or escalate the chemistry, you need to see her actually use the inhaler. Ask her to demonstrate her home technique — 'muéstreme cómo la usa' — and say 'tómesela como si estuviera en la casa' so she performs habit, not best behavior. This is a low-register, non-judgmental ask; it should land as curiosity, not as a test. Keep the nebulizer running while she demonstrates with her hands.

Entiendo. Pero antes de cambiar la medicina otra vez, déjeme ver cómo la usa — eso nos va a decir mucho. Cuando pueda hablar un poquito mejor con el nebulizador puesto, ¿me puede mostrar con las manos cómo usa la bombita en la casa? Como si estuviera en la sala de su casa, no pensando en mí. No hay respuesta mala — solo quiero ver cómo le sale.

PATIENT · A FEW
MINUTES INTO
THE NEB,
CALMER,
DEMONSTRATING
WITH HER HANDS

#5

Así, doctora — me la pongo en la boca, aprieto, y respiro. A veces dos veces seguidas si todavía me falta el aire. Así como me enseñó la farmacia. Igualito.

Like this, doctor — I put it in my mouth, I press, and I breathe. Sometimes twice in a row if I'm still short of breath. Just the way the pharmacy showed me. Exactly like that.

ASTHMA EXACERBATION — ALBUTEROL-NOT-WORKING IS REALLY SPACER-NEVER- TAUGHT — CONTINUED

YOU

#6

There is the gap — no pause between actuations, no deep slow inhale, no breath-hold, no spacer. Don't blame her or the pharmacy; reframe as 'now I understand why' — this is a technique problem, not a disease problem, not a medicine problem. Announce the two corrections you're going to make before you do them: she gets a spacer, and she gets the demo. Use BOTH 'espaciador' and 'cámara de inhalación' in the same sentence so she recognizes whichever term the pharmacy uses. Keep the blame frame off — 'la mitad del medicamento se queda pegada en la boca' is physics, not fault.

Ahora sí entiendo por qué no le funciona — y no es la medicina, y no es la farmacia, es la técnica. Cuando se aprieta la bombita y se respira rápido, la mitad del medicamento se queda pegada en la boca y los dientes, y nunca le llega al pulmón. Eso le pasa a muchísima gente, no es culpa suya. Hoy vamos a hacer dos cambios. Primero, le vamos a dar un espaciador — también le dicen cámara de inhalación — es un tubo de plástico que se le pone a la bombita. Segundo, le voy a enseñar ahorita, antes de que se vaya, cómo usarlo paso por paso.

PATIENT · TALKING IN SHORT SENTENCES NOW, CURIOUS

¿Un espaciador? Nunca me lo dieron. ¿Y cómo se usa? Porque yo ya creía que sabía usar la bombita — me la daban sin nada.

A spacer? They never gave me one. And how do you use it? Because I thought I already knew how to use the inhaler — they just handed it to me without anything.

YOU

#8

This is the six-step spacer teaching. Number the steps in Spanish — the numeric cadence is what survives a stressed 3 a.m. home use, not 'inhale slowly with a breath-hold.' Hand her an actual spacer as you say the steps; ask her to repeat them back after. Keep it in plain verbs: agite (shake), ponga (put), bote (breathe out), apriete (press), cuente (count), aguante (hold). One puff per actuation, full minute between puffs, two puffs total. The minute between matters — bronchospasm opens progressively with each puff, so back-to-back puffs waste the second one.

Son seis pasos. Póngame atención — le voy a dar uno para que lo tenga en la mano. Uno: agite la bombita, fuerte, como diez veces. Dos: póngale el espaciador en la punta. Tres: bote todo el aire de los pulmones, así (demuestra). Cuatro: ponga la boca alrededor del espaciador, sellada, y apriete la bombita UNA sola vez. Cinco: respire despacio y hondo — cuente uno, dos, tres, cuatro — y aguante cinco segundos con el aire adentro. Seis: bote el aire despacio. Espere un minuto COMPLETO. Después haga los seis pasos otra vez para la segunda puffada. Dos puffadas, una por una, con un minuto entre cada una. ¿Me los puede repetir?

HUSBAND · WHILE SHE TRIES THE STEPS

#9

Doctora, ¿y cuántas veces al día la usa? ¿Nada más cuando le falta el aire, o todos los días? Porque el doctor dice una cosa y la farmacia dice otra, y nosotros ya no sabemos.

Doctor, and how many times a day does she use it? Only when she's short of breath, or every day? Because the doctor says one thing and the pharmacy says another, and we don't know anymore.

ASTHMA EXACERBATION — ALBUTEROL-NOT-WORKING IS REALLY SPACER-NEVER-TAUGHT — CONTINUED

YOU

#10

The critical discharge teaching. Controller vs. rescue taught by canister color, not by chemical name. 'La azul' = rescue (albuterol); 'la gris' = controller (budesonide-formoterol / Symbicort). Dose the controller clearly: morning + night, with spacer, every day even when she feels fine. The adherence sentence 'aunque se sienta bien' has to land twice. Teach the husband the same accessory-muscle cue you named in turn 2 — 'los músculos del cuello' — as the home trigger to come back. Add the 5-5-5 prednisone burst with 'juntas, en la mañana, con comida.' Close by making the husband her home monitor — the family-witness teaching discipline, fourth reinforcement (stroke / hypoglycemia / overdose / asthma).

Buena pregunta — y le van a salir dos bombitas diferentes, se usan diferente. La bombita AZUL, la que ya tenía, es de rescate — solo cuando le falta el aire, como hoy. Dos puffadas con el espaciador, puede repetirlo cada cuatro horas si lo necesita. La bombita GRIS que le vamos a mandar hoy se llama Symbicort, esa es de prevención — esa se usa TODOS los días, mañana y noche, dos puffadas con el espaciador, aunque se sienta perfectamente bien. Eso es lo más importante que le voy a decir, y se los digo a los dos: aunque se sienta bien, úsela todos los días. Si se siente bien, es porque la gris está trabajando, no es porque ya se le quitó el asma. Si la deja, le vuelve a pasar esto en un mes. También le vamos a mandar prednisona — cinco pastillas, todas juntas, en la mañana, con comida, por cinco días — para bajar la inflamación de este ataque. Y señor, usted es el que la va a estar viendo en la casa: si la ve otra vez usando los músculos del cuello para respirar como hoy, o que no puede terminar una oración, tráigala enseguida — esa es la señal, no espere.

WHAT TO NOTICE

- Don't assume inhaler technique — ASK to see it. The single highest-yield teaching move in adult-asthma ED care is 'muéstreme cómo usa la bombita, tómesela como si estuviera en la casa.' Most 'my albuterol isn't working' complaints — and most repeat ED visits for the same asthma picture — are technique problems, not medicine problems. A patient who has had three ED visits this spring and two pharmacy swaps has almost certainly never been watched using her inhaler by a clinician. The 60 seconds you spend on the demo is higher-yield than any medication change you will make.
- Controller-vs-rescue teaching must be taught BY CANISTER COLOR, not by chemical name. 'La azul es de rescate; la gris es de prevención' — pair color to function in every repetition. Patients do not remember 'albuterol vs budesonide/formoterol' at 3 a.m. from a discharge sheet; they remember la azul y la gris. If your discharge printer supports it, print a color swatch next to each inhaler name; if not, write it by hand. The chemistry is for the chart; the color is for the patient.
- 'Aunque se sienta bien' is the single most load-bearing adherence phrase in Spanish-language asthma care. The most common reason a patient stops the controller is 'ya me siento bien, no la necesito' — teach the counter-intuitive frame: 'si se siente bien, es porque la gris está trabajando.' Say it twice in the room, not once. 'Aunque se sienta bien' is this scenario's analogue to 'nunca use solo' (scenario 14) and the 15-15 rule (scenario 13): a named, repeatable Spanish phrase that survives a stressed moment when the clinician is not there.

ASTHMA EXACERBATION — ALBUTEROL-NOT-WORKING IS REALLY SPACER-NEVER-TAUGHT — CONTINUED

- Spacer technique taught in numbered Spanish cadence — 'Uno: agite. Dos: ponga. Tres: bote el aire. Cuatro: apriete una vez. Cinco: cuente 1-2-3-4 y aguante. Seis: bote' — is retainable. 'Inhale slowly with breath-hold' is not. Numbered steps in plain verbs are the shape spacer teaching needs in Spanish. The one-full-minute-between-puffs also matters and is the most-skipped step: bronchospasm opens progressively with each actuation, so back-to-back puffs waste the second one.
- Fourth reinforcement of the family-witness teaching discipline (scenario 11 stroke / 13 hypoglycemia / 14 opioid overdose / 15 asthma). The accessory-muscle cue you named at the bedside — 'usando los músculos del cuello para respirar' and 'se le hunde la piel entre las costillas' — is also the home-monitoring trigger you give the husband. Same visible sign the clinician used becomes the family's at-home 'go back now, don't wait' trigger. Name visible body parts, not syndrome names, when the cue is going to a non-clinical monitor.
- Inhaler teaching is not discharge housekeeping — it IS the clinical care for this visit. The three ED visits this spring are a technique problem, not a disease-severity problem, and chasing the chemistry misses the actual lesion. Budget two minutes at the end of the encounter to run the six-step spacer demo with the actual device in her hand; it is the single highest-leverage thing you will do for this patient today, and the single thing most likely to prevent ED visit #4 this month.

DIALECT NOTES

- Wheezing runs three registers in Mexican-leaning Spanish and you will hear all three in one shift. Patients almost always say 'me hace pito' or 'estoy haciendo pito' — the informal, onomatopoeic. 'Silbido' / 'respiración silbante' is the half-formal register you will see on some pharmacy handouts. 'Sibilancia' is the chart term. Do NOT correct the patient who says 'pito' to 'sibilancia' — use their word back to them ('sí, oí el pito cuando entró'), then write 'sibilancias' on the chart. Correcting the register at the bedside slows the history and reads as pedantic.
- 'Me aprieta el pecho' is the universal Spanish-bedside phrase for the chest-tightness of asthma. Patients rarely say 'opresión' or 'pecho apretado' unprompted. 'Me aprieta' in a wheezing patient is asthma chest-tightness; 'me duele el pecho' with a fist on the sternum (Levine sign) is cardiac. The verb is the tell: apretar = tightness = asthma, doler = pain = think cardiac. Confirmed by the exam; but the phrase is a real Bayesian update.
- 'Bombita' is the near-universal Mexican-Spanish patient term for inhaler — a diminutive of 'bomba,' because it pumps. 'Inhalador' is chart-Spanish and what the pharmacy label reads. Some patients say 'pompa' or 'pompita' (Colombian, Venezuelan). At the bedside say 'bombita'; on the chart write 'inhalador.' The patient who hears 'inhalador' for the first time at discharge sometimes does not recognize what you mean, and you lose a minute of teaching time to clarifying a word.
- Spacer terminology splits by region and is the single most missable dialect note in asthma care. 'Espaciador' is universal in US-Latino / Mexican-American pharmacy Spanish. 'Cámara de inhalación' is what the pharmacy label will say in Spain-Spanish and some Central / South American markets. When you introduce the device, use both in one sentence ('un espaciador — también le dicen cámara de inhalación') so the patient recognizes whichever word the pharmacist uses at pickup. Use 'espaciador' for the rest of the encounter; it's the higher-yield word bedside.
- Accessory-muscle use in Spanish is an observable body-part description, not a syndrome name. 'Está usando los músculos del cuello para respirar' (neck muscles) and 'se le hunde la piel entre las costillas' (intercostal retractions) are the two phrases that are immediately understandable to a non-clinical family member AND are the exact at-home monitoring cue you want the husband to learn. 'Musculatura accesoria' is chart-Spanish. Naming the visible anatomy makes the teaching double as exam and home-trigger.

ASTHMA EXACERBATION — ALBUTEROL-NOT-WORKING IS REALLY SPACER-NEVER-TAUGHT — CONTINUED

- There is no standard patient-Spanish phrase for 'tripod position.' Describe the position — 'siéntese bien derecha, inclinada hacia adelante, apoye los codos en las rodillas' — and name what it does ('así entra más aire a los pulmones'). The position IS the teaching; telling a wheezing patient in Spanish to 'siéntese en tripode' is meaningless.
- Controller-vs-rescue inhaler teaching is cemented BY CANISTER COLOR in bedside Spanish, never by chemical name. 'La azul es de rescate, cuando le falta el aire. La gris es de prevención, todos los días aunque se sienta bien.' Patients will not remember 'salbutamol' vs 'budesonida/formoterol' at 3 a.m. from a discharge sheet; they will remember la azul y la gris. In Mexican-American pharmacy Spanish, Symbicort ships in a gray/grey (gris) canister, albuterol generics in a blue (azul); pair the color to the function in every repetition.
- 'Aunque se sienta bien' is the single most load-bearing controller-adherence phrase in Spanish. The most common reason a patient stops their controller inhaler is 'ya me siento bien, no la necesito.' The sentence that fights this is: 'aunque se sienta bien, úsela todos los días — si se siente bien, es porque la gris está trabajando, no es porque ya se le quitó el asma.' Say it twice before they leave the room, not once.
- Prednisone burst Spanish: 'cinco pastillas, todas juntas, en la mañana, con comida, por cinco días.' Every noun here carries: 'juntas' because patients otherwise split to 5 doses/day; 'en la mañana' because evening doses disrupt sleep; 'con comida' because GI side-effects are the most common reason patients stop on day 2; 'cinco días' — not indefinite — because patients left vague will either over- or under-take. The 5-5-5 numeric cadence (5 pills × 5 days) is the memorable shape.

Pediatric febrile seizure — terrified parent, 18-month-old post-ictal

6 min · 10 turns

CONTEXT

A 28-year-old mother carries her 18-month-old son into your triage bay, crying, the child limp and sweaty in her arms but tracking voice. EMS report: generalized tonic-clonic seizure at home ~20 minutes ago, witnessed by mother, duration 'about ten minutes' by parent estimate, self-terminated before paramedics arrived, no focal deficits on their exam. Rectal temp 39.8°C / 103.6°F, no meningismus, no rash, anterior fontanelle long closed. Mother is frantic, convinced her son 'was dying' and 'has epilepsy now,' and volunteers during history that she put a spoon in his mouth during the event because her own mother taught her that without it children swallow their tongue. This is the first peds emergency of your shift and the first Spanish-language peds emergency of the day. Your job in the next ten minutes: stabilize the parent enough to get a clean history and source the fever, name the event correctly ('convulsión febril,' not 'epilepsia'), correct the spoon-in-the-mouth folk intervention without shaming, teach the four-rule home rescue protocol, and deliver the load-bearing myth correction that lowering fever does NOT prevent another febrile seizure.

CLINICAL GOAL

Reassure an acutely terrified Spanish-speaking parent without dismissing her frame; name the diagnostic distinction that matters most to her (convulsión febril vs epilepsia) with the age window and benign course; redirect 'mal de ojo' cultural framing to a biomedical explanation without mocking it; correct the 'cuchara en la boca' folk rescue with empathy-first ('muchas mamás lo aprenden así') before the choking-risk reason; teach the four-rule home rescue protocol in numbered Spanish cadence (de lado / nada en la boca / cuente los minutos / 5-minutos-911); and deliver the load-bearing myth correction that bajarle la fiebre NO previene otra convulsión — the seizure is caused by how fast the fever rises, not by the absolute temperature, so she has not failed her child if it happens again. Source the fever while doing all of this — urine, throat, ears — since the workup is for the cause, not for the seizure itself.

DIALOGUE

**MOTHER · 28F,
CARRYING HER
18-MONTH-OLD
SON, SON
TRACKING VOICE
BUT LIMP AND
SWEATY**

¡Ay, doctora, ayúdeme! Mi niño, se me estaba muriendo — se puso todo tieso, los ojitos se le fueron para atrás, le salía baba por la boca. Como diez minutos así. Le eché agua fría y llamé al nueve-uno-uno. Tiene fiebre desde anoche.

Oh, doctor, help me! My son — he was dying — he got all stiff, his little eyes rolled back, he had drool coming out of his mouth. About ten minutes like that. I splashed cold water on him and called 911. He's had a fever since last night.

PEDIATRIC FEBRILE SEIZURE — TERRIFIED PARENT, 18-MONTH-OLD POST-ICTAL — CONTINUED

YOU

#2

A terrified mother arriving with a post-ictal toddler. Your first clinical move is to stabilize HER, because the child is already post-ictal and tracking voice — you need a clean history and a parent who can answer questions. Lead with one sentence of reassurance that names the present reality ('él está aquí'), then ask for the TWO facts that matter most in the next minute: age and fever-onset. Do NOT launch into the long explanation yet; the parent is too flooded to absorb it. This is the register-stabilization move — get her heart rate down to where she can give you a history.

Respire — él está aquí, con usted, y yo lo estoy viendo. Está despierto, está respirando, está bien en este momento. Vamos a revisarlo ahora mismo. Dígame dos cosas rápidas para empezar: ¿cuántos años tiene él, y desde cuándo tiene la fiebre?

**MOTHER ·
STARTING TO
STEADY**

#3

Tiene un año y siete meses. La fiebre le empezó ayer en la tarde. Le puse Tylenol anoche y otra vez en la mañana, pero no le bajó. Estaba jugando en la sala, y de repente se cayó del sillón, todo tieso. No me respondía. No me reconocía a mí, doctora — no me reconocía.

He's a year and seven months old. The fever started yesterday afternoon. I gave him Tylenol last night and again this morning, but it didn't come down. He was playing in the living room and suddenly he fell off the couch, completely stiff. He wasn't responding to me. He didn't recognize me, doctor — he didn't recognize me.

YOU

#4

The parent said 'ten minutes' in turn 1 — but 'ten minutes' from a parent watching their child seize is almost always one to three in clock-time. The distinction matters: < 15 minutes is a simple febrile seizure (reassuring, workup-for-fever only); > 15 is complex and warrants EEG / neuro consult. You need a real number, not a parent-time number. Ask in a way that lets the parent admit she did not clock it without feeling interrogated. Normalize the time-distortion ('a los papás se les hace eterno') BEFORE asking for the recount — this is the empathy-first framing that unlocks the honest answer. Reach for external anchors (the clock, the 911 call timestamp, paramedic arrival relative to seizure offset) rather than asking her to re-estimate, because the second estimate will be the same panic-number.

Cuando me dijo diez minutos — ¿usted miró el reloj, o se le hizo larguísimo? Eso es muy normal, a los papás se les hace eterno cuando están viendo a su hijo así. No le pregunto para juzgarla, sino para entender bien qué pasó. Piénselo otra vez: cuando llegaron los paramédicos, ¿él todavía estaba tieso, o ya estaba despertando? ¿Alcanzó a llamar al nueve-uno-uno antes, durante, o después?

MOTHER · QUIETER, ANSWERING THE ANCHOR QUESTIONS

Ay... no, no miré el reloj. Se me hizo larguísimo. Pero... cuando llegaron los paramédicos, él ya estaba despertando — llamé al nueve-uno-uno después, cuando vi que no me respondía. Tal vez fueron dos o tres minutos, doctora, no sé. Pero mire — lo que yo le quiero preguntar es esto: ¿mi niño va a tener epilepsia? Mi primo tiene epilepsia, y dice mi tía que fue igualito — empezó así cuando era bebé.

Oh... no, I didn't look at the clock. It felt endless to me. But... when the paramedics arrived, he was already waking up — I called 911 after, when I saw he wasn't responding to me. Maybe it was two or three minutes, doctor, I don't know. But look — what I want to ask you is this: is my son going to have epilepsy? My cousin has epilepsy, and my aunt says it was exactly the same — it started like this when he was a baby.

YOU

#6

This is THE load-bearing reassurance and it cannot wait. Name the thing in Spanish — 'convulsión febril' — and explicitly distinguish it from epilepsia IN THE SAME SENTENCE. Give her the age window (6 months to 5 years), the benign-course expectation (most kids never have another; the ones who do outgrow it), and the brain-damage reassurance. Then redirect her mental energy to the actual workup: the seizure already happened; what you are looking for now is WHY the fever came on. Three classic fever sources at 18 months are UTI, otitis media, pharyngitis — name the workup in plain words ('orina, garganta, oídos') so she knows what is about to happen. Do NOT use 'síndrome convulsivo benigno' or 'crisis febril simple' — textbook-Spanish that does not reassure. Stay in clinician-Spanish: 'convulsión febril, NO es epilepsia.'

Escúcheme bien, porque lo que le voy a decir es lo más importante: lo que le pasó a su hijo tiene nombre, y se llama 'convulsión febril.' Eso NO es epilepsia. Es diferente. Le pasa a niños sanos entre los seis meses y los cinco años cuando la fiebre les sube muy rápido — el cerebro del niño, a esta edad, es sensible a los cambios rápidos de temperatura. La mayoría de estos niños nunca vuelven a tener otra convulsión en la vida. Los pocos que sí tienen otra, también crecen y se les quita — para los cinco o seis años ya no les pasa. NO es daño al cerebro. NO es epilepsia. Lo de su primo es otra cosa — yo no lo he visto, pero 'igualito cuando era bebé' casi nunca quiere decir la misma enfermedad. Ahora, lo que sí tenemos que averiguar es por qué le dio la fiebre. Eso es lo que vamos a revisar ahora mismo — la orina, la garganta, los oídos. La convulsión ya pasó; lo que buscamos ahora es de dónde salió la fiebre.

MOTHER ·
RELIEVED, THEN
SHEEPISH

Gracias, doctora... gracias. Ay, se me quita un peso. Pero le tengo que decir la verdad — cuando se puso tieso, le metí una cuchara en la boca para que no se mordiera la lengua. Así me enseñó mi mamá, dice que eso los salva, que si no, se tragan la lengua. ¿Hice mal? Y también... mi suegra llegó esta mañana y dice que esto fue mal de ojo, que vinieron muchas personas ayer al cumpleaños de mi otro hijo y lo vieron mucho. Que tenemos que hacerle una cura de susto.

Thank you, doctor... thank you. Oh, a weight comes off me. But I have to tell you the truth — when he got stiff, I put a spoon in his mouth so he wouldn't bite his tongue. That's what my mom taught me, she says that saves them, that otherwise they swallow their tongue. Did I do wrong? And also... my mother-in-law came this morning and she says this was mal de ojo (evil eye), that a lot of people came to my other son's birthday yesterday and looked at him a lot. That we have to do a 'cura de susto' (folk fright-cure) on him.

YOU

#8

TWO corrections, both delivered without shame. First, the spoon: lead with 'muchas mamás lo aprenden así' BEFORE you say it is dangerous — a shamed parent disengages and does not adopt the four-rule rescue. Name the tongue-swallowing myth explicitly ('no se puede tragar la lengua — eso es un mito'), then the real risks (choking on the spoon, broken teeth, bitten fingers on the caregiver). Second, the mal de ojo: do NOT mock the frame and do NOT use the word 'superstición.' Acknowledge that the mother-in-law's fear is real ('el susto de su suegra es real') and redirect to the biomedical cause ('esto no fue el mal de ojo — fue la fiebre'). Then, immediately, give her the four-rule rescue protocol in numbered Spanish cadence — same shape as scenarios 14 and 15 — because she is the one who will be there if it happens again tonight, and she needs an action plan now. Hand her the protocol while she is flooded-but-absorbing, because that is when the structured steps land. Name each rule's reason in one clause.

Usted no hizo mal — usted hizo lo que le enseñaron, y muchísimas mamás aprenden lo de la cuchara de sus propias mamás, no me extraña. Pero hoy le voy a pedir que nunca más lo haga, y le voy a decir por qué. Primero, el niño NO se puede tragar la lengua — eso es un mito. No puede pasar. Lo que SÍ puede pasar con la cuchara es que se ahogue con ella, o que le rompa un diente, o que a usted le muerda el dedo sin querer. Y lo del mal de ojo — yo entiendo a su suegra, el susto de ella es real, y lo que quiere es protegerlo. Pero esto no fue el mal de ojo, señora — esto fue la fiebre. Le pasó porque tenía fiebre alta que le subió rápido, no porque lo vieron. Ahora, lo más importante — le voy a enseñar cuatro cosas para que sepa qué hacer si le vuelve a dar, que ojalá no. Son cuatro reglas. Uno: acuéstelo de lado, NUNCA boca arriba — así si le sale baba no se ahoga. Dos: NO le meta nada en la boca — ni cuchara, ni dedo, ni agua — nada. Tres: mire el reloj — cuente los minutos exactos, porque a los papás se les hace eterno y nosotros necesitamos el número de verdad. Cuatro: si dura más de CINCO minutos, llame al nueve-uno-uno mientras él sigue acostado de lado. Cinco minutos — con reloj.

MOTHER ·
WRITING THE
FOUR RULES ON
HER PHONE,
THEN LOOKS UP

De lado, nada en la boca, el reloj, cinco minutos — nueve-uno-uno. Ya lo apunté. Y una pregunta más — si mañana le vuelve la fiebre en la casa, ¿le doy Tylenol otra vez? ¿O Motrin? Mi hermana dice que se los puedo alternar cada tres horas — que así baja más rápido. ¿Y así le evito otra convulsión?

On his side, nothing in the mouth, the clock, five minutes — 911. I wrote it down already. And one more question — if the fever comes back tomorrow at home, do I give him Tylenol again? Or Motrin? My sister says I can alternate them every three hours — that way the fever comes down faster. And that way I can prevent another seizure?

YOU

#10

The discharge-teaching close. Three moves, and the third is the load-bearing myth correction that must be said explicitly, not implied. (1) Fever medicine: Tylenol OR Motrin (he is 18 months old, so ibuprofen is allowed) — pick one and stick with it; alternation creates dosing confusion, does not help the child, and is not worth the risk of a double-dose. Give weight context in both units ('como doce kilos, que son veintiséis libras') and tell her the dose will be on the discharge paper — do NOT ask her to memorize a milligram number. (2) The load-bearing reframe — deliver it verbatim in Spanish, twice if needed: 'bajarle la fiebre NO evita que le dé otra convulsión — la convulsión le dio porque la fiebre SUBIÓ rápido, no porque estaba alta.' This is the single most common myth in Spanish-speaking peds fever care and the one that makes a parent blame herself when it recurs. She needs to hear that it is not in her hands. (3) Return precautions — enumerate the specific triggers: another seizure in the next 24 hours, any seizure > 5 minutes, cannot wake him fully, stiff neck on head-movement, refuses to drink water, or still not recognizing her 30 minutes after the event. This is the fifth reinforcement of the family-witness teaching discipline (scenarios 11/13/14/15/16): the witness walks out with a named, numbered protocol and specific triggers tied to what they just saw.

Respuesta rápida a las tres cosas. Primero: puede darle cualquiera de los dos — Tylenol o Motrin, los dos le sirven a esta edad — pero NO los alterne. Escoja uno y sígase con ese; al alternar se confunden las horas y se le puede dar doble dosis sin querer. Él pesa como doce kilos, que son veintiséis libras más o menos — lo vamos a dejar escrito en el papel de alta, con la dosis exacta. No se la memorice ahora. Segundo, y esto es lo más importante que le voy a decir hoy, escúcheme bien: bajarle la fiebre NO evita que le dé otra convulsión. Se lo repito porque se lo van a preguntar en la casa: la convulsión le dio porque la fiebre le SUBIÓ rápido, no porque estaba muy alta. Si mañana le vuelve a dar una convulsión, no va a ser porque usted no le dio Tylenol a tiempo — eso no está en sus manos. Le damos la medicina para que él esté más cómodo, no para prevenir la convulsión. Tercero, regrese aquí enseguida si pasa cualquiera de estas cosas: le vuelve a dar otra convulsión en las próximas veinticuatro horas, o le dura más de cinco minutos, o no puede despertarlo bien, o no quiere tomar agua, o después de media hora de despertar todavía no la reconoce a usted, o si le ve el cuellito tieso cuando le mueve la cabecita. Cualquiera de esas — no espere, tráigalo.

WHAT TO NOTICE

PEDIATRIC FEBRILE SEIZURE — TERRIFIED PARENT, 18-MONTH-OLD POST-ICTAL — CONTINUED

- Name the diagnosis in Spanish AND distinguish it from epilepsia in the same sentence. 'Convulsión febril' and 'epilepsia' are different words to a clinician and the same word to a terrified parent. Every Spanish-speaking parent of a seizing toddler arrives thinking their child has epilepsy for life — often because of a cousin or uncle 'que era igualito cuando era bebé' — and will NOT ask you again if you do not address it the first time. The load-bearing reassurance is four pieces in one Spanish sentence: (1) it has a name — convulsión febril; (2) it is NOT epilepsia; (3) age window 6 months to 5 years; (4) most kids never have another, the ones who do outgrow it. Say all four together; the reassurance compounds.
- The 'cuchara en la boca' correction must lead with cultural empathy, not with the choking-risk reason. 'Muchas mamás lo aprenden así' BEFORE 'pero hoy le voy a pedir que nunca más lo haga' BEFORE 'porque el niño no se puede tragar la lengua — eso es un mito.' A shamed parent disengages and does not adopt the four-rule rescue; an acknowledged parent adopts it. The folk intervention is load-bearing emotionally — her own mother taught it to her, and correcting it without empathy reads as a correction of her mother, her family, her origin. Same discipline applies with 'mal de ojo': acknowledge the grandmother's fear is real, then redirect to the fever. Do NOT use the word 'superstición.'
- THE single most important myth-correction in Spanish-language pediatric febrile-seizure care: bajarle la fiebre NO evita que le dé otra convulsión. State it verbatim. State it twice. This is the analogue in peds-Spanish of scenario 15's 'aunque se sienta bien' and scenario 14's 'nunca use solo' — a named, repeatable Spanish sentence that survives a stressed 3 a.m. moment. A parent who thinks fever-lowering is prevention will blame herself when the next febrile seizure happens, and will not come back to the ED when she should. The physiology she needs to hear: the seizure is triggered by how fast the temperature rises, not by its absolute height; treat fever for comfort, not for prevention.
- Four-rule home rescue in numbered Spanish cadence — Uno de lado, Dos nada en la boca, Tres cuente los minutos, Cuatro 5-minutos-911 — is the retainable shape. Same numbered-cadence pattern as scenario 14 (Narcan 4-step to brother) and scenario 15 (spacer 6-step to patient and husband). Each rule carries a one-clause reason so the parent understands WHY — 'así si le sale baba no se ahoga,' 'porque a los papás se les hace eterno y nosotros necesitamos el número de verdad.' The reason is what turns the rule from a memorized list into a retained behavior.
- Fifth reinforcement of the family-witness teaching discipline — scenarios 11 (stroke / husband), 13 (hypoglycemia / daughter), 14 (opioid overdose / brother), 15 (asthma / husband), 16 (febrile seizure / mother). The witness walks out with a named, numbered rescue protocol and specific return triggers tied to what they just saw. Scenario 16 sharpens the pattern — the witness IS the primary caregiver and the patient is a toddler, so the teaching lands in the same person who will execute it, without the witness-to-teach-back step that scenarios 11/13/14/15 required. This is now a library-wide editorial pattern across five consecutive scenarios; the debrief names it so future sessions know the pattern exists and should extend it deliberately.
- Time-distortion during a child's seizure is universal — 'ten minutes' from a parent is almost always one to three in clock-time. Do NOT correct the parent ('no, no fueron diez') — that reads as doubting her. Instead, normalize the distortion first ('a los papás se les hace eterno') and THEN reach for external anchors: the clock, the 911 call timestamp, paramedic arrival relative to seizure offset. Anchors let her give you the real number without having to take back her own estimate. The real number matters clinically because the simple-vs-complex febrile-seizure threshold is 15 minutes, and the workup, disposition, and neurology-consult decision all depend on which side of that line the event was on.

DIALECT NOTES

PEDIATRIC FEBRILE SEIZURE — TERRIFIED PARENT, 18-MONTH-OLD POST-ICTAL — CONTINUED

- Seizure runs three registers in Spanish. Parents describe by what they SAW: 'se puso tieso' (he got stiff), 'los ojitos se le fueron para atrás' (his little eyes rolled back), 'le salía baba' (he was drooling). 'Ataque' is the everyday word. 'Convulsión' is half-formal. 'Convulsión febril' is the chart term AND the one you must say to the parent, because it names the thing. Lead with their visual ('ya sé lo que vio — se puso tieso'), then teach the chart term ('eso se llama una convulsión febril'), then hold that term through the rest of the encounter. Correcting 'se puso tieso' to 'convulsión tónico-clónica' at the bedside slows everything and teaches nothing.
- 'Convulsión febril' vs 'epilepsia' is the single most load-bearing lexical distinction in Spanish-language pediatric-seizure care. Parents arrive convinced their child has epilepsy for life — often because a cousin or uncle 'era igualito cuando era bebé' — and they will NOT ask you a second time if you do not address it the first time. Name both terms in the same sentence: 'esto se llama convulsión febril; NO es epilepsia.' Do not use 'síndrome convulsivo benigno' or 'crisis febril simple' — those are textbook-Spanish and do not communicate the reassurance you need to deliver.
- Tylenol / acetaminofén / paracetamol are three words for the same molecule and all three appear in a Spanish-speaking US family's medicine cabinet. Families recognize 'paracetamol' from home-country pharmacies — it is the universal over-the-counter term in Mexico, Central and South America. 'Tylenol' is what the US pharmacy label reads. 'Acetaminofén' is chart-Spanish. Say both 'Tylenol' and 'paracetamol' in the same sentence the first time — 'le puede dar Tylenol, que también le llaman paracetamol' — so the parent recognizes whichever the pharmacy label uses. Thereafter use 'Tylenol' for bedside.
- Motrin / ibuprofeno — Motrin is the US-pharmacy brand the parent will see on the shelf; 'ibuprofeno' is what the prescription will read. Same bilingual pairing rule as Tylenol / paracetamol. One caution: ibuprofeno in infants < 6 months is contraindicated. Confirm the child is older than six months before you recommend it. At 18 months you are clear; at 4 months you are not.
- 'Cuchara en la boca' is the folk rescue every Latin-American-origin mother was taught by her own mother, and it kills children — aspiration, broken teeth, bitten fingers on the caregiver. Correct it WITH a reason and WITHOUT shame: 'muchas mamás lo aprenden así, no me extraña — pero hoy le voy a pedir que nunca más lo haga, porque...' A shamed parent disengages and does not hear the four-rule rescue; an acknowledged parent adopts it. The myth to name and kill: 'el niño NO se puede tragar la lengua — eso es un mito.' Name the myth explicitly; implying it is wrong does not land.
- 'Mal de ojo' / 'susto' / 'cura de susto' are legitimate cultural frames for the unexplainable — often voiced by the grandmother, not the parent — and they are how a Spanish-speaking family absorbs a shocking event. Do NOT use the word 'superstición' and do NOT dismiss the frame. Acknowledge the feeling ('el susto de su suegra es real') and redirect to the biomedical explanation ('pero esto no fue mal de ojo — fue la fiebre'). If you mock the frame, the grandmother tells the family not to trust you, and the four-rule teaching never lands at home.
- Weight in pediatric dosing bridges three number systems: the family thermometer may be Celsius, the grandmother may think in kilos, the US pharmacy label will be in milligrams per kilogram, and the parent will ask 'how many spoonfuls.' Translate everything in both units the first time ('pesa como doce kilos, que son veintiséis libras más o menos') and then WRITE the dose on the discharge paper — do not ask the parent to memorize a milligram number bedside. The parent retains weight-range, not mg/kg, and a discharge paper with the specific dose in a box is the handoff that survives the ride home.
- Positioning language: the Spanish everyday terms for body position are 'boca arriba' (face-up / supine), 'boca abajo' (face-down / prone), and 'de lado' (on the side / lateral). Say the positioning in those plain words — 'acuéstelo de lado, NUNCA boca arriba' — NOT 'posición lateral de seguridad,' which is textbook-Spanish and does not land. 'De lado' is the word both a mother and a grandmother will act on without thinking.

PEDIATRIC FEBRILE SEIZURE — TERRIFIED PARENT, 18-MONTH-OLD POST-ICTAL — CONTINUED

- 'Bajarle la fiebre NO evita que le dé otra convulsión' is the single most important myth-correcting sentence in pediatric-Spanish febrile-seizure care. Memorize the Spanish verbatim: 'bajarle la fiebre NO evita que le dé otra convulsión — la convulsión le dio porque la fiebre SUBIÓ rápido, no porque estaba alta.' This is the analogue in peds-Spanish of scenario 15's 'aunque se sienta bien' and scenario 14's 'nunca use solo' — a named, repeatable Spanish sentence that survives the stressed 3 a.m. moment when the clinician is not in the room and the parent is blaming herself.
- Emergency number: always say '9-1-1' as 'nueve-uno-uno,' digit by digit, to a Spanish-speaking parent under stress. 'Novecientos once' is incorrect and confuses the parent; 'noventa y uno uno' is a different number. The number gets dialed faster when the parent has rehearsed it as three digits, and in a crisis she will say it back to you in whatever register you said it to her — so say it digit-by-digit every time you name it.

Geriatric fall — syncope uncovered + advance-directive conversation before hip surgery

6 min · 10 turns

CONTEXT

An 82-year-old Spanish-speaking woman is wheeled into your bay by her 54-year-old daughter. Mechanism from daughter: 'se cayó esta mañana en el baño.' Right leg is visibly shortened and externally rotated at the hip; she cannot bear weight, cannot flex the hip without wincing. Vitals: BP 138/76 supine !' 108/62 seated after 3 minutes (positive orthostatics), HR 58 and regular, SpO2 98%, afebrile. Point-of-care glucose 104. ECG pending. No head strike per daughter, no loss of consciousness per daughter — though the daughter admits 'no estaba en el baño con ella.' Patient is A&Ox3, quiet, formally polite ('sí, doctora' to everything), and visibly minimizing her pain. Pertinent history from the daughter: lisinopril + hydrochlorothiazide for hypertension, metformin for Type-2 diabetes, 'otra para el colesterol,' donepezil for 'problemas de memoria' — though today she is fully oriented. No anticoagulant. Husband died two years ago following a complicated surgery ('no despertó después de la operación'). This is your first elder-patient encounter of the shift. The emergency medicine resident has already told the daughter 'looks like a hip fracture, we'll get an x-ray' — so the consent-for-surgery conversation will land on you. Your job in the next ten minutes: address the patient directly at eye level (not through the daughter), distinguish a mechanical fall from a syncopal collapse (the single highest-leverage history question in a geriatric fall), defeat the elder-stoicism pain-scale bias, deliver the diagnosis and surgical recommendation together so the family has time to absorb urgency before the consent form appears, and open the advance-directive conversation as three specific reversible questions rather than one vague ask. This is the library's first elder-patient scenario and first advance-directive teaching in Spanish.

CLINICAL GOAL

Conduct a high-stakes geriatric ED encounter entirely in Spanish that (1) addresses the elder patient directly FIRST — at eye level — before accepting the daughter's answers, and invites the daughter as support-not-substitute; (2) distinguishes mechanical fall from syncope by asking '¿se cayó o se tiró?' and listening for 'se me nubló la vista' — the finding that converts this from a hip-x-ray encounter into a full syncope workup with orthostatics, EKG, and telemetry; (3) defeats elder-Latina pain-scale stoicism by anchoring the 10 to 'el peor dolor que ha sentido en su vida — partos, operaciones' and framing dynamic pain against movement; (4) delivers the clinical finding in plain-Spanish visible-anatomy terms ('la pierna derecha se le ve más corta, el pie se le va para afuera — es muy probable que se haya roto el hueso de la cadera') and pre-frames the surgical recommendation before the x-ray returns so the family has 10 minutes to absorb urgency; (5) opens the advance-directive conversation not as '¿tiene directivas por adelantado?' (which gets 'no sé qué es') but as three specific reversible questions — resucitación if the heart stops during surgery, ventilator-duration limits if she cannot be extubated, and poder notarial médico if she cannot speak for herself — each framed as changeable tomorrow so the patient answers honestly without fear of committing. Sixth consecutive scenario where the witness (here, the daughter) walks out with a named, specific, carrying-home teaching — the three advance-directive questions she will need to recall during inpatient admission.

DIALOGUE

GERIATRIC FALL — SYNCOPE UNCOVERED + ADVANCE-DIRECTIVE CONVERSATION BEFORE HIP SURGERY — CONTINUED

DAUGHTER · 54F,
SPEAKING FIRST
FOR HER 82-
YEAR-OLD
MOTHER IN THE
WHEELCHAIR
#1
BESIDE HER

Doctora, mi mamá se cayó esta mañana en el baño. Tiene ochenta y dos años. Le duele mucho la cadera derecha, no la puede mover. Ella es muy fuerte, nunca se queja — si ella le dice que le duele, es que le duele muchísimo. El doctor joven nos dijo que parece que se rompió la cadera y que le van a tomar una radiografía.

Doctor, my mom fell this morning in the bathroom. She's 82. Her right hip hurts a lot, she can't move it. She's very strong, she never complains — if she tells you it hurts, it means it hurts a lot. The young doctor told us it looks like a broken hip and they're going to take an x-ray.

YOU

#2

Your first move sets the register for the whole encounter. Address the patient directly, at eye level, BEFORE you accept the daughter's answers. Use 'Doña' + apellido if offered (assume you don't have it yet, so 'Doña' + señora). Invite the daughter as support, not substitute — explicitly ('voy a preguntarle a usted primero, y si necesita ayuda, su hija está aquí'). Then, because mechanism is the single most load-bearing history question in a geriatric fall, ask it directly: was it a slip, or did she feel something first? Offer three specific pre-syncope descriptors ('se resbaló / se le nubló la vista / se le oscureció todo'), because a stoic elder will accept 'slip' as the path of least social friction unless you explicitly offer the alternate path.

Buenas tardes, señora. Yo soy la Doctora ____ . Gracias por traerla (a la hija), aquí vamos a cuidarla bien. (Me agacho a su altura, la miro a los ojos.) Doña, ¿me permite preguntarle algo directamente a usted primero? Si usted necesita ayuda para explicarme algo, su hija está aquí con nosotras. Dígame una cosa, y no hay respuesta mala: ¿usted se cayó porque se resbaló, o se cayó porque primero se sintió mareada, se le nubló la vista, o se le oscureció todo? A veces uno se cae porque el piso está mojado; a veces uno se cae porque primero se desmayó. La razón cambia lo que tenemos que revisar.

PATIENT · 82F,
'DOÑA
HERMINIA,'
QUIET, POLITE,
#3
VISIBLELY
MINIMIZING

Gracias, doctora. Mi hija dice la verdad — me caí en el baño. (Pausa larga.) Pues... ahora que me pregunta... yo estaba levantándome del inodoro, y sí, se me nubló un poquito la vista, doctora. Pensé que era normal, porque me levanté rápido. Pero sí — primero se me nubló, y después me caí. No me resbalé.

Thank you, doctor. My daughter is telling the truth — I fell in the bathroom. (Long pause.) Well... now that you ask... I was standing up from the toilet, and yes, my vision got a little blurry, doctor. I thought it was normal, because I stood up fast. But yes — first it got blurry, and then I fell. I didn't slip.

GERIATRIC FALL — SYNCOPE UNCOVERED + ADVANCE-DIRECTIVE CONVERSATION BEFORE HIP SURGERY — CONTINUED

YOU

#4

That answer just converted this encounter from a hip-x-ray-and-go into a full syncope workup — the patient has positive orthostatics (138/76 !' 108/62), is on lisinopril + hydrochlorothiazide, and just described pre-syncope. You need to name the finding back to her so she knows what you heard (and so the daughter knows to tell the admitting team), then pivot to the pain-scale question using the elder-stoicism defeat frame. Anchor 10 to 'the worst pain of your life — childbirth, surgeries' to break the 'no quiero molestar' floor. Ask for pain both at rest AND with movement — the static number will be minimized, the dynamic number is the honest one.

Gracias por decírmelo, Doña — eso es muy importante. Lo que usted me está describiendo — la vista nublada antes de caerse — nos dice que a lo mejor no es solo una caída; a lo mejor primero se le bajó la presión, y por eso se cayó. Le vamos a hacer unos estudios del corazón y de la presión, además de la radiografía de la cadera. (A la hija, una frase.) Eso es importante que se lo diga al médico de arriba cuando la suban. Ahora, Doña, el dolor: le voy a pedir que no sea tímida conmigo. Si el diez es el peor dolor que usted ha sentido en su vida — partos, operaciones, lo peor que haya vivido — y el uno es casi nada, ¿en qué número pone el dolor de la cadera ahorita, quieta, sin moverla? ¿Y cuando se la mueven?

PATIENT · DOÑA
HERMINIA · THE
DAUGHTER HAS
JUST REACHED
FOR HER HAND

#5

Doctora, es que yo no me quejo... (la hija, suavemente: 'mamá, dígame la verdad, dígame que sí le duele') ... bueno. Quieta, como un cinco. Pero cuando me mueven — cuando vine en la camilla — como un nueve, doctora. No me lo haga mover otra vez, por favor.

Doctor, it's that I don't complain... (the daughter, softly: 'mom, tell her the truth, tell her that yes it hurts') ... well. Lying still, about a five. But when they move me — when I came in on the stretcher — about a nine, doctor. Don't make me move it again, please.

GERIATRIC FALL — SYNCOPE UNCOVERED + ADVANCE-DIRECTIVE CONVERSATION BEFORE HIP SURGERY — CONTINUED

YOU

#6

Honest dynamic pain at 9/10 with the classic externally-rotated shortened limb finding — this is a hip fracture until x-ray proves otherwise, and you have 10 minutes before the images land. The high-leverage editorial move is to deliver the diagnosis AND the surgical recommendation TOGETHER, pre-framed, so the family has the 10 minutes of x-ray-wait to absorb urgency rather than 10 seconds after the images appear. Use plain-Spanish visible anatomy ('la pierna se le ve más corta, el pie se le va para afuera — el hueso de la cadera'). Name that IF the x-ray confirms, the treatment is surgery in hours not days, and explain WHY — thrombosis and pneumonia — in the family's register, not in percentages-of-mortality. Lead the surgery word with 'cirugía — una operación' so the patient recognizes both registers. No consent conversation yet; this is the information drop so the next conversation is informed.

Gracias, Doña — eso es exactamente lo que necesitaba saber. Lo que yo le estoy viendo es esto: la pierna derecha se le ve más corta que la izquierda, y la punta del pie se le va para afuera. Eso, con el dolor que usted me está describiendo, me dice que es muy probable que se haya roto el hueso de la cadera en la caída. La radiografía nos lo va a confirmar en unos diez minutos. Quiero que usted y su hija sepan desde ahorita, antes de que vuelva la radiografía, que si está rota, el tratamiento es cirugía — una operación de la cadera — en las próximas horas, no mañana. No es que tengamos prisa por prisa; es que si esperamos, suben los riesgos de trombosis en las piernas y de neumonía, y esos son los riesgos que matan a la gente después de una cadera rota, no la operación misma. La buena noticia es que es una cirugía que hacemos muchísimo, y las personas de su edad se recuperan bien cuando se opera rápido.

DAUGHTER,
QUIETLY, WHILE
HER MOTHER
LOOKS DOWN AT
HER HANDS

#7

Doctora... (voz baja) mi mamá tiene mucho miedo de la anestesia. Mi papá, su esposo, murió después de una operación hace dos años — no despertó de la anestesia. Mamá me dijo en el camino para acá que si esto era grave, ella quería que habláramos de... de lo que ella quiere si algo le pasa. Ella no me quiso decir qué exactamente, doctora, pero yo creo que usted sabe a lo que se refiere. Y yo no sé cómo empezar esa conversación con ella.

Doctor... (quietly) my mom is very afraid of anesthesia. My dad, her husband, died after an operation two years ago — he didn't wake up from the anesthesia. Mom told me on the way here that if this was serious, she wanted us to talk about... about what she wants if something happens to her. She didn't want to tell me exactly what, doctor, but I think you know what she means. And I don't know how to start that conversation with her.

GERIATRIC FALL — SYNCOPE UNCOVERED + ADVANCE-DIRECTIVE CONVERSATION BEFORE HIP SURGERY — CONTINUED

YOU

#8

The daughter has just handed you the cleanest possible opening for the advance-directive conversation — do not waste it and do not off-load it to social work or palliative. Turn back to the patient. Address her directly again. Name what the daughter has just said kindly and clearly, and then open the advance-directive conversation — NOT as '¿tiene directivas por adelantado?' (which gets 'no sé qué es') but as three specific, concrete, reversible questions, in order: (1) resucitación if the heart stops during surgery; (2) ventilator-duration limits if she cannot be extubated; (3) poder notarial médico if she cannot speak for herself. Frame the whole thing as reversible ('lo que usted diga hoy, usted lo puede cambiar mañana') so the patient answers honestly without fear of committing. Pair 'poder notarial médico' with the English chart term 'healthcare proxy' so she sees what will be written down. This is the single most load-bearing Spanish teaching in the library for geriatric admissions — three questions, in order, reversible.

Gracias, hija. Doña, le voy a hablar directamente a usted — su hija hizo muy bien en traer esto. Lo que usted quiere hablar, en este hospital lo llamamos 'directivas por adelantado' — en inglés, advance directives. Son las decisiones que usted toma AHORA, mientras está despierta y puede hablar por sí misma, sobre qué quiere que hagamos si durante la cirugía o después algo no saliera bien. Y algo muy importante antes de empezar: cualquier cosa que usted me diga hoy, usted la puede cambiar mañana. No se casa con ninguna respuesta.

PATIENT · DOÑA
HERMINIA,
LOOKING UP,
SQUEEZING HER
DAUGHTER'S
HAND

Está bien, doctora. Ya me dijo mi hija que usted es buena gente. Pregúnteme lo que necesite. Lo que le pasó a mi Arturo — mi esposo — yo no quiero que me pase así a mí. No quiero estar conectada a las máquinas meses sin despertar. Pero tampoco quiero rendirme si puedo regresar. Pregúnteme, doctora.

That's all right, doctor. My daughter already told me you're a good person. Ask me what you need to. What happened to my Arturo — my husband — I don't want that to happen to me. I don't want to be connected to machines for months without waking up. But I don't want to give up if I can come back, either. Ask me, doctor.

GERIATRIC FALL — SYNCOPE UNCOVERED + ADVANCE-DIRECTIVE CONVERSATION BEFORE HIP SURGERY — CONTINUED

YOU

#10

Now ask the three questions — in this order, slowly, one at a time, giving the patient time to answer before asking the next. (1) DNR: if the heart stops during surgery, do you want us to try to revive you with compressions and machines, or let you go in peace? Name the English chart term ('DNR') so the family recognizes it on discharge paperwork. (2) Ventilator-duration limit: if after the surgery you need a breathing tube and you cannot come off it, for how long do you want us to keep you connected to the machines — a few days, a week, two weeks — before we stop if there is no improvement? (This is the question that most closely matches what happened to her husband, and the one she most needs to answer.) (3) Poder notarial médico — who speaks for you if you cannot speak? Pair with the English 'healthcare proxy.' Close by naming that all three answers get written in her chart TODAY, before surgery, and that a social worker will bring the paper to sign after the x-ray. Sixth consecutive scenario ending with a family witness (the daughter) carrying a named, specific home-return task — in this case the three advance-directive answers she will need to recall for floor staff and the admitting team.

Gracias, Doña. Tres preguntas, una por una, y tome el tiempo que necesite para cada una. La primera: si durante la cirugía el corazón se le parara, ¿quiere que tratemos de revivirla con compresiones y con máquinas — lo que se llama resucitación, en inglés 'DNR' cuando uno dice que no — o prefiere que la dejemos irse en paz, sin esa parte? La segunda, y esta es la que se parece a lo que le pasó a don Arturo: si después de la cirugía necesita un tubo para respirar, y no la pudiéramos quitar del tubo — ¿por cuántos días quiere que la mantengamos conectada a las máquinas antes de parar, si no hay mejoría? Unos días, una semana, dos semanas — lo que usted decida, nosotros lo respetamos, pero necesitamos el número. La tercera: si en algún momento usted no puede hablar por usted misma, ¿quién habla por usted? Eso se llama 'poder notarial médico' — en inglés, 'healthcare proxy.' Casi siempre es un hijo o una hija, pero es la decisión de usted. Y esto, Doña, también se lo repito: todo lo que me conteste hoy se lo vamos a escribir en el expediente antes de la cirugía, y la trabajadora social va a venir con el papel para que usted lo firme cuando vuelva la radiografía. Y cualquier respuesta, usted puede cambiarla mañana.

WHAT TO NOTICE

- '¿Se cayó o se tiró?' — the single highest-leverage history question in a geriatric ED fall, and the one that determines whether this is a hip-x-ray-and-admit encounter or a full syncope workup (orthostatics, EKG, telemetry, medication review for the diuretic + ACE-inhibitor polypharmacy that caused it). A stoic elder Latina will accept 'se resbaló' as the path of least social friction unless you explicitly offer the alternate path — 'se cayó porque se resbaló, o se cayó porque primero se sintió mareada, se le nubló la vista, o se le oscureció todo.' Offering three specific pre-syncope descriptors lets her match against memory instead of categorize. Missing this question creates a charted 'mechanical fall' that hides the unstable bradyarrhythmia or the orthostatic-hypotension-on-polypharmacy that will cause the next fall in two weeks.

GERIATRIC FALL — SYNCOPE UNCOVERED + ADVANCE-DIRECTIVE CONVERSATION BEFORE HIP SURGERY — CONTINUED

- Address the elder patient directly, at eye level, FIRST — before accepting the daughter's answers. 'Doña, voy a preguntarle a usted primero, y si necesita ayuda, su hija está aquí' is the exact phrasing. The daughter will often redirect the patient appropriately ('mamá, dígame la verdad, dígame que sí le duele') — that is the pattern working as intended, not an interruption to be silenced. Starting with the daughter forfeits the history only the patient knows (pre-syncope, pain onset, medication timing) AND trains the family dynamic that the elder is the object of care, not the subject. 'Doña' + pausing at eye level is the single register move that unlocks the trust needed for the advance-directive conversation in turn 10.
- Elder-stoicism pain-scale correction is clinical discipline, not bedside manner. Latin-American elder women systematically under-report pain — 'no quiero molestar' / 'estoy bien' / 'no es nada' are the surface signs. NEVER ask '¿le duele?' — the answer is always 'no, doctora.' ALWAYS ask '¿qué tanto le duele, del uno al diez?' and anchor 10 to lived experience ('el peor dolor que ha sentido en su vida — partos, operaciones, lo peor') so the scale has floor-raising force. Frame pain against movement — 'quieta' vs 'moviendo' — because the static number will still be minimized but the dynamic number forces the honest answer. Undertreated pain in geriatric Latino ED patients is predominantly a register failure at the bedside, not a dosing failure at the pharmacy.
- Deliver the diagnosis and the surgical recommendation together, pre-framed, BEFORE the x-ray returns. Don't split 'the x-ray will tell us' from the surgical-consent setup. Pre-frame the surgery while you're ordering the x-ray, so the family has 10 minutes to absorb urgency rather than 10 seconds after the images appear. Include the 'why hours not days' timing (thrombosis, pneumonia) in plain Spanish — 'esos son los riesgos que matan a la gente después de una cadera rota, no la operación misma.' This compresses what would otherwise be three separate conversations (x-ray results, surgical recommendation, urgency rationale) into one, and the family enters the consent conversation already aligned with the plan rather than encountering it cold.
- Advance directive as THREE specific reversible questions, not one vague ask. '¿Tiene directivas por adelantado?' gets 'no sé qué es eso' and closes the conversation. Instead: (1) resucitación if the heart stops during surgery; (2) ventilator-duration limit if she cannot be extubated; (3) poder notarial médico if she cannot speak for herself. Each question is concrete, bounded, and frame-matched to the patient's anatomy — (1) matches the cardiac-arrest scenario, (2) matches exactly what happened to her husband ('no despertó de la anestesia'), and (3) names who speaks for her. Frame the entire conversation as reversible — 'cualquier cosa que usted me diga hoy, usted la puede cambiar mañana' — so the patient answers honestly without fear of committing to a permanent decision. The reversibility frame is what converts a refusal into an answer.
- 'Poder notarial médico' is the phrase that lands for healthcare power-of-attorney. Spanish-speaking elders recognize 'poder notarial' as a legal document because it IS one in their countries. 'Representante de salud' or 'apoderado de salud' sound informal and patients misread them as suggestions rather than legal designations. Pair the Spanish phrase with the English chart term the first time — 'poder notarial médico — en inglés, healthcare proxy o healthcare power of attorney' — so the patient sees what will be written down and so the family recognizes the term on discharge paperwork and in the admission note. Same bedside-pair-with-chart-term pattern as 'DNR / no resucitar' in this scenario and 'convulsión febril / simple febrile seizure' in scenario 16.
- Sixth consecutive reinforcement of the family-witness teaching discipline. Scenarios 11 (stroke / husband), 13 (hypoglycemia / daughter), 14 (opioid overdose / brother), 15 (asthma / husband), 16 (febrile seizure / mother), and now 17 (hip fracture / daughter) all end with a specific family witness carrying a named, specific home-return task tied to what they just witnessed. In scenario 17 the task is the three advance-directive answers the daughter will need to recall during inpatient admission — which floor nurse asks, which admitting physician asks, and which consulting surgeon asks, all at different hours, and the patient is going to be sedated or post-op for part of that time. The library-wide pattern now spans six scenarios across six specialties and should continue to be extended deliberately in future sessions.

GERIATRIC FALL — SYNCOPE UNCOVERED + ADVANCE-DIRECTIVE CONVERSATION BEFORE HIP SURGERY — CONTINUED
DIALECT NOTES

- Advance directive runs three registers across Latin-American Spanish and US healthcare forms. 'Directivas por adelantado' is the Mexican-leaning US-healthcare-form register and the one most Latino patients in CA/TX/FL/NY/IL hospital bilingual intake packets have seen. 'Voluntad anticipada' is the Mexican legal-code register used in Mexico City's Ley de Voluntad Anticipada — legally precise in Mexico, but many US Latinos won't have heard it. 'Instrucciones anticipadas' is the Spain-leaning register, common in Puerto Rico and Dominican Republic. Say 'directivas por adelantado' first (US-healthcare register), and if the patient looks puzzled, pair it with 'lo que en inglés llaman advance directives' so she sees the chart term too. Do NOT assume a patient from Mexico will recognize 'voluntad anticipada' — it's a Mexico-City-law term that rural-Mexican patients often do not know.
- 'Poder notarial médico' is the phrase that lands for healthcare power-of-attorney. Spanish-speaking elders recognize 'poder notarial' as a legal document because it IS one in their countries — the notarized legal-power instrument. Adding 'médico' scopes it to health decisions. 'Representante de salud' and 'apoderado de salud' both sound informal and patients routinely misunderstand them as suggestions rather than legal designations. Pair it the first time with the English chart term — 'poder notarial médico — en inglés, healthcare proxy o healthcare power of attorney' — so the patient sees what will be written down. 'Poder' alone is ambiguous (it also means 'power' as in strength); always use the three-word phrase 'poder notarial médico' bedside.
- DNR in Spanish is 'no resucitar' or 'no reanimar' — both are understood, 'no resucitar' is the more common patient-facing US-Latino term, 'no reanimación' is the textbook-Spanish noun. Frame it always as the outcome of a decision, not as the name of a form: '¿si el corazón se le parara, quiere que tratemos de revivirla con compresiones y máquinas, o prefiere que la dejemos irse en paz?' Asking '¿quiere un DNR?' gets 'no sé qué es eso' or a reflex 'sí.' Include the English chart acronym once — 'eso se llama DNR en inglés' — so the family recognizes it on discharge papers and can ask floor staff about it. NEVER use the cognate false friend 'resucitar' (not a Spanish word) or 'reanimar' without explanation (patients think of CPR dummies, not what the decision means for them).
- '¿Se cayó o se tiró?' is the single highest-leverage syncope-vs-mechanical question in a geriatric ED fall, and it does not translate well in one word. 'Tirarse' colloquially = to throw oneself = collapsed / dropped / lost consciousness first. A cleaner bedside phrasing than the two-verb contrast is: '¿se cayó porque se resbaló, o se cayó porque primero se sintió mareada, se le nubló la vista, o se le oscureció todo?' That gives the patient three specific pre-syncope descriptors to match against memory, instead of asking her to categorize. Stoic elders will accept 'se resbaló' as the path of least social friction unless you offer the alternate path explicitly.
- Pre-syncope runs three registers and all three come from elder patients. 'Se me nubló la vista' — most common, the tunnel-vision descriptor. 'Se me oscureció todo' — more severe, implies actual blackout-onset. 'Me dio vahído' — older rural-Mexican / Central-American register (Central Mexico, Guanajuato, Michoacán, CA) that younger patients don't use; older clinicians won't always recognize it. If a patient says 'me dio vahído,' accept it without correction, chart as 'pre-syncope.' 'Mareo' alone is ambiguous — it collapses dizziness, vertigo, nausea, and pre-syncope; disambiguate with 'vueltas, o se le oscureció, o ganas de vomitar.'
- 'Cadera' vs 'cuadril' — hip. 'Cuadril' is the older, rural-Mexican / Central-American register — elder patients from those regions will often say 'me duele el cuadril' and younger US-trained clinicians won't recognize it as 'hip.' Teach yourself to hear 'cuadril' = 'cadera.' Accept 'cuadril' without correction, chart as 'cadera / hip.' Never correct an 82-year-old's regional vocabulary at the bedside — the relationship is worth more than the lexical precision.

GERIATRIC FALL — SYNCOPE UNCOVERED + ADVANCE-DIRECTIVE CONVERSATION BEFORE HIP SURGERY — CONTINUED

- The 'no quiero molestar' stoicism is structural, not individual. Elder Latin-American women (especially from Mexico, Guatemala, Honduras, El Salvador) systematically under-report pain and symptoms out of politeness — 'no quiero molestar' / 'estoy bien' / 'no es nada' are the surface signs. NEVER ask '¿le duele?' — the answer is 'no, doctora' even at 9/10. ALWAYS ask '¿qué tanto le duele, del uno al diez?' and anchor 10 to lived experience: 'diez es el peor dolor que ha sentido en su vida — partos, operaciones, lo peor.' Frame against movement — 'quieta' vs 'moviendo' — because the static answer will still be minimized but the dynamic answer forces the honest number. Elder stoicism is the leading cause of undertreated pain in geriatric Latino ED patients; the pain-scale frame is clinical discipline, not bedside manner.
- 'Mi hija habla por mí' is a common elder-Latino family dynamic — the adult child answering for the parent. It is NOT a cognitive-impairment signal by itself (though donepezil on the med list means you should re-evaluate orientation, as here). The correct move is to address the patient directly, at eye level, FIRST — 'doña ____, voy a preguntarle a usted primero, y si necesita ayuda, su hija está aquí.' The daughter will often redirect the patient appropriately — 'mamá, dígame la verdad, dígame que sí le duele' — that is the pattern working as intended, not an interruption to be silenced. Starting with the daughter trains the dynamic that the elder is the object of care, not the subject, and forfeits the history that only the patient knows (whether she felt pre-syncope).
- 'Doña ____' is the formal register for elder Spanish-speaking women; use it unprompted for any Spanish-speaking woman over about 60, paired with the apellido (Doña García, Doña Hernández) if you know it, or with the nombre (Doña María) if you don't. Elder male equivalent is 'Don ____.' 'Señora' is correct but colder; 'Doña' signals that you see her as a person with history, not as the patient in bed 4. Every elder Spanish-speaking patient relaxes a notch when a clinician opens with 'Doña.' This is the register move — more than the vocabulary — that buys the trust you need for the advance-directive conversation in turn 10.
- 'El hueso de la cadera' is plain-Spanish for the femoral neck. Do NOT say 'fractura de cuello femoral' or 'fractura de fémur proximal' bedside — those are chart terms. Say 'el hueso de la cadera' bedside, chart the precise term. Same bedside-vs-chart split as scenario 13 ('azúcar muy bajo' / 'hipoglucemia'), scenario 14 ('la medicina que le quita el efecto' / 'naloxona'), scenario 15 ('bombita' / 'inhalador'). Two-word rule: use the most visible noun the patient's body gives you, then the anatomical register.
- 'Cirugía' vs 'operación' — 'operación' is the everyday patient register, 'cirugía' is the chart term. Use both in the same sentence the first time to build the bridge: 'necesita cirugía — una operación del hueso de la cadera.' After that, use whichever the patient uses back. Same two-register pattern as 'bombita/inhalador' (scenario 15) — mirror the patient's register rather than imposing the chart term.
- Surgical timing in geriatric hip fracture carries clinical urgency that the family needs to understand — operating within 24-48 hours reduces mortality, pneumonia, and VTE risk compared to delayed surgery. In plain Spanish: 'tiene que ser en las próximas horas, no mañana — si esperamos, suben los riesgos de trombosis y de neumonía.' Do NOT cite the literature bedside; the framing the family needs is 'hours not days, because waiting is worse than operating' — in their register, not in the percentages-of-mortality register that makes the family freeze rather than consent.

CT with IV contrast — informed consent, allergy screen, and contrast-sensation pre-description

6 min · 10 turns

CONTEXT

A 52-year-old Spanish-speaking woman is on the gurney in your urgent-care bay with six hours of right-flank pain radiating to the groin, no fever, urinalysis positive for trace blood. Your working diagnosis is ureteral stone; CT abdomen/pelvis with IV contrast confirms it, rules out AAA, and distinguishes uncomplicated colic from obstructive pyelonephritis. Vitals stable, not pregnant per history, on metformin twice a day for Type-2 diabetes ('como mi vecina — pero a mí me dicen que es leve'), lisinopril for hypertension. Creatinine pending. She tells the tech she is 'alérgica al camarón' the moment the IV tray appears — and the tech passes that to you with eyebrows up, because most working clinicians have been told 'shellfish + iodine = no contrast' even though that link was debunked a decade ago (the allergen in shrimp is parvalbumin/tropomyosin, NOT iodine). The radiology tech is ten feet away with the gurney brake off and a ten-minute slot on the scanner; if you cannot get real consent in the next three minutes, she loses the slot to the next patient and her diagnosis gets pushed an hour. Your job: obtain real consent (not signature-capture), distinguish a shellfish allergy from a contrast allergy, triage the severity of the ONE real allergy she does have (prior antibiotic reaction), screen for kidney function + metformin + pregnancy in one compact block, pre-describe the warm-wave + urinary-urge contrast sensation so she does not press the stop-scan button mid-injection, and deliver the post-contrast metformin-hold rule in cadenced Spanish the patient will remember. This is the library's first procedural-consent scenario.

CLINICAL GOAL

Conduct a CT-with-IV-contrast informed-consent conversation entirely in Spanish that (1) opens with a shared-decision frame ('le voy a explicar y al final le pregunto si está de acuerdo') rather than a signature-capture frame, and closes with '¿me da permiso de hacerle el estudio?' rather than 'firma aquí'; (2) distinguishes a shellfish food-allergy from a contrast-medium allergy without escalating on 'alérgica al camarón' — the iodine-in-shrimp theory is debunked, and the specific question that matters is whether the patient has ever had a reaction to iodinated contrast itself; (3) triages the severity of her ONE real allergy (antibiotic-induced hives) with the three-register Spanish question 'se le cerró la garganta, se le hinchó la cara, tuvo problemas para respirar — o fue solo la piel?' — because 'soy alérgica' in patient Spanish covers everything from 'made me nauseous' to 'I coded'; (4) compresses the three red-flag screens (kidney function + metformin hold + pregnancy) into one compact block, uses the common-Spanish kidney screen '¿alguien le ha dicho que tiene algo con los riñones?' instead of the unrecognized '¿tiene insuficiencia renal?', and possibility-frames the pregnancy question ('¿existe alguna posibilidad de que esté embarazada?') rather than stating it, so the embarazada/embarassed false cognate doesn't derail the conversation and post-menopausal patients can age themselves out in their own register ('ya pasé por el cambio'); (5) pre-describes the warm-wave-with-urinary-urge contrast sensation in specific observable Spanish ('un calor fuerte por el cuerpo, como una ola de calor, y por dos o tres segundos va a sentir que tiene muchas ganas de orinar — NO se está orinando') so the patient does not press the emergency-stop button mid-injection; (6) delivers the metformin-hold rule in cadenced Spanish the patient retains ('pare hoy — no la tome por DOS días — si no la llamamos, vuelva a tomarla normal'); (7) closes with the shared-decision '¿me da permiso?' consent ritual. First procedural-consent scenario in the library; extends the named-rules carrying-home discipline of scenarios 11/13/14/15/16/17 into a patient-as-sole-carrier shape (no family witness in the bay — the patient is the carrier of the metformin-hold rule and the post-scan kidney-symptom watch).

DIALOGUE

PATIENT · 52F ON GURNEY, RIGHT-FLANK PAIN, IV TRAY VISIBLE ON THE TABLE BESIDE HER
#1

Doctora, la enfermera me dijo que me van a meter en una máquina grande. Yo... le tengo que decir algo antes de que me hagan nada — yo soy alérgica al camarón. No sé si eso importa. Y me van a poner algo por la vena, ¿verdad? Eso es lo que más miedo me da.

Doctor, the nurse told me they're going to put me in a big machine. I... I have to tell you something before they do anything to me — I'm allergic to shrimp. I don't know if that matters. And they're going to put something in my vein, right? That's what scares me the most.

YOU

#2

Your opening move sets the register for the whole consent ritual. Do NOT lead with 'firma aquí' or 'necesito su firma' — that frame loses the patient for the metformin-hold rule downstream. Lead instead with the shared-decision frame: name what you're about to do, name that you'll explain it first, name that you'll ask at the end if she agrees. Reassure her on the fear she just volunteered (the IV). Buy yourself permission to ask a few questions — 'está bien?' — and only THEN move into the screening. Warmth and respect at the opening buy you honest answers to the kidney, metformin and pregnancy questions in turn 8.

Señora, buenas tardes. Gracias por decírmelo — todo lo que usted me diga ahora mismo me ayuda a cuidarla bien. Le voy a explicar qué le vamos a hacer y por qué. Le voy a hacer unas preguntas, y al final le pregunto si está de acuerdo. No le vamos a hacer nada hasta que usted me diga que sí. ¿Está bien así? Lo del camarón — gracias por avisarme — a eso le vamos a dar una vuelta en un momento, porque es una pregunta distinta de la que yo le tengo que hacer.

PATIENT · 52F

#3

Sí, doctora, está bien. Lo que usted diga. Pregúnteme.

Yes, doctor, that's fine. Whatever you say. Ask me.

YOU

#4

Distinguish the shellfish-allergy red herring from the contrast-allergy question that actually matters. Do NOT escalate on 'camarón' — the iodine-in-shrimp link was debunked over a decade ago (the allergen is parvalbumin/tropomyosin, not iodine). But DO ask the specific question that matters: has she ever had a reaction to iodinated contrast itself, i.e. to a prior CT-with-contrast or cardiac catheterization? Name both study types explicitly so she can match against memory. Thank her for volunteering the shellfish information while redirecting the actual screen — she did the right thing by telling you, it just isn't the question on the form.

Bueno. Lo del camarón, le voy a ser honesta: hace años, los médicos pensábamos que si alguien era alérgico al camarón, no podíamos ponerle el líquido del estudio — el contraste. Eso resultó ser falso, ya no lo usamos como regla. Lo que YO le tengo que preguntar es algo diferente, y es lo importante: ¿alguna vez, antes de hoy, le han puesto una inyección por la vena para una tomografía — una tomografía del abdomen o del pecho — o para un estudio del corazón en el hospital? Y si se la pusieron, ¿esa inyección le hizo alguna reacción?

PATIENT · 52F

#5

No, doctora. Nunca me han hecho una tomografía. Del corazón tampoco. Pero una vez, en México, me pusieron un antibiótico — creo que era penicilina — y me salieron ronchas por todo el cuerpo. Me asusté muchísimo.

No, doctor. They've never done a CT on me. The heart test either. But one time, in Mexico, they gave me an antibiotic — I think it was penicillin — and hives came out all over my body. I got really scared.

YOU

#6

She's just handed you the ONE real allergy question that matters — but 'ronchas' alone is not anaphylaxis. 'Soy alérgica' in patient Spanish covers everything from 'me dio náuseas' to 'I coded.' Triage the severity: ask the specific three-register follow-up — skin-only, facial swelling / angioedema, or airway / breathing difficulty. Name the three concrete body-signs the patient can answer against memory ('se le cerró la garganta, se le hinchó la cara, tuvo problemas para respirar — o fue solo la piel?') rather than asking her to categorize the reaction. Also ask what treated it — a trip to an ED for IV epinephrine is different signal from a Benadryl at the corner clinic.

Gracias, muy importante. Cuénteme más de esa reacción del antibiótico, porque hay reacciones de piel y hay reacciones más fuertes, y son distintas. Cuando le salieron las ronchas, ¿qué más le pasó? ¿Se le cerró la garganta, o se le hinchó la cara, o los labios — o tuvo problemas para respirar? ¿O fue solamente la piel, las ronchas y la comezón? Y ¿qué le dieron para que se le quitara — una pastilla, como el Benadryl, o tuvo que ir a la sala de urgencias para que le pusieran algo por la vena?

PATIENT · 52F

#7

Solo la piel, doctora. Ronchas por todos lados y me daba mucha comezón. Pero no se me cerró la garganta, no se me hinchó la cara — nada de eso. Fui a la clínica de la esquina y la enfermera me dio una pastilla — creo que era Benadryl, sí — y se me quitó en unas horas. No tuve que ir al hospital. Pero desde entonces ya no me dan penicilina.

Just the skin, doctor. Hives all over and it itched a lot. But my throat didn't close, my face didn't swell — nothing like that. I went to the corner clinic and the nurse gave me a pill — I think it was Benadryl, yes — and it went away in a few hours. I didn't have to go to the hospital. But since then they don't give me penicillin.

CT WITH IV CONTRAST — INFORMED CONSENT, ALLERGY SCREEN, AND CONTRAST-SENSATION PRE-DESCRIPTION — CONTINUED

YOU

#8

Skin-only, Benadryl-responsive, no airway = this is not a contraindication to IV contrast, and she has no prior contrast exposure. Document the reaction in her chart as skin-only, carry the penicillin allergy forward, and move on — do NOT keep probing the allergy. Now compress three red-flag screens into one tight block: (1) kidney function, using the COMMON-Spanish register '¿alguien le ha dicho que tiene algo con los riñones?' NOT '¿tiene insuficiencia renal?'; (2) metformin, because it affects the post-scan rule; (3) pregnancy, POSSIBILITY-framed, never statement-framed — '¿existe alguna posibilidad de que usted esté embarazada?' Explicitly flag that the last question isn't personal, it's protocol, because patients from some regions find the question intrusive. This is the compact 3-in-1 screen that separates a fast procedural-consent conversation from a slow one.

Perfecto — lo de la piel con el antibiótico no nos va a parar para el estudio de hoy, pero yo lo voy a anotar en su expediente para que no la confundan con la penicilina. Ahora tres preguntas rápidas, para que le podamos hacer el estudio con el contraste sin preocupaciones. La primera: ¿alguien — un doctor, una clínica, un análisis de sangre — alguna vez le ha dicho que tiene algo con los riñones? La segunda: ¿está usted tomando metformina para la diabetes? Si sí, ¿cuántas veces al día? Y la tercera — y no es por ser personal, doctora, es por protocolo cuando le ponemos el contraste a una mujer — ¿existe alguna posibilidad de que usted esté embarazada?

PATIENT · 52F

#9

De los riñones nadie me ha dicho nada, doctora. Orino normal. La metformina sí la tomo — una pastilla en la mañana y otra en la noche, con la comida. Y embarazada no — tengo cincuenta y dos años, ya pasé por el cambio hace como cuatro años. Ya no me baja desde entonces.

Nobody has told me anything about my kidneys, doctor. I urinate normally. I do take the metformin — one pill in the morning and one at night, with meals. And pregnant, no — I'm 52, I went through the change about four years ago. I haven't had a period since then.

CT WITH IV CONTRAST — INFORMED CONSENT, ALLERGY SCREEN, AND CONTRAST-SENSATION PRE-DESCRIPTION — CONTINUED

YOU

#10

Clean history — no renal red flags, metformin bid, post-menopausal (she's answered LMP in her own register, 'ya pasé por el cambio' = post-menopausal, no need to re-ask). Now the closing move, which does three things in one turn: (a) pre-describe the warm-wave + urinary-urge contrast sensation in specific observable Spanish so she doesn't press the stop-scan button mid-injection; (b) deliver the metformin-hold rule in cadenced Spanish the patient will retain — 'pare hoy, no la tome por DOS días, si no la llamamos vuelva a tomarla normal' — and explain the kidney-symptom watch briefly (dark urine, less urine, nothing for 24 hours !' call); (c) close with the shared-decision '¿me da permiso de hacerle el estudio?' — NOT 'firma aquí.' Name the English word 'CT' once and the contrast ritual in full so she recognizes it on the order sheet. This is the single highest-leverage closing move: pre-describe the sensation !' cadenced metformin rule !' '¿me da permiso?'

Perfecto. Entonces hacemos la tomografía — en inglés le dicen CT, es lo mismo — con el contraste por la vena. Dos cosas que quiero que sepa antes de que la lleve el técnico, y son importantes. La primera: cuando le pongan el contraste — el líquido — por la vena, usted va a sentir un calor fuerte por TODO el cuerpo, como una ola de calor, y por dos o tres segundos va a sentir que tiene muchísimas ganas de orinar. Eso es NORMAL. NO se está orinando, no la está quemando nada, no es una reacción mala. Solo dura unos segundos y después se le pasa. Le aviso porque a veces la gente se asusta, aprieta el botón, y se tiene que parar el estudio — y después hay que empezar todo de nuevo. La segunda cosa, y esta es para después del estudio, por la metformina: pare la metformina HOY. No la tome por DOS días. Si en esos dos días no la llamamos con algo raro de los riñones — por ejemplo si orina muy poquito, muy oscuro, o no orina nada en veinticuatro horas, ahí sí nos llama — después de los dos días, la vuelve a tomar normal, como siempre. ¿Tiene alguna pregunta? Y si no — ¿me da permiso de hacerle la tomografía?

WHAT TO NOTICE

- Consent in Spanish lands as a conversation, not a signature capture. Open with a shared-decision frame — 'le voy a explicar qué le vamos a hacer y por qué, y al final le pregunto si está de acuerdo' — and close with '¿me da permiso de hacerle el estudio?' NOT 'firma aquí.' This is the single highest-leverage register move in procedural-consent Spanish. Patients who feel asked-not-instructed grant consent and comply with the pre- and post-scan rules (in this scenario, the metformin hold). Patients who feel processed sign the form and then don't take the metformin-hold rule seriously, because they experienced the whole conversation as paperwork rather than as medicine. First time in the library this pattern is named as a clinical teaching beat; extends the editorial discipline into procedural-consent shape.
- Shellfish allergy is NOT a contrast-allergy contraindication — this is a debunked myth that still circulates in US clinical training. The allergen in shrimp and shellfish is parvalbumin or tropomyosin (a muscle protein), not iodine. The old '1970s radiologist rule' was dropped from ACR contrast-safety guidance over a decade ago. Do NOT escalate on 'alérgica al camarón.' Thank the patient for volunteering the information, then redirect the screen to the question that actually matters: '¿alguna vez, antes de hoy, le han puesto una inyección por la vena para una tomografía o un estudio del corazón, y le ha hecho una reacción?' If yes !' allergy consult or non-contrast study. If no !' shellfish is not a contraindication.

CT WITH IV CONTRAST — INFORMED CONSENT, ALLERGY SCREEN, AND CONTRAST-SENSATION PRE-DESCRIPTION — CONTINUED

- Allergy-severity triage in three Spanish registers. 'Soy alérgica' in patient Spanish covers everything from 'it gave me nausea' to 'I coded.' Never accept it as a full history. Ask the three-register severity follow-up, naming the body signs the patient can answer against memory: 'se le cerró la garganta, se le hinchó la cara, tuvo problemas para respirar — o fue solamente la piel?' Skin-only + Benadryl-responsive = not anaphylaxis, not a contrast contraindication, document and carry the allergy forward. Angioedema / airway / ED-epinephrine = serious — consult allergy or use non-contrast imaging. Same three-register pattern as scenario 14's respiratory-status triage and scenario 16's seizure-duration triage: specific observable body signs, not medical-noun categorization.
- Kidney-function screen in patient Spanish is '¿alguien le ha dicho que tiene algo con los riñones?' NOT '¿tiene insuficiencia renal?' or '¿tiene enfermedad renal crónica?'. Patients with CKD frequently do not know the chart terms even if they carry the diagnosis; they know 'me dijeron que los riñones estaban malitos' or 'me mandaron al especialista de los riñones.' The common-Spanish framing surfaces the history the chart-register misses. Same bedside-Spanish discipline as scenario 13's '¿qué comió hoy?' vs '¿comió?' — ask by observation, not by medical-noun.
- Metformin hold after IV contrast: teach the CADENCE, not the mechanism. 'Pare hoy. No la tome por DOS días. Si no la llamamos con algo raro de los riñones, la vuelve a tomar normal.' Triplet cadence — patients retain cadence, not eGFR thresholds. Do NOT explain lactic acidosis bedside; it frightens the diabetic patient and does not change the rule she needs to follow. Name the kidney-symptom watch briefly in observable terms ('muy poquito, muy oscuro, o no orina nada en veinticuatro horas, ahí sí nos llama'). Same cadenced-rule-over-mechanism pattern as scenario 13's 15-15-rule and scenario 14's Narcan 4-step.
- Pregnancy screening in Spanish must be POSSIBILITY-framed, not statement-framed. '¿Existe alguna posibilidad de que usted esté embarazada?' — NEVER '¿está embarazada?' (accusatory + triggers the embarazada/embarassed false-cognate confusion in patients who speak some English). Flag explicitly that the question is protocol, not personal ('no es por ser personal, es por protocolo cuando le ponemos el contraste a una mujer'), because patients from some regions find the question intrusive. Accept self-aging-out in the patient's own register ('ya pasé por el cambio' / 'ya me quitaron la matriz' / 'ya no me baja desde hace años') without re-asking in clinician-Spanish. If the answer is 'a lo mejor' or 'no sé,' order the urine HCG — do NOT take 'a lo mejor' as a no.
- Pre-describe the contrast sensation in specific observable Spanish or the patient will press the emergency-stop button mid-injection. The warm-wave + perceived-urinary-urge is universal, self-limited, and terrifies patients who aren't warned — they think they're burning or being poisoned. Bedside Spanish: 'un calor fuerte por TODO el cuerpo, como una ola de calor, y por dos o tres segundos va a sentir que tiene muchísimas ganas de orinar — NO se está orinando, no la está quemando nada.' Three specific sensations — warmth, perceived urge to urinate, brief duration — because 'le va a dar una sensación rara' is too vague to prevent the stop-scan panic. This is the procedural-consent analogue of scenario 15's 'aunque se sienta bien' and scenario 17's 'lo puede cambiar mañana' — a named, specific Spanish sentence that survives the stressed in-scanner moment when the clinician is not in the room.
- First procedural-consent scenario in the library, extending the named-rules carrying-home discipline of scenarios 11/13/14/15/16/17 into a patient-as-sole-carrier shape. No family witness in the bay — the PATIENT is the carrier of two rules: the metformin-hold cadence ('pare hoy — no la tome por dos días — si no la llamamos, normal') and the kidney-symptom watch ('si orina muy poquito, muy oscuro, o no orina en veinticuatro horas, llámenos'). The pattern works in patient-alone shape because the rules are the same cadenced, observable, self-referential format — and because the consent ritual itself trains the patient to become the carrier. Seventh consecutive scenario reinforcing the discipline; the first where the pattern lands in procedural-consent shape rather than emergency-rescue shape.

CT WITH IV CONTRAST — INFORMED CONSENT, ALLERGY SCREEN, AND CONTRAST-SENSATION PRE-DESCRIPTION — CONTINUED
DIALECT NOTES

- Consent in Spanish lands as a conversation, not a signature. Open the consent ritual with a shared-decision frame — 'le voy a explicar qué le vamos a hacer y por qué, y al final le pregunto si está de acuerdo' — NOT with 'firma aquí' or 'aquí está el papel.' Close with '¿me da permiso de hacerle el estudio?' — the phrase that turns the patient from a subject-being-processed into the decision-maker. Patients who feel asked-not-instructed grant consent and comply with pre/post-scan rules; patients who feel processed sign the form and then don't take the metformin-hold rule seriously. This is the single highest-leverage register move in procedural-consent Spanish.
- The shellfish-allergy / contrast-allergy link is a debunked myth — do NOT escalate on 'alérgica al camarón' or 'alérgica al marisco.' The allergen in shrimp and shellfish is parvalbumin or tropomyosin (a muscle protein), NOT iodine; the old '1970s radiologist rule' has been off the ACR contrast-safety guideline for over a decade. The question that actually matters is specific and different: '¿alguna vez le han puesto una inyección para una tomografía o un estudio del corazón, y le ha hecho una reacción?' If yes '!' allergy consult or non-contrast study. If no '!' shellfish is not a contraindication. Thank her for volunteering the information, but redirect the screen to the real question.
- Allergy-severity triage runs three registers in Spanish. 'Ronchas' (hives) — skin-only, most common, almost never anaphylaxis. 'Me hinché la cara / se me hinchó la cara' — angioedema, airway concern. 'Se me cerró la garganta / no podía respirar / me desmayé' — anaphylaxis. The key move: never accept 'soy alérgica' as a full history. Ask the specific follow-up: '¿cuando le pasó esa reacción, fue solo la piel, o se le cerró la garganta, se le hinchó la cara, tuvo problemas para respirar?' In patient Spanish 'soy alérgica' covers everything from 'me dio náuseas' to 'coded in the ED' — you have to elicit the severity before you can triage the risk.
- The kidney-function screen in patient Spanish is '¿alguien le ha dicho que tiene algo con los riñones?' — NOT '¿tiene insuficiencia renal?' or '¿tiene enfermedad renal crónica?' or '¿cómo está su función renal?' Patients with CKD frequently do not know the chart term even if they have the diagnosis; they'll say 'sí, el doctor me dijo algo de los riñones' or 'me dijeron que los riñones estaban un poquito malitos' or 'me mandaron al especialista de los riñones.' The common-Spanish framing surfaces the history the chart term misses. Same pattern as scenario 13's insulin question — ask by function/observation, not by medical-noun.
- Metformin + IV contrast: current ACR guidance (post-2020) says no hold needed for eGFR "e 30 in non-AKI patients, but most US hospital and urgent-care protocols still hold metformin for 48 hours post-contrast as a belt-and-suspenders safety pattern. In Spanish, teach the cadence, not the mechanism: 'Pare hoy. No la tome por DOS días. Si no la llamamos con algo raro de los riñones, la puede volver a tomar normal.' Triplet cadence. Patients retain cadence, not eGFR thresholds. Do NOT explain lactic acidosis bedside — it frightens the diabetic patient and does not change the rule they need to follow.
- Pregnancy screening must be possibility-framed in Spanish, never statement-framed. Say '¿existe alguna posibilidad de que usted esté embarazada?' — NEVER '¿está embarazada?' (accusatory in Spanish and triggers the well-known embarazada/embarassed false-cognate confusion in patients who also speak some English). The possibility frame also lets post-menopausal women age themselves out in their own register — 'ya pasé por el cambio' / 'ya me quitaron la matriz' / 'ya no me baja desde hace años.' Accept whichever she volunteers and move on. If she says 'a lo mejor' or 'no sé,' order the urine HCG — do NOT take 'a lo mejor' as a 'no.'
- 'Ya pasé por el cambio' is the universal patient-Spanish idiom for menopause. 'El cambio' / 'el cambio de vida' / 'la menopausia' all map to the same thing and all are recognized; 'el cambio' is the most common bedside register. Other post-menopausal volunteers: 'ya me quitaron la matriz' (hysterectomy), 'me hicieron la histerectomía' (same, chart-register), 'ya no me baja' (amenorrheic). A patient who volunteers any of these has answered the LMP question — don't ask her to re-answer it in clinician-register.

CT WITH IV CONTRAST — INFORMED CONSENT, ALLERGY SCREEN, AND CONTRAST-SENSATION PRE-DESCRIPTION — CONTINUED

- 'Tomografía' vs 'TAC' vs 'CT' — three registers for the same study. 'Tomografía' is the full Spanish and the universal bedside register — every Spanish-speaking patient in the US knows it. 'TAC' (tomografía axial computarizada) is the technical/Spain register; US-Mexican patients often do NOT recognize 'TAC' at the bedside. 'CT' is the English chart term patients see on the order sheet. Lead bedside with 'tomografía.' Pair with the English 'CT' once the first time the order sheet is shown so she recognizes it in writing. Never lead with 'TAC' in US urgent-care — you will get a puzzled look.
- 'Inyección por la vena' vs 'IV' — pair them once. Bedside, 'por la vena' is the register that lands: 'le vamos a poner un líquido por la vena — esto que llaman IV en inglés.' After that, either is fine. 'Intravenosa' is chart-Spanish — you can say it, but lead with 'por la vena.' Same bedside-pair-with-chart-term pattern as 'DNR / no resucitar' (scenario 17), 'convulsión febril / simple febrile seizure' (16), 'bombita / inhalador' (15), 'naloxona / la medicina que le quita el efecto' (14), 'azúcar muy bajo / hipoglucemia' (13).
- The contrast-injection sensation is universal and temporary — but patients who aren't told will press the emergency-stop button mid-scan thinking they're burning or being poisoned. Pre-describe it in specific observable Spanish: 'cuando le pongan el líquido por la vena — lo que llamamos contraste — usted va a sentir un calor fuerte por TODO el cuerpo, como una ola de calor, y por dos o tres segundos va a sentir que tiene muchas ganas de orinar. Eso es NORMAL. NO se está orinando, no la está quemando nada, no es una reacción mala. Solo dura unos segundos, y después se le pasa.' Name the three specific sensations — warmth, perceived urge to urinate, brief duration — because 'le va a dar una sensación rara' is too vague to prevent the stop-scan panic. Bedside name: 'calor por el cuerpo + ganas de orinar que no son reales.'
- 'Le va a arder' vs 'le va a doler' vs 'le va a picar' — three sensations in escalating register for the IV-insertion itself. 'Le va a picar / un piquete' is the right register for an IV needle going in — a brief sharp pinch. 'Le va a doler' is too vague (patients brace for much more). 'Le va a arder' is for antibiotics and some infusions, not for the stick itself. For the contrast injection AFTER the IV is in, 'calor' is the right word — 'un calor por el cuerpo,' not 'le va a arder' (which reads as acid). Mismatching these words is the single most common reason a patient stops the scan: the clinician said 'le va a arder' and the patient waited to feel something like acid and panicked when the warmth came.

Lumbar puncture for suspected meningitis — informed consent, paralysis-fear anatomy reassurance, and "presión, no dolor" sensation pre-description

6 min · 10 turns

CONTEXT

A 34-year-old Spanish-speaking man, brought to your ED by his 32-year-old wife with 18 hours of severe occipital headache, photophobia, fever 39.2°C / 102.6°F, neck stiffness on exam, no rash, no focal neurological deficits, no anticoagulants, no recent neurosurgery. CBC shows WBC 16.2K with left shift, lactate normal, head CT just back — clean, no mass effect, no bleed. He is alert, oriented x3, speaks fluent Spanish and very limited English, and is fully competent to consent. Working diagnosis is bacterial vs viral meningitis. Empiric ceftriaxone + vancomycin + dexamethasone are already running through his peripheral IV — antibiotic was started in triage, you did NOT wait for the LP. Your next step is the LP itself: confirm the diagnosis, distinguish bacterial from viral, identify the organism on Gram stain + culture, and refine the antibiotic regimen. He volunteers — terrified — that 'me van a meter una aguja en la espalda — no me vayan a paralizar,' and that his uncle in Honduras 'le hicieron algo así y nunca volvió a caminar bien.' His wife is at the bedside, scared and quiet, asking what to do. The procedure room is open in 15 minutes. Your job: obtain real informed consent in Spanish (NOT signature-capture); deliver the load-bearing anatomy reassurance that converts the universal 'me van a paralizar' fear into cooperation by naming in specific bedside Spanish where the spinal cord ends (mid-back) and where the needle enters (lower back, BELOW the cord, where only CSF and floating nerve roots sit); validate the tío-en-Honduras family story without dismissing it; explain why the LP refines (not replaces) the antibiotic decision — the antibiotic is running NOW, the LP tells you WHICH bug !' WHICH antibiotic; set the awake-with-local-anesthesia expectation explicitly so he doesn't expect to be sedated; pre-describe the 'presión, no dolor' sensation as the LP analogue of scenario 18's contrast warm-wave pre-description; position-teach the fetal curl as 'como un caracol' with the wife as the position-coach; name the post-LP headache risk honestly (~1 in 10, positional, treatable with a 'parche de sangre' / blood patch); honestly update the historical lie-flat rule with current evidence; and close with the shared-decision '¿me da permiso de hacer la prueba?' rather than 'firma aquí.' Library's second procedural-consent scenario, building on scenario 18's consent-as-conversation discipline in a higher-acuity, higher-fear frame. First scenario where the family-witness role is named explicitly as support-not-substitute for consent — the patient signs; the wife holds the position, watches for the post-LP positional-headache pattern over 24-48 hours, but the consent decision belongs to the patient alone.

CLINICAL GOAL

Conduct a lumbar-puncture informed-consent conversation entirely in Spanish that (1) opens with a shared-decision frame ('le voy a explicar primero, le voy a contestar todo lo que me pregunte, y al final le pregunto si está de acuerdo') matching scenario 18's consent ritual, and closes with '¿me da permiso de hacer la prueba?' rather than 'firma aquí'; (2) delivers the single load-bearing anatomy reassurance that converts the universal 'me van a paralizar' fear into cooperation — name in specific bedside Spanish where the spinal cord ends (middle of the back, last-rib level), where the needle enters (lower back, near the waist), and what's there (cerebrospinal fluid + nerve roots that float in the fluid and move out of the way when the needle enters); (3) validates the family-story 'mi tío en Honduras le hicieron algo así y nunca volvió a caminar bien' without dismissing it ('eso pasaba antes — hoy es diferente: aguja más fina, en el lugar correcto, con anestesia'); (4) explains why the LP refines, not replaces, the antibiotic — the antibiotic is running NOW; the LP tells us

DIALOGUE

PATIENT · 34M,
FEVER 39.2 /
PHOTOPHOBIA /
NUCHAL
RIGIDITY, WIFE
AT BEDSIDE,
PERIPHERAL IV
RUNNING CEFTRI
AXONE+VANC+DE
X

Doctor, mi esposa me trajo porque tengo un dolor de cabeza horrible desde anoche, y no puedo voltearme — me duele el cuello cuando me muevo. La luz me hace daño. La enfermera me dijo que me van a meter una aguja aquí, en la espalda, para sacar líquido. Doctor, por favor — yo a mi tío en Honduras le hicieron algo así, y desde entonces no camina bien. No me vayan a paralizar.

Doctor, my wife brought me because I've had a horrible headache since last night, and I can't turn my head — my neck hurts when I move. The light bothers me. The nurse told me they're going to put a needle here, in my back, to take out fluid. Doctor, please — they did something like that to my uncle in Honduras, and since then he doesn't walk right. Don't paralyze me.

LUMBAR PUNCTURE FOR SUSPECTED MENINGITIS — INFORMED CONSENT, PARALYSIS-FEAR ANATOMY REASSURANCE, AND "PRESIÓN, NO DOLOR" SENSATION PRE-DESCRIPTION — CONTINUED

#2

Open the consent ritual the same way scenario 18 did — shared-decision frame, NOT signature-capture. Validate the paralysis fear and the tío-en-Honduras story OUT LOUD; do NOT dismiss either. Name the procedure in plain bedside Spanish — 'tomar un poquito del líquido que rodea la espina y el cerebro' — and pair it once with the chart term 'punción lumbar' so he recognizes it on the form. Buy permission to explain in pieces ('le voy a explicar primero, le voy a contestar todo lo que me pregunte, y al final le pregunto si está de acuerdo'). Do NOT lead with 'firma aquí.' Bring the wife into the conversation explicitly — 'señora, usted también me puede preguntar lo que sea, en cualquier momento.' Save the anatomy explanation itself for turn 6 when he asks; the consent ritual has to land first.

Señor, buenas noches. Lo primero — gracias por decírmelo todo así, directo, lo del miedo a paralizarse y lo de su tío. Esas son preocupaciones reales, y se las voy a contestar con calma, en un momento. Antes de meterle nada, quiero explicarle. Le voy a contar qué es la prueba, por qué la necesitamos, y qué riesgos tiene — y al final le voy a preguntar si está de acuerdo. No le vamos a hacer nada hasta que usted me diga que sí. La prueba se llama 'punción lumbar' — en español es 'tomar un poquito del líquido que rodea la espina y el cerebro.' Es lo que necesitamos para saber qué le está causando este dolor de cabeza y la fiebre, y para saber cuál antibiótico es el que sirve para usted. Señora — usted también me puede preguntar lo que sea, en cualquier momento, ¿está bien?

PATIENT · 34M

#3

Está bien, doctor. Pregúnteme — no, perdón, explíqueme. Pero antes, una cosa — la enfermera dijo que ya me están poniendo antibiótico ahorita por la vena. Si ya me están poniendo el antibiótico, ¿no se puede solo con eso? ¿Para qué la aguja en la espalda?

Okay, doctor. Ask me — no, sorry, explain it to me. But first, one thing — the nurse said they're already giving me antibiotics through the IV. If they're already giving me the antibiotic, can't we just do that? Why the needle in the back?

LUMBAR PUNCTURE FOR SUSPECTED MENINGITIS — INFORMED CONSENT,
PARALYSIS- FEAR ANATOMY REASSURANCE, AND "PRESIÓN, NO DOLOR"
SENSATION PRE-DESCRIPTION — CONTINUED

#4

Don't refuse, refine. Affirm explicitly that the antibiotic is running NOW — you didn't wait for the LP. Frame the dangerous shortcut: a broad antibiotic that doesn't cover his specific organism is the most dangerous outcome — that is what kills people, not the wait for the LP. The LP tells us WHICH bug, which tells us WHICH antibiotic. Also name viral-vs-bacterial as treatment-changing — viral meningitis does not need the same antibiotic course. Give the timing honestly: initial Gram-stain + cell-count + glucose results in ~30 minutes; final culture 24–48 hours. End with a question that earns turn 5's anatomy ask — 'la aguja en la espalda asusta — ¿quiere que le explique exactamente DÓNDE va y por qué no le va a paralizar?'

Buena pregunta — y le voy a ser honesto. El antibiótico ya está corriendo por la vena, no estamos esperando para tratarlo — la enfermera lo empezó cuando lo metieron al cuarto. Lo que pasa es que ese antibiótico que tiene ahorita es uno fuerte que cubre la mayoría de las cosas — pero no cubre TODAS. La prueba me dice exactamente qué bicho es el que lo tiene enfermo, y eso me dice cuál antibiótico es el que SÍ sirve para usted. Lo más peligroso sería darle un antibiótico que no cubra lo que tiene — eso es lo que hace daño, no la prueba. También me dice si la infección es por una bacteria — que sí necesita antibiótico, todos los días por una o dos semanas — o si es por un virus, que necesita un tratamiento distinto. Los primeros resultados los tenemos en como media hora; el cultivo completo tarda uno o dos días. Yo sé que la aguja en la espalda asusta — ¿quiere que le explique exactamente DÓNDE va, y por qué no le va a paralizar?

PATIENT · 34M

#5

Sí, doctor, por favor. Eso es lo que más me asusta. Mi tío... a él lo dejaron sin caminar después de algo en la espalda, hace como veinte años. Y mi esposa también — ella tiene miedo. Dígame por qué a mí no me va a pasar lo mismo.

Yes, doctor, please. That's what scares me the most. My uncle... they left him unable to walk after something in his back, about twenty years ago. And my wife is scared too. Tell me why it won't happen to me the same way.

LUMBAR PUNCTURE FOR SUSPECTED MENINGITIS — INFORMED CONSENT,
PARALYSIS-FEAR ANATOMY REASSURANCE, AND "PRESIÓN, NO DOLOR"
SENSATION PRE-DESCRIPTION — CONTINUED

#6

This is the single most load-bearing turn in the scenario — the anatomy reassurance that converts the paralysis fear into cooperation. Name in specific bedside Spanish where the spinal cord ENDS (middle of the back, last-rib level) and where the needle GOES IN (lower back, near the waist, BELOW where the cord ends). Name what is there: 'agua' (CSF in plain Spanish) and 'raíces de nervios que flotan' (nerve roots in CSF) — and the key reassurance: those nerve roots MOVE OUT OF THE WAY when the needle enters because they are loose, not attached. Then address the tío-en-Honduras story DIRECTLY — DO NOT dismiss with 'ese es otro caso.' Validate ('eso pasaba antes, sí, hace años, cuando las agujas eran más gruesas y a veces se hacía sin saber bien dónde'). Explain what is different today: thinner needle, correct location, local anesthesia. End by inviting the wife in — she'll be the position coach in turn 8 and you want her to have heard the anatomy reassurance now.

Mírelo así, señor — y esto es lo importante. La médula — el cordón grueso de nervios que pasa por adentro de la espina, el que conecta el cerebro con todo el cuerpo — termina aquí, como en la mitad de la espalda, más o menos a la altura de la última costilla. La aguja NO entra ahí — entra mucho más abajo, casi en la cintura, en la parte baja de la espalda. En ese lugar, donde voy a poner la aguja, ya no hay médula. Solo hay agua — el líquido que estamos buscando — y unas raíces de nervios que flotan en esa agua, sueltas, no pegadas. Cuando la aguja entra, esas raíces se hacen a un lado solas — flotan, se mueven. Por eso, con esta prueba, no es posible que le toquemos la médula. Lo de su tío — eso pasaba más antes, hace veinte o treinta años, cuando las agujas eran más gruesas y a veces se hacía sin saber bien dónde. Hoy es diferente: aguja muy fina, en el lugar correcto, con anestesia local. No es la misma prueba que le hicieron a él. Señora — ¿usted me oyó eso, lo de la médula que termina arriba y la aguja que entra abajo? Eso es lo importante para que ustedes dos entiendan qué va a pasar.

PATIENT · 34M

#7

Sí, sí oí, doctor. Eso me deja un poco más tranquilo. Pero dígame — ¿me va a doler? ¿Y me van a dormir, o voy a estar despierto durante la prueba?

Yes, yes I heard, doctor. That makes me a little calmer. But tell me — is it going to hurt? And will you put me to sleep, or will I be awake during the procedure?

LUMBAR PUNCTURE FOR SUSPECTED MENINGITIS — INFORMED CONSENT,
PARALYSIS-FEAR ANATOMY REASSURANCE, AND "PRESIÓN, NO DOLOR"
SENSATION PRE-DESCRIPTION — CONTINUED

#8

Set the awake-with-local-anesthesia expectation EXPLICITLY — 'va a estar despierto para todo. Anestesia LOCAL, la que duerme solo la piel, como en el dentista — NO la que lo duerme entero.' The dentist analogy lands universally. Pre-describe the sensation: 'va a sentir PRESIÓN cuando entre la aguja, no DOLOR. Si siente dolor, me lo dice — le pongo más anestesia. Eso lo decide usted, no yo.' Then teach the position with the bedside register that lands — 'como un caracol' (NOT 'posición fetal'). Be specific about WHY ('si no se enrosca, yo no puedo entrar — no es por usted, es por la anatomía') so cooperation is informed, not blind. Bring in the wife as the position-coach: 'señora, usted le va a sostener la mano, le va a decir que respire, y le va a ayudar a quedarse así de enroscado durante la prueba.' Name the wife's role explicitly as SUPPORT — the consent decision still belongs to the patient, not her. This is the first scenario where support-not-substitute is named bedside.

Las dos preguntas que hace todo el mundo, y son las correctas. Primero: usted va a estar DESPIERTO para todo. Anestesia LOCAL — la que duerme solo la piel ahí donde entra la aguja, como cuando le pone una inyección el dentista — NO la anestesia general, no la que lo duerme entero. Va a oír todo, va a poder hablar conmigo, y si quiere que pare le digo que pare y paro. Segundo, lo que va a SENTIR: presión, no dolor. La aguja entra, va abriéndose paso, y eso se siente como una empujada por dentro — presión. Si en algún momento siente DOLOR — un dolor real, una corriente, una quemadura — usted me lo dice y yo le pongo MÁS anestesia. Eso lo decide usted, no yo. La posición — usted se va a acostar de lado, las rodillas pegadas al pecho, la cabeza para abajo, hecho como un caracol. Lo más enroscadito que pueda. Esa posición abre el espacio entre los huesos de la espalda; si usted no se enrosca, yo no puedo entrar — no es por usted, es por la anatomía. Señora — usted lo va a ayudar: le agarra la mano, le dice que respire despacio, y lo ayuda a quedarse enroscado durante la prueba. Lo que decide hacer la prueba es ÉL, lo apoya usted. ¿Está bien así?

PATIENT · 34M

#9

Está bien, doctor. Mi esposa me ayuda. Y... ¿después? ¿Voy a estar bien después? ¿Me puedo levantar? ¿Me va a doler la espalda? ¿Qué tengo que cuidar?

Okay, doctor. My wife will help me. And... after? Am I going to be okay after? Can I get up? Will my back hurt? What do I need to watch out for?

LUMBAR PUNCTURE FOR SUSPECTED MENINGITIS — INFORMED CONSENT, PARALYSIS-FEAR ANATOMY REASSURANCE, AND "PRESIÓN, NO DOLOR" SENSATION PRE-DESCRIPTION — CONTINUED

#10

Name the risks honestly in three groups: (a) post-LP HEADACHE — about 1 in 10, distinct from the meningitis headache (positional: better lying down, worse sitting or standing, comes 1–2 days after), treatable with a 'parche de sangre' / blood patch if it's bad. NEVER hide this risk. (b) BACK PAIN at the puncture site — common, mild, lasts 1–2 days, helps with heat. (c) Infection or bleeding at the site — RARE, but he should call if redness / heat / drainage at the site. Then update the lie-flat rule HONESTLY: 'antes le decíamos que se quedara plano por una hora — los estudios nuevos dicen que no cambia nada. Usted se levanta cuando se sienta bien. ESO sí: tome MUCHA agua hoy y mañana — eso sí ayuda.' Name the wife's role for after the procedure: she watches for the positional-headache pattern over 24–48 hours and you both call. Then the red-flag escalation: new fever, leg weakness, loss of bowel/bladder control = come back IMMEDIATELY. Close with '¿me da permiso de hacer la prueba?' — NOT 'firma aquí.' This is the LP analogue of scenario 18's '¿me da permiso de hacerle el estudio?' close.

Sí, son las preguntas correctas. Le digo lo que SÍ puede pasar y lo que casi nunca pasa. Lo más común: dolor de cabeza DESPUÉS de la prueba, en uno o dos días, en cerca de uno de cada diez pacientes. Es DISTINTO del que tiene ahorita: este nuevo se le QUITA cuando está acostado y le VUELVE cuando se sienta o se para. Esa señal — mejor acostado, peor sentado — esa es la clave. Si le pasa, hay un tratamiento que lo arregla — se llama 'parche de sangre.' No se asuste, llámenos y nosotros lo arreglamos. Le va a doler la espalda en el lugar del piquete — eso es normal, le dura uno o dos días, mejora con calor. Lo raro, lo que casi no pasa: una infección o un sangrado en el lugar — usted llame si ve enrojecimiento, calor, o si le sale líquido de ahí. Después de la prueba: antes le decíamos a la gente que se quedara plana por una hora — los estudios nuevos dicen que no cambia nada. Usted se levanta cuando se sienta bien. Eso SÍ: tome MUCHA agua hoy y mañana — eso sí ayuda con el dolor de cabeza. Señora, usted dos cosas: en estos dos días, si le da un dolor de cabeza nuevo que se le quita acostado y le vuelve sentado, ese es el de la prueba — nos llaman. Y si tiene fiebre nueva más alta que la de ahorita, o si pierde fuerza en las piernas, o no puede controlar la orina o la popó, vénganse al hospital de inmediato — eso no espera. Señor, entonces — ¿me da permiso de hacer la prueba?

WHAT TO NOTICE

- The single highest-leverage reassurance in Spanish LP consent is the anatomy answer. Every Spanish-speaking patient walks in convinced 'me van a paralizar,' often reinforced by a specific tío-en-Honduras family story. Name in specific bedside Spanish where the spinal cord ENDS (middle of the back, last-rib level), where the needle GOES IN (lower back, near the waist, BELOW the cord), and what's there ('agua' + 'raíces de nervios que flotan y se hacen a un lado cuando entra la aguja, porque están sueltas, no pegadas'). Without this answer the patient signs reluctantly, won't curl into the position properly, and may refuse mid-procedure. With it the patient consents and stays still. This is the LP-consent analogue of scenario 18's '¿me da permiso?' move and scenario 17's 'lo puede cambiar mañana' — a named, specific Spanish sentence that has to be said before consent will land.

LUMBAR PUNCTURE FOR SUSPECTED MENINGITIS — INFORMED CONSENT, PARALYSIS-FEAR ANATOMY REASSURANCE, AND "PRESIÓN, NO DOLOR"

- Address the family-story **DIRECTLY**, do NOT dismiss it. The tío-en-Honduras / primo-en-México / compadre-en-Guatemala story is real medical history from an era and a place when LP was riskier (thicker needles, less landmark accuracy, no local anesthesia in some settings). Validate the family memory ('eso pasaba antes, sí, hace veinte o treinta años') and explain what is different today (thinner needle, correct anatomical location, local anesthesia). Dismissing the story tells the patient you don't take his fear seriously and you don't believe his uncle. Validating it tells him you understand his fear and you've answered it specifically — and that converts him from skeptical to cooperative. Same respect-then-redirect discipline as scenario 16's mal-de-ojo correction and scenario 18's shellfish-allergy correction.
- Pre-describe 'PRESIÓN, no DOLOR' with the local-anesthesia frame — the LP analogue of scenario 18's contrast warm-wave + urinary-urge pre-description. Without naming the specific normal sensation, patients interpret expected procedural feel as 'the anesthesia didn't work' and either move involuntarily (which makes the procedure harder) or stop the procedure entirely. Name three specific moves: (a) 'presión' as the expected normal sensation, (b) 'dolor / corriente / quemadura' as the trigger to escalate, and (c) explicit patient-controlled escalation ('si siente dolor, me lo dice — le pongo más anestesia. Eso lo decide usted, no yo'). Same naming-the-normal-sensation discipline as scenario 18's contrast pre-description.
- Position teaching IS the procedure. 'Como un caracol' (like a snail) is the bedside register that lands universally; NOT 'posición fetal' (clinical, doesn't land — patients hear 'fetal' and think 'baby') or 'decúbito lateral' (textbook, doesn't land at all). Tell the patient WHY honestly — 'si no se enrosca, yo no puedo entrar — no es por usted, es por la anatomía.' Patient cooperation with the position is the single largest determinant of how long the procedure takes and how often a second-attempt is needed. Naming the mechanic in patient-Spanish converts blind cooperation into informed cooperation, which is more durable through the procedure.
- Don't refuse the 'antibiótico y ya' shortcut — refine it. The antibiotic is started NOW, before the LP — name this explicitly so the patient understands you're not delaying treatment. The LP tells us WHICH bug, which tells us WHICH antibiotic. Frame the dangerous shortcut: a broad-spectrum that doesn't cover the actual organism is the most dangerous outcome — that is what kills people, not the wait for the LP. Naming this — 'no estamos esperando para tratarlo, estamos averiguando cuál tratamiento sirve' — converts the patient's instinct (broader = safer) into the correct understanding (specific = safer). Same don't-refuse-refine discipline as scenario 17's surgical-recommendation pre-frame and scenario 18's metformin-hold cadence.
- Name the post-LP headache risk HONESTLY — DO NOT hide it. About 1 in 10 patients experience it; positional (better lying down, worse sitting up); comes 1–2 days after the procedure; treatable with a 'parche de sangre' / blood patch. Distinguishable from the meningitis headache (which is constant, not positional). Patients who are warned recognize the pattern, lie down, hydrate, and call appropriately. Patients who weren't warned think something went wrong, go to a different ED, refuse the next workup, or sue. Disclosed risk is informed consent; hidden risk is not. Same disclosed-risk discipline as scenario 18's compact 3-in-1 red-flag screen.
- Update the historical lie-flat rule HONESTLY with current evidence. The old 'lie flat for an hour' recommendation has been debunked by Cochrane reviews; modern evidence does NOT show it changes the post-LP headache rate. Be honest: 'antes le decíamos eso — los estudios nuevos dicen que no cambia nada. Tome mucha agua, levántese cuando se sienta bien.' Patients whose family or other clinicians have told them the strict bed-rest rule WILL check; an honest 'we used to say that, the newer studies don't show it helps' is more credible than parroting the old rule, and improves trust on the OTHER teaching (hydration, warning-sign watch). First library scenario where outdated-rule-honestly-updated is named as a clinical teaching beat.

LUMBAR PUNCTURE FOR SUSPECTED MENINGITIS — INFORMED CONSENT, PARALYSIS-FEAR ANATOMY REASSURANCE, AND "PRESIÓN, NO DOLOR"

SEPARATION PRE-DESCRIPTION, CONTINUED

Eight consecutive scenarios reinforcing the family-witness teaching discipline (scenarios 11/13/14/15/16/17/18/19), with a NEW twist named explicitly: scenario 19 is the first where the family-witness role is named bedside as SUPPORT-not-SUBSTITUTE for consent. The patient signs — 'la decisión es suya, yo le pregunto a usted.' The wife is named explicitly as support: she holds his hand, helps him stay curled in the position during the procedure, counts his breaths, and watches for the post-LP positional-headache pattern over 24–48 hours. Naming this separation prevents two failures common in Spanish-speaking household dynamics: (a) the patient deferring consent to a family member who 'decides for me' (compromising autonomy), and (b) the family member feeling shut out of the room (which loses post-procedure compliance and the at-home headache-pattern monitoring). First library scenario where this support-not-substitute distinction is named explicitly as a clinical teaching beat.

DIALECT NOTES

- Three-register lexical pattern for the procedure: 'punción lumbar' (chart/clinical Spanish) / 'spinal tap' (English chart term he may see on the order sheet) / 'tomar un poquito del líquido que rodea la espina y el cerebro' (bedside Spanish that lands). Lead bedside with the plain-Spanish description; pair once with the chart term 'punción lumbar' so he recognizes it on the form. 'Punción' alone reads as 'puncture' and adds anxiety. 'Tomar el líquido' is honest, accurate, and lands. Same bedside-pair-with-chart-term discipline as scenarios 13–18 (azúcar bajo / hipoglucemia, naloxona / la medicina que le quita el efecto, bombita / inhalador, convulsión febril / simple febrile seizure, poder notarial médico / healthcare proxy, tomografía / CT).
- The single most load-bearing reassurance in Spanish LP consent is the anatomy answer. Every Spanish-speaking patient walks in convinced 'me van a paralizar,' often reinforced by a specific family story ('mi tío en Honduras / mi primo en México / mi compadre en Guatemala'). Name in specific bedside Spanish where the spinal cord ENDS (middle of the back, last-rib level — gesture if at the bedside), where the needle GOES IN (lower back, near the waist, BELOW where the cord ends), and what's there (CSF as 'agua' + 'raíces de nervios que flotan en el agua y se hacen a un lado cuando entra la aguja, porque están sueltas, no pegadas'). Without this answer the patient signs reluctantly, won't curl up properly, and may refuse mid-procedure. With it the patient consents and stays still. This is the LP-consent analogue of scenario 18's '¿me da permiso?' move and scenario 17's 'lo puede cambiar mañana' — a named, specific Spanish sentence that has to be said before consent will land.
- Address the family-story DIRECTLY — do NOT dismiss it with 'ese es otro caso' or 'eso no es lo que va a pasar.' Validate the family memory ('eso pasaba antes, sí, hace años') and explain what is different today (thinner needle, correct anatomical location, local anesthesia, fluoroscopic or landmark verification when needed). The family story is not paranoia — it is real medical history from an era and a place where LP was riskier. Dismissing it tells the patient you don't take his fear seriously and you don't believe his uncle. Validating it tells him you understand his fear and you've answered it specifically.
- 'Despierto vs dormido' — every Spanish-speaking patient assumes that any procedure with a needle and a bed = sedation. State explicitly: 'usted va a estar DESPIERTO para todo. Anestesia LOCAL — la que duerme solo la piel, como cuando le pone una inyección el dentista — NO la anestesia general que lo duerme entero.' Otherwise the patient signs consent expecting to wake up afterward and panics when he finds himself fully conscious on the table. The dentist analogy is universal in US Spanish-speaking populations and lands in one breath.

LUMBAR PUNCTURE FOR SUSPECTED MENINGITIS — INFORMED CONSENT, PARALYSIS-FEAR ANATOMY REASSURANCE, AND "PRESIÓN, NO DOLOR"

- SEPARATION PRE-DESCRIPTION CONTINUED
- Presión, no dolor — pre-describe the sensation in specific bedside Spanish so the patient does NOT interpret normal procedural feel as 'the anesthesia didn't work.' 'Va a sentir PRESIÓN cuando entre la aguja, no dolor — como una empujada por dentro. Si en algún momento siente DOLOR — un dolor real, una corriente, una quemadura — usted me lo dice y yo le pongo más anestesia. Eso lo decide usted, no yo.' Naming 'presión' as the expected normal sensation, naming 'dolor / corriente / quemadura' as the trigger to escalate, and giving the patient explicit control over the escalation are three specific moves. This is the LP analogue of scenario 18's warm-wave + urinary-urge contrast pre-description and scenario 16's specific-rescue cadence — the named-Spanish-sensation that survives the moment when the clinician's hands are full and the patient is on the table.
- Position-teach the fetal curl as 'como un caracol' (like a snail) — the bedside register that lands universally. Do NOT use 'posición fetal' (clinical, doesn't land in patient Spanish — patients hear 'fetal' and think 'baby') or 'decúbito lateral' (textbook, doesn't land at all). 'Como un caracol — las rodillas pegadas al pecho, la cabeza para abajo, lo más enroscadito que pueda' is universally understood and immediately demonstrable. Tell the patient WHY honestly: 'esa posición abre el espacio entre los huesos de la espalda; si usted no se enrosca, yo no puedo entrar — no es por usted, es por la anatomía.' Patient cooperation with the position is the single largest determinant of how long the procedure takes and how often a second attempt is needed.
 - The 'antibiótico y ya' (just-give-me-the-antibiotic) shortcut question is universal in any Spanish-speaking patient facing a workup for an infection. Don't refuse — refine. Name explicitly that the antibiotic is running NOW, before the LP, you didn't wait. The LP tells us WHICH bug, which tells us WHICH antibiotic. The most dangerous outcome is a broad-spectrum that doesn't cover the actual organism; that is what kills people, not the wait for the LP. Frame: 'no estamos esperando para tratarlo, estamos averiguando cuál tratamiento sirve.' Also name viral-vs-bacterial as a treatment-changing distinction — viral meningitis does not need the same antibiotic course and the prognosis is different.
 - 'Dolor de cabeza después del estudio' — the post-LP headache. Name it with three specifics, never hide it: (a) it is DIFFERENT from the meningitis headache he has now — this is the universal teaching beat that distinguishes informed consent from hidden risk; (b) it is POSITIONAL — better lying down, worse sitting or standing — that pattern is the diagnostic; (c) it happens to about 1 in 10 patients and there is a treatment ('parche de sangre' / blood patch) that arranges it. Patients who are warned recognize the pattern, lie down, hydrate, and call. Patients who weren't warned think something went wrong, go to a different ED, and either refuse the next workup or sue. Disclosed risk is informed consent; hidden risk is not.
 - Post-procedure 'acostarse plano' (lie flat) is the historically over-prescribed bed-rest rule. Modern evidence (Cochrane reviews) shows it does NOT change the post-LP headache rate. Be honest in Spanish: 'antes le decíamos a la gente que se quedara plana por una hora — los estudios nuevos dicen que no cambia nada. Usted se levanta cuando se sienta bien. ESO sí: tome MUCHA agua hoy y mañana — eso sí ayuda.' Patients whose family or other clinicians have told them the strict bed-rest rule will check; an honest 'we used to say that — newer studies don't show it helps' is more credible than parroting the old rule and improves trust on the OTHER teaching (hydration, warning-sign watch).
 - Clear separation of consent-decision from caregiving-support, in Spanish, when family is at the bedside. The PATIENT signs the consent — 'la decisión es suya, yo le pregunto a usted, no a ella.' The wife is named explicitly as SUPPORT — she holds his hand, helps him stay curled in the position, counts his breaths, and watches over the next 24-48 hours for the post-LP positional-headache pattern. Naming this separation prevents two failures: (a) the patient deferring consent to the family member who 'decides for me' (a common pattern in Spanish-speaking households that compromises his autonomy), and (b) the family member feeling shut out of the room (which loses the post-procedure compliance and the headache-pattern monitoring). First library scenario where this support-not-substitute distinction is named explicitly as a clinical teaching beat.

Cardiac catheterization with possible PCI — informed consent, "no le vamos a abrir el pecho" anatomy reassurance, and combined diagnostic + intervention consent

6 min · 10 turns

CONTEXT

A 58-year-old Spanish-speaking man, sent from his PCP's clinic to your ED with 3 hours of substernal chest pressure radiating to his left arm, diaphoretic on arrival, nitroglycerin-responsive. Initial troponin 0.12 ng/mL (elevated but not massive), EKG with T-wave inversions V4–V6, no ST elevation. Vital signs stable — BP 142/88, HR 86, SpO2 97% on room air. On metformin 1000 mg BID for T2DM x 15 years, lisinopril, atorvastatin, no known contrast allergy. His father died of a myocardial infarction in Mexico at 52 — 'y a él le abrieron el pecho y no sobrevivió.' Aspirin 325 mg and a weight-based heparin drip are already running through his peripheral IV. Working diagnosis is NSTEMI; cardiology has seen him in the ED and ordered urgent (within-24-hour) left heart catheterization with possible PCI, and has asked YOU — the ED attending — to obtain consent because his Spanish comprehension is stronger than the cath team's. His wife (56) is at the bedside, scared and quiet. He is alert, oriented x3, speaks fluent Spanish and very limited English, and is fully competent to consent. He opens — scared — 'doctor, yo no quiero que me abran el pecho. Mi papá murió de un infarto en México, a él le abrieron el pecho y no sobrevivió.' Your job: obtain real informed consent in Spanish (NOT signature-capture); handle the urgency question honestly (NSTEMI within-24-hr guideline, NOT within-minutes like STEMI — time for a real conversation, AND the aspirin + heparin already running are the first line of protection); deliver the load-bearing cardiac-anatomy reassurance — 'no le vamos a abrir el pecho, no le vamos a operar el corazón, no va a haber cirugía a corazón abierto' — early, as three specific negations, BEFORE the positive explanation; explain the positive anatomy with the 'carril que ya está ahí adentro' metaphor for the arterial highway from wrist to heart; validate the father-died-of-MI-in-Mexico family-history story without dismissing it ('eso pasaba más antes, en los ochentas o noventas — la única opción era abrir el pecho; hoy hay más opciones antes de llegar a eso'); name the 'una cosa o dos cosas' combined-consent pattern — diagnostic angiogram + same-session PCI with stent if a blockage is found — as the library's first combined-consent teaching beat; name the stent in bedside Spanish as 'un aparatito como un resorte, muy pequeñito, que se queda ahí adentro pegado a la pared del carril para que el carril siga abierto'; teach DAPT — 'dos medicinas para que la sangre no se pegue al aparatito' — with three 'no' triggers for never-stopping ('no las deje aunque se sienta bien, no las deje aunque se acabe el paquete, no las deje aunque otro doctor le diga otra cosa sin primero llamar a cardiología') and the consequence of skipping ('si las deja, se puede tapan el aparatito, y eso es un infarto más grande que el de ahorita'); handle the radial-vs-femoral access choice in bedside Spanish ('por la muñeca' default / 'por la ingle' backup); deliver the NPO rule now + metformin-hold triplet cadence (same as scenario 18) + access-site bleeding watch in three specific observables ('sangre saliendo del piquete, un bulto grande que antes no estaba, los dedos fríos blancos o morados'); and close with the library's first dual-permission consent ask — '¿me da permiso de hacer la prueba? Y si vemos un tapón, ¿me da permiso de abrirlo en el mismo tiempo?' — NOT 'firma aquí.' Library's third procedural-consent scenario, building on scenarios 18 and 19's consent-as-conversation discipline in the highest-acuity frame (active myocardial ischemia with running anticoagulation). Second consecutive scenario (after scenario 19) where the family-witness role is named bedside as SUPPORT-not-SUBSTITUTE for consent — the patient signs alone, the wife carries four specific at-home rules (NPO now, access-site bleeding watch after, DAPT compliance monitoring, red-flag escalation) — solidifying support-not-substitute as a deliberate library discipline rather than a one-time move.

Conduct a cardiac-catheterization informed-consent conversation entirely in Spanish that (1) opens with the shared-decision consent ritual used in scenarios 18 and 19 ('le voy a explicar primero, le voy a contestar todo lo que me pregunte, y al final le pregunto si está de acuerdo') and closes with the library's first DUAL-permission consent ask — '¿me da permiso de hacer la prueba? Y si vemos un tapón, ¿me da permiso de abrirlo en el mismo tiempo?' — NOT 'firma aquí'; (2) handles the 'is it urgent, do I go NOW?' question honestly — NSTEMI is a within-24-hr urgency, not a within-minutes urgency; the aspirin and heparin already running are the first line of protection RIGHT NOW — same don't-refuse-refine discipline as scenarios 17/18/19; (3) delivers the single load-bearing cardiac-anatomy reassurance in three specific negations, OUT LOUD, early, BEFORE the positive explanation — 'no le vamos a abrir el pecho, no le vamos a operar el corazón, no va a haber cirugía a corazón abierto'; (4) explains the positive anatomy with the 'carril que ya está ahí adentro' metaphor — arterial highway from wrist (radial) to heart, the tubito delgadito follows the existing carril, nothing is cut; (5) validates the father-died-of-MI-in-Mexico family-history story directly — 'eso pasaba más antes, en los ochentas o noventas — la única opción era abrir el pecho; hoy hay más opciones antes de llegar a eso' — same respect-then-redirect discipline as scenarios 16/18/19; (6) names the 'una cosa o dos cosas' combined-consent pattern as the library's first teaching beat of same-session diagnostic + intervention consent — '¿me da permiso de ver? Y si vemos un tapón, ¿me da permiso de abrirlo en el mismo tiempo, sin sacar el tubito y volverlo a meter otro día?'; (7) names the stent in bedside Spanish as 'un aparatito como un resorte, muy pequeñito, que se queda ahí adentro pegado a la pared del carril para que el carril siga abierto' — library's first stent-naming beat; (8) teaches DAPT as 'dos medicinas para que la sangre no se pegue al aparatito,' with three 'no' triggers for never-stopping and the consequence of skipping named in patient Spanish ('si las deja, se puede tapar el aparatito, y eso es un infarto más grande que el de ahorita') — same cadence-over-mechanism discipline as scenarios 13/14/18/19; (9) handles the radial-vs-femoral access choice in bedside Spanish — 'por la muñeca' as the explained default, 'por la ingle' as the named backup; (10) delivers NPO-now + metformin-hold triplet cadence (same cadence as scenario 18) + access-site bleeding watch in three specific observables as the wife's four at-home rules; (11) names the wife's role as SUPPORT-not-SUBSTITUTE for the second library scenario in a row (after scenario 19), solidifying the pattern as a deliberate library discipline rather than a one-time move — the patient signs; the wife carries NPO now, access-site bleeding watch after, DAPT compliance monitoring at home, and red-flag escalation back to the hospital.

DIALOGUE

**PATIENT · 58M,
3H SUBSTERNAL
CHEST PAIN
RADIATING TO L
ARM, TROP 0.12,
T-WAVE
INVERSIONS V4-
V6, WIFE AT
BEDSIDE,
ASA+HEPARIN
RUNNING**

Doctor, yo tengo un dolor fuerte en el pecho desde hace tres horas. El doctor de mi clínica me mandó para acá y me dijeron que es del corazón, que me tienen que meter un tubo para ver qué tiene. Pero doctor, por favor — mi papá murió de un infarto en México cuando tenía cincuenta y dos años. A él le abrieron el pecho, y no sobrevivió. Yo no quiero que me abran el pecho. Por favor. Mi esposa está aquí — ella también está asustada.

Doctor, I've had a strong pain in my chest for three hours. My clinic doctor sent me here and they told me it's my heart, that they have to put in a tube to see what's going on. But doctor, please — my father died of a heart attack in Mexico when he was fifty-two. They opened his chest, and he didn't survive. I don't want them to open my chest. Please. My wife is here — she's also scared.

CARDIAC CATHETERIZATION WITH POSSIBLE PCI — INFORMED CONSENT, "NO LE VAMOS A ABRIR EL PECHO" ANATOMY REASSURANCE, AND COMBINED DIAGNOSTIC + INTERVENTION CONSENT — CONTINUED

#2

Open with the shared-decision consent ritual — same as scenarios 18 and 19. Validate the father-died-in-Mexico story and the fear-of-open-chest OUT LOUD in the first breath; do NOT dismiss either. Do NOT start the anatomy explanation yet — the consent ritual has to land first; the 'no le vamos a abrir el pecho' reassurance comes in turn 4 when he asks the urgency question and opens the door for you to explain the anatomy. Name the procedure in plain bedside Spanish — 'meter un tubito muy delgadito por una arteria para ver cómo están las arterias del corazón' — and pair once with the chart term 'cateterismo cardíaco' so he recognizes it on the form. Buy permission to explain in pieces ('le voy a explicar primero, le voy a contestar todo lo que me pregunte, y al final le pregunto si está de acuerdo'). Bring the wife in explicitly — 'señora, usted también me puede interrumpir y preguntar lo que sea, en cualquier momento.' Do NOT lead with 'firma aquí.' This structure mirrors scenarios 18 + 19.

Señor, buenas tardes. Señora. Antes que nada — gracias por decírmelo directo, lo de su papá y lo del miedo a que le abran el pecho. Esa es una preocupación muy real, y se la voy a contestar con calma, en un momentito. Antes de meterle nada, quiero explicarle bien — vamos a ir paso por paso, y nada se va a hacer hasta que usted me diga que sí. Le voy a contar qué es la prueba, por qué la necesitamos, y qué riesgos tiene. Le voy a contestar todo lo que usted y su esposa me pregunten. Y al final — y sólo al final — le voy a preguntar si está de acuerdo. La prueba se llama 'cateterismo cardíaco' — en español sencillo es 'meter un tubito muy delgadito por una arteria para ver cómo están las arterias del corazón.' Señora — usted también me puede interrumpir y preguntar lo que sea, en cualquier momento. ¿Está bien así si empezamos?

PATIENT · 58M

#3

Está bien, doctor. Explíqueme. Pero una cosa antes — si es del corazón, ¿no es urgente? La enfermera me dijo que los análisis de sangre salieron malos. ¿No me tiene que llevar YA, ahorita mismo? Si espero, ¿no me puede dar otro infarto, uno más grande? ¿Qué estamos esperando para hablar?

Okay, doctor. Explain it to me. But one thing first — if it's my heart, isn't it urgent? The nurse said the blood tests came back bad. Don't you have to take me NOW, right this minute? If I wait, couldn't I have another heart attack, a bigger one? What are we waiting for, to be talking?

CARDIAC CATHETERIZATION WITH POSSIBLE PCI — INFORMED CONSENT, "NO LE VAMOS A ABRIR EL PECHO" ANATOMY REASSURANCE, AND COMBINED DIAGNOSTIC + INTERVENTION CONSENT — CONTINUED

#4

Handle the urgency question HONESTLY — this is NSTEMI, not STEMI: elevated troponin but no ST elevation. The guideline window for urgent cath is within 24 hours, not within minutes. There IS time for a proper conversation, AND the aspirin and heparin already running are doing the first line of protection RIGHT NOW — name this explicitly. Same don't-refuse-refine discipline as scenarios 17, 18, 19. Then — and this is the load-bearing move of the scenario — deliver the single most important reassurance in Spanish cardiac-cath consent: 'no le vamos a abrir el pecho, no le vamos a operar el corazón, no va a haber cirugía a corazón abierto.' Say those THREE specific negations OUT LOUD, in a row, early, BEFORE the positive explanation — because patients in fear hear selectively and repeating the negation three ways is how the message lands. Then give the positive: *tubito delgadito entering through the wrist ('por la muñeca'), following the existing arterial 'carril que ya está ahí adentro' to the heart. Do NOT explain femoral access yet — that comes in turn 6 when he asks about the alternative. Address the father-in-Mexico story DIRECTLY — 'eso pasaba más antes, en los ochentas o noventas, cuando la única opción era abrir el pecho. Hoy hay más opciones antes de llegar a eso.'* Same respect-then-redirect as scenarios 16/18/19.

Le voy a ser honesto — y esto es importante para que entienda. Es urgente, Sí — pero NO es tan urgente que yo no tenga cinco minutos para explicarle esto bien. Si fuera un infarto enorme, yo estaría corriendo con usted al cuarto de la prueba ahorita mismo. Los análisis muestran que su corazón está sufriendo, pero no es el tipo de infarto más grande; es un tipo distinto, y esos se atienden en las próximas horas, no en los próximos minutos. Además — y esto es lo que mucha gente no sabe — las dos medicinas que ya le están pasando por la vena, la aspirina y el anticoagulante, esas medicinas están protegiéndolo AHORITA. Están haciendo la primera parte del trabajo, ya. La prueba la vamos a hacer hoy mismo, en las próximas horas. Ahora — lo del pecho. Señor, escúcheme bien: NO le vamos a abrir el pecho. NO le vamos a operar el corazón. NO va a haber cirugía a corazón abierto. Lo que hacemos es esto: le metemos un tubito MUY delgadito por la arteria de aquí, la de la muñeca. Esa arteria es como un carril que ya está ahí adentro de su brazo, y ese carril va directo al corazón. El tubito va por ese carril, sin cortar nada, hasta llegar al corazón. Allí adentro le echamos un líquido especial que se ve en los rayos X, y así vemos cuáles arterias del corazón están bien y cuáles están tapadas. Lo de su papá — eso pasaba más antes, en los ochentas o noventas. En aquel tiempo, cuando había un infarto, la única opción era abrir el pecho. Hoy hay más opciones ANTES de llegar a la operación — y la primera de esas opciones es esta prueba. No es la misma medicina que le hicieron a él.

Por la muñeca, doctor... de verdad. Yo pensaba que iba a ser por la pierna, como le hicieron a mi primo hace años. Si es por la muñeca — me siento un poquito más tranquilo. Pero dígame — y si ya adentro encuentran algo tapado, ¿qué? ¿Me sacan, me mandan a mi cuarto, y me abren después? ¿Cuántas veces me van a meter el tubo?

Through the wrist, doctor... really. I thought it was going to be through the leg, like they did to my cousin years ago. If it's through the wrist — I feel a little calmer. But tell me — and if once you're inside you find something blocked, what happens? Do you pull me out, send me to my room, and open me up later? How many times are they going to put the tube in?

This is the library's FIRST combined-consent turn — the 'una cosa o dos cosas' teaching beat. Name it explicitly: 'entramos a VER — y si vemos un tapón, lo ABRIMOS en el MISMO tiempo. No lo vamos a sacar y volverlo a meter otra vez en otro momento.' Explain why same-session is safer: fewer tube-insertions, fewer bleeds, fewer contrast exposures. Then name the stent in bedside Spanish — 'un aparatito como un resorte, muy pequeñito, que se queda ahí adentro pegado a la pared del carril para que el carril siga abierto' — never 'stent' alone (English), never 'endoprotesis' (chart-only). Then handle the radial-vs-femoral question he just raised with honest disclosure: radial is default ('por la muñeca'), femoral is backup ('por la ingle'); explain why radial is preferred ('ahí la arteria es más pequeña, se controla el sangrado mejor, y usted se levanta más rápido'). This is the same disclosed-option discipline as scenario 19's post-LP headache disclosure. Close this turn by asking permission for BOTH at once — the library's first dual-permission ask: '¿me da permiso de ver? Y si vemos un tapón, ¿me da permiso de abrirlo en el mismo tiempo?' Save the stent-forever + DAPT teaching for turn 8 when he asks about what happens afterward.

Esa es la pregunta correcta, señor — y es la MÁS importante. Le explico con cuidado. La prueba se hace en dos pasos, PERO en el MISMO momento, todo junto — no sale usted y vuelve a entrar otro día. Primero, VEMOS: metemos el tubito, echamos el líquido, miramos las arterias del corazón. Si todas están bien — sacamos el tubito, terminamos, usted va a su cuarto. Pero si vemos una arteria tapada — un 'tapón' — entonces ABRIMOS ese tapón ahí mismo, en el MISMO momento, sin sacar el tubito y sin volverlo a meter otro día. Para mantener ese carril abierto después, le ponemos un aparatito ahí, en el lugar del tapón — en inglés le dicen un 'stent,' pero en español sencillo es un aparatito como un resorte, muy pequeñito, que se queda pegado a la pared del carril para que el carril siga abierto. Hacerlo todo junto, en el mismo tiempo, es más seguro — menos veces que metemos el tubo, menos veces que usted sangra, menos líquido especial en el cuerpo. Por la muñeca es como lo preferimos — ahí la arteria es más pequeña, se controla el sangrado mejor, y usted se levanta más rápido después. Si por alguna razón no pudimos por la muñeca, pasamos a la ingle — la parte de arriba de la pierna. Tenemos las dos opciones, pero la primera es la muñeca. Entonces señor, le tengo que preguntar dos cosas ahorita, las dos: ¿me da permiso de hacer la prueba para VER las arterias del corazón? Y si vemos un tapón — ¿me da permiso de ABRIRLO en el mismo tiempo, ahí adentro, con el aparatito?

Si, doctor — doy permiso. Las dos cosas. Si es para no tener que entrar dos veces, mejor hágalo de una vez. Pero — ese aparatito que se queda adentro... ¿se queda ahí para siempre? ¿Y yo qué tengo que hacer después? Yo trabajo como carpintero, doctor, cargo madera todos los días — ¿voy a poder seguir trabajando? ¿O me va a quedar algo mal del corazón para toda la vida?

Yes, doctor — I give permission. Both things. If it's so I don't have to go in twice, better to do it all at once. But — that little thing that stays inside... does it stay there forever? And what do I have to do afterward? I work as a carpenter, doctor, I carry wood every day — will I be able to keep working? Or will something be wrong with my heart for the rest of my life?

CARDIAC CATHETERIZATION WITH POSSIBLE PCI — INFORMED CONSENT, "NO LE VAMOS A ABRIR EL PECHO" ANATOMY REASSURANCE, AND COMBINED DIAGNOSTIC + INTERVENTION CONSENT — CONTINUED

#8

This is the single most load-bearing at-home rule turn of the scenario — the DAPT teaching, and it is the equivalent of scenario 18's metformin-hold cadence and scenario 19's 'como un caracol' position teach. Name the stent honestly — YES it stays forever, but it becomes part of him (no rejection, no noise, no metal-detector issues — pre-empt the three common questions). Then DAPT in bedside Spanish: 'dos medicinas para que la sangre no se pegue al aparatito.' NOT 'antiagregantes.' Do NOT teach the mechanism; teach the CONSEQUENCE of skipping — 'si las deja, se puede tapar el aparatito — y eso es un infarto MÁS GRANDE que el de ahorita.' Name the three 'no' triggers — those are the three real-world reasons patients stop: (a) se siente bien, (b) se acabó el paquete, (c) otro doctor le dijo otra cosa. Explicitly bring the wife in as the second check on DAPT compliance — she's not just a bystander, she's the compliance co-monitor. Then the carpentry/work question — do NOT over-commit a return-to-work date; that is cardiology's call, not the ED's. Name what IS known: 3–5 days minimum for radial access-site healing, no heavy lifting during that window; beyond that is cardiology's call. Close with the honest bleeding-risk warning on DAPT: 'más moretones, más fácil de sangrar — esto es NORMAL con estas medicinas, NO las deje solas por eso, llame a cardiología.'

Muy bien — se lo explico con calma, porque esto es lo más importante que se lleva a la casa. El aparatito se queda ahí para siempre, pero es muy pequeño, y con el tiempo se vuelve parte de usted — ni se va a dar cuenta que está. No lo va a sentir, no hace ruido, y no dispara los detectores de metal en los aeropuertos, por si se lo pregunta. Ahora lo MÁS importante — las medicinas. Si hoy le ponemos el aparatito, usted va a tomar DOS medicinas para que la sangre no se pegue al aparatito. Las DOS — no una, LAS DOS — todos los días, por lo menos un año, y a veces para siempre. Estas dos medicinas son las más importantes de todas las que va a tomar; más importantes que la medicina para la presión, más importantes que la de la diabetes. Si las deja — aunque sea por una semana — el aparatito se puede tapar, y eso es un infarto MÁS GRANDE que el que tiene ahorita. Escuche las tres reglas, por favor, y señora, ayúdele a cuidarlas: no las deje aunque se sienta bien; no las deje aunque se le acabe el paquete — pida la receta ANTES; y no las deje aunque otro doctor le diga otra cosa — llame primero a cardiología. Del trabajo — la carpintería con la madera pesada — eso no lo decido yo hoy. Cardiología lo va a ver mañana en el hospital y ellos le dicen cuándo puede volver. Por lo menos tres a cinco días no va a cargar nada pesado, para que la muñeca sane bien. Y una cosa más: las medicinas de la sangre le van a hacer que le salgan moretones más fáciles, y que le sangre más si se corta afilando una herramienta. Eso es NORMAL con esta medicina, NO la deje sola por eso — llame a cardiología y ellos deciden si le cambian algo.

PATIENT 58M
#9

Doctor, mi esposa quiere preguntarle algo. Dice: '¿Doctor, y yo qué tengo que cuidar en la casa? Si le damos de comer ahorita, o si se le sale algo de sangre, o si no sé qué mirar — yo soy la que lo cuida en la casa. Yo no hablo inglés, la receta me la van a dar en inglés. Por favor, explíqueme despacito para no olvidarme.'

Doctor, my wife wants to ask you something. She says: 'Doctor, what do I have to watch at home? If we give him something to eat now, or if some blood comes out, or if I don't know what to look for — I'm the one who takes care of him at home. I don't speak English, they're going to give me the prescription in English. Please, explain slowly so I don't forget.'

CARDIAC CATHETERIZATION WITH POSSIBLE PCI — INFORMED CONSENT, "NO LE VAMOS A ABRIR EL PECHO" ANATOMY REASSURANCE, AND COMBINED DIAGNOSTIC + INTERVENTION CONSENT — CONTINUED

#10

This is the 10th turn close. Name the wife's role explicitly as SUPPORT-not-SUBSTITUTE — second library scenario in a row (after scenario 19) where the pattern is named bedside, which solidifies it as deliberate library discipline rather than a one-time move. She carries FOUR specific things: (a) NPO now — no food, no water, no chewing gum, 'hasta que salga de la prueba'; (b) after the procedure: 48-hour access-site bleeding watch in three specific observables — bleeding at the site, growing hematoma ('bulto grande que antes no estaba'), fingers going cold/white/blue on the cath side — 'vuelvan al hospital de inmediato, no esperen'; (c) DAPT compliance monitoring at home — she's the second check on the 'don't stop the blood medicines' rule; (d) red flags — new chest pain, shortness of breath, stopped medications for any reason = call / come back. Then the metformin-hold triplet cadence, same as scenario 18: 'pare HOY, no la tome por DOS días, si no la llamamos vuelva a tomarla normal.' End with the library's first DUAL-permission consent close — '¿me da permiso de hacer la prueba? Y si vemos un tapón, ¿me da permiso de abrirlo en el mismo tiempo?' — NOT 'firma aquí.' This is the LP-analogue of scenario 18's '¿me da permiso de hacerle el estudio?' and scenario 19's '¿me da permiso de hacer la prueba?' closes, with the combined-consent twist.

Señora, muchas gracias por preguntar — y de verdad, usted tiene razón en preguntar todo esto. Le explico las CUATRO cosas que usted es quien las va a cuidar, despacio, y se las apuntamos antes de que se vayan. Uno, lo de AHORITA, antes de la prueba: él no come ni toma nada — ni agua, ni café, ni un chicle, nada — hasta que salga de la prueba. Esa regla es de este momento hasta que se acabe. Dos, después de la prueba, cuando se vayan a la casa — durante dos días mire el lugar donde le entró el tubito, la muñeca. Tres cosas específicas que nos avisan: si ve sangre saliendo del piquete, si le crece un bulto grande donde antes no estaba, o si los dedos de esa mano se le ponen fríos, blancos, o morados — no esperen, vuelvan al hospital de inmediato, aunque sea las tres de la mañana. Tres — las dos medicinas nuevas, las de la sangre que le dije — él las toma todos los días. Usted lo ayuda: si se le olvida, usted le pregunta. Si se le acaba el paquete, usted llama a cardiología ANTES de que se acabe. Y si algún otro doctor le dice que las deje, usted dice 'primero llamamos a cardiología.' Cuatro, las señales de alarma, para volver al hospital sin pensarlo: si le vuelve el dolor del pecho, si le falta el aire, si los dedos se ponen morados, o si por cualquier razón él dejó de tomar una de las medicinas de la sangre — eso no espera, se vienen al hospital. La decisión de hacer la prueba es de ÉL — yo le pregunto a él, no a usted — pero usted lo apoya con estas cuatro cosas, y eso es igual de importante que la prueba misma. Señor, una cosa más, por la diabetes: la metformina — PARE hoy, no la tome por DOS días, y si no lo llamamos nosotros con algo raro, la vuelve a tomar normal como siempre. Entonces la pregunta final, señor — y son dos: ¿me da permiso de hacer la prueba para ver? Y si vemos un tapón, ¿me da permiso de abrirlo en el mismo tiempo, con el aparatito?

WHAT TO NOTICE

CARDIAC CATHETERIZATION WITH POSSIBLE PCI — INFORMED CONSENT, "NO LE VAMOS A ABRIR EL PECHO" ANATOMY REASSURANCE, AND COMBINED DIAGNOSTIC + INTERVENTION CONSENT — CONTINUED

- The single highest leverage reassurance in Spanish cardiac-cath consent is 'NO le vamos a abrir el pecho' — delivered as THREE specific negations OUT LOUD, early, BEFORE the positive anatomy explanation: 'no le vamos a abrir el pecho, no le vamos a operar el corazón, no va a haber cirugía a corazón abierto.' Every Spanish-speaking patient facing this conflates catheterization with open-heart surgery, often reinforced by a specific father/uncle/brother-in-Mexico family story. Patients in fear hear selectively, and repeating the negation three ways is what makes the message land where one negation would not. Only after the three negations land does the positive anatomy explanation become useful — the 'carril que ya está ahí adentro' metaphor for the arterial highway from wrist to heart. Third scenario in a row (after scenarios 18 and 19) where a load-bearing physical-anatomy sentence has to be said before consent will land.
- The library's FIRST combined diagnostic + intervention consent teaching beat — 'una cosa o dos cosas.' Diagnostic cath + same-session PCI with stent is the modern standard, AND the patient who consents to only the diagnostic half and not the intervention forces the team to either wake him up mid-procedure (not possible) or terminate and do a second cath another day (inferior outcomes, more exposure, more bleeding risk). Name the pattern explicitly bedside: 'entramos a VER; y si vemos un tapón, lo ABRIMOS en el MISMO tiempo. No le vamos a sacar y volver a meter otra vez en otro momento.' Ask permission for BOTH at once: '¿me da permiso de ver? Y si vemos un tapón, ¿me da permiso de abrirlo en el mismo tiempo?' — the library's first dual-permission consent close, carrying forward into every subsequent interventional-cardiology or IR scenario.
- Validate the father-died-of-MI-in-Mexico family-history story DIRECTLY — do NOT dismiss with 'ese es otro caso.' The story is real medical history from an era (1980s–1990s) when PCI was not widely available and the only surgical option for an acute MI with a surgical lesion was CABG via sternotomy. Name what is different today: 'eso pasaba más antes, en los ochentas o noventas — la única opción era abrir el pecho; hoy hay más opciones ANTES de llegar a eso.' Dismissing the story tells the patient you don't take his fear seriously; validating the story and specifically naming what is different today converts skeptical into cooperative. Same respect-then-redirect discipline as scenarios 16 mal-de-ojo, 18 shellfish-allergy-myth, and 19 tío-en-Honduras LP story.
- DAPT teaching is the single most load-bearing at-home rule in this scenario — equivalent to metformin-hold cadence in scenario 18 and 'como un caracol' position teach in scenario 19. Name it bedside: 'dos medicinas para que la sangre no se pegue al aparatito.' NOT 'antiagregantes plaquetarios.' Do NOT teach the mechanism (COX-1 inhibition, P2Y12 inhibition) — teach the CONSEQUENCE of skipping: 'si las deja, se puede tapar el aparatito — y eso es un infarto MÁS GRANDE que el de ahorita.' Name three explicit 'no' triggers because those are the three real-world reasons patients stop: 'no las deje aunque se sienta bien, no las deje aunque se acabe el paquete, no las deje aunque otro doctor le diga otra cosa sin primero llamar a cardiología.' Also name the expected side-effect — bruising / easier bleeding are NORMAL, NOT a reason to stop the medicine — so the patient doesn't quit on his own to fix a bruise. Same cadence-over-mechanism discipline as scenario 13's 15-15-rule, scenario 14's Narcan 4-step, scenario 18's metformin triplet, and scenario 19's position-teach + 'PRESIÓN, no DOLOR.'
- Radial-vs-femoral access explained in bedside Spanish with HONEST disclosure of both options — 'por la muñeca' (radial, default) vs 'por la ingle' (femoral, backup). Radial is now the default at most US centers because the arterial anatomy is smaller, bleeding is easier to control, and patients ambulate sooner. Name the preference AND the backup honestly up front — patients who hear only 'wrist' and wake up with a femoral sheath feel betrayed; patients who hear both options from the start tolerate a radial-to-femoral conversion intra-procedure without losing trust. Same disclosed-option discipline as scenario 18's compact 3-in-1 red-flag screen and scenario 19's post-LP-headache honest disclosure.

CARDIAC CATHETERIZATION WITH POSSIBLE PCI — INFORMED CONSENT, "NO LE VAMOS A ABRIR EL PECHO" ANATOMY REASSURANCE, AND COMBINED

DIAGNOSTIC AND INTERVENTION CONSENT — CONTINUED

- Un aparato como un resorte is the library's first stent-naming beat. Never 'stent' alone (reads as English and doesn't land for a patient with limited English); never 'endoprotesis vascular' (chart-only, doesn't land). The 'resorte' metaphor carries both the shape (coiled, expandable) and the function (holds the carril open). Pair with the three most common pre-empted questions: 'no lo va a sentir, no hace ruido, no dispara los detectores de metal en los aeropuertos.' This beat will carry forward into every subsequent cardiology / interventional-cardiology / IR scenario where a device is left behind — the editorial template is now set.
- Post-cath access-site bleeding watch taught as three specific observables, NOT as 'any problem with the wound.' Specific observable Spanish that works at home: (a) 'sangre saliendo del piquete' (frank bleeding); (b) 'un bulto grande que antes no estaba' (hematoma); (c) 'los dedos de esa mano se ponen fríos, blancos, o morados' (access-site arterial compromise). Patients taught three specific observables recognize the pattern at home and come back in time. Patients told 'watch for problems' rationalize real problems as not-worth-coming-back-for. Same specific-observable discipline as scenario 18's three-observable contrast-sensation pre-description and scenario 19's three-observable post-LP positional-headache pattern.
- Ninth consecutive scenario reinforcing the family-witness teaching discipline (scenarios 11/13/14/15/16/17/18/19/20), and SECOND in a row (after scenario 19) where the support-not-substitute separation is named explicitly at the bedside. The wife carries FOUR specific at-home rules: NPO now (pre-procedure), 48-hour three-observable access-site bleeding watch (post-procedure), daily DAPT-compliance monitoring (ongoing), and red-flag escalation (new chest pain / shortness of breath / stopped medications for any reason). The patient signs the consent alone — 'la decisión es suya, yo le pregunto a usted, no a ella.' Naming this separation a SECOND scenario in a row solidifies support-not-substitute as a deliberate library discipline, not a one-time move, and sets the editorial template for every future consent-with-family-at-bedside scenario in the library.

DIALECT NOTES

- Three-register lexical pattern for the procedure: 'cateterismo cardíaco' (chart Spanish) / 'cardiac cath' (English chart term he may see on the order sheet) / 'meter un tubito delgadito por la arteria para ver las arterias del corazón' (bedside Spanish that lands). Avoid 'catéter' alone bedside — reads as 'a tube stuck into you' and adds fear. Lead bedside with 'tubito delgadito' + the 'carril' metaphor, pair once with the chart term 'cateterismo cardíaco' so he recognizes it on the form. Same bedside-pair-with-chart-term discipline as scenarios 13–19 (azúcar bajo / hipoglucemia, naloxona / la medicina que le quita el efecto, bombita / inhalador, convulsión febril / simple febrile seizure, poder notarial médico / healthcare proxy, tomografía / CT, punción lumbar / spinal tap).
- 'NO le vamos a abrir el pecho' is the single most load-bearing sentence in Spanish-language cardiac-cath consent, and it has to be said OUT LOUD in three specific negations, EARLY, before the positive explanation: 'no le vamos a abrir el pecho, no le vamos a operar el corazón, no va a haber cirugía a corazón abierto.' Every Spanish-speaking patient facing this conflates catheterization with open-heart surgery, often reinforced by a specific family story ('mi papá / mi tío / mi hermano en [Mexico/Honduras/Guatemala]'). The three negations in a row land where one would not — because patients in fear hear selectively, and repeating the negation three ways makes sure the message gets through. Only after the negations should the positive explanation begin. This is the cardiac-cath analogue of scenario 19's 'la médula termina aquí, la aguja entra acá abajo' anatomy reassurance — a named, specific Spanish sentence that has to be said before consent will land.

CARDIAC CATHETERIZATION WITH POSSIBLE PCI — INFORMED CONSENT, "NO LE VAMOS A ABRIR EL PECHO" ANATOMY REASSURANCE, AND COMBINED

DIAGNOSTIC + INTERVENTION CONSENT — CONTINUED

- The 'carril que ya está ahí dentro' metaphor is the bedside register for the arterial anatomy from wrist to heart that lands universally. Name the radial artery as 'un carril que ya está ahí dentro de su brazo, que va directo al corazón,' and the catheter as following that carril rather than cutting a new one — 'el tubito va por ese carril, sin cortar nada, hasta llegar al corazón.' Lands more reliably than explaining arterial anatomy in clinical Spanish ('por la arteria radial subimos a la aorta y cateterizamos los ostia coronarios' — non-starter bedside). Combined with 'NO le vamos a abrir el pecho,' this is the anatomy reassurance that converts fear into cooperation.
- Address the father-died-of-MI family-history story DIRECTLY — do NOT dismiss with 'ese es otro caso' or 'eso no es lo que le va a pasar a usted.' Validate the memory ('eso pasaba más antes, en los ochentas o noventas') and explain what is different today: before, when there was a heart attack, the only option was to open the chest — today there are more options BEFORE getting to that, and the first of those options is this procedure. The family story is not paranoia — it is real medical history from an era when PCI was not widely available. Same respect-then-redirect discipline as scenarios 16 mal-de-ojo, 18 shellfish-allergy-myth, 19 tío-en-Honduras-LP-story.
 - 'Una cosa o dos cosas' — the combined diagnostic + intervention consent pattern, named as a library-first clinical teaching beat. Diagnostic cath + same-session PCI with stent is the modern standard, AND the patient who consents to the diagnostic part but not the intervention forces the team to either wake him up mid-procedure (not possible) or terminate and do a second cath another day (inferior outcomes, more exposure, more bleeding risk). Name it explicitly bedside: 'entramos a VER, y si vemos un tapón, lo ABRIMOS en el MISMO tiempo. No le vamos a sacar y volver a meter otra vez en otro momento.' Ask permission for BOTH at once: '¿me da permiso de ver? Y si vemos un tapón, ¿me da permiso de abrirlo en el mismo tiempo?' This is the library's first combined-consent close.
 - 'Un aparatito como un resorte' is the bedside register for stent that lands universally. Never 'stent' alone (reads as English and doesn't land for a patient with limited English); never 'endoprotesis vascular' (chart-only, doesn't land). 'Un aparatito como un resorte, muy pequeñito, que se queda ahí adentro pegado a la pared del carril para que el carril siga abierto' — the resorte metaphor carries both the shape (coiled, expandable) and the function (holds the carril open). Also name what the stent is NOT: 'no lo va a sentir, no hace ruido, no dispara los detectores de metal en los aeropuertos' — patients ask, and pre-empting the three most common questions builds trust.
 - DAPT teaching — 'dos medicinas para que la sangre no se pegue al aparatito.' NOT 'antiagregantes plaquetarios' (chart-only, doesn't land). Do NOT teach the mechanism (COX-1 inhibition, P2Y12 inhibition) — teach the CONSEQUENCE of skipping: 'si las deja, se puede tapar el aparatito — y eso es un infarto más grande que el de ahorita.' Name three explicit 'no' triggers, because those are the three real-world reasons patients stop: 'no las deje aunque se sienta bien, no las deje aunque se acabe el paquete, no las deje aunque otro doctor le diga otra cosa sin primero llamar a cardiología.' Then name the expected side-effect honestly — bruising and easier bleeding are NORMAL on these medicines — so the patient doesn't stop the medicine on his own to fix a bruise. Same cadence-over-mechanism discipline as scenario 13's 15-15-rule, scenario 14's Narcan 4-step, scenario 18's metformin triplet, scenario 19's 'como un caracol' position teach.
 - Radial-vs-femoral access in bedside Spanish — 'por la muñeca' (radial, default) vs 'por la ingle' (femoral, backup). Radial is the default at most US centers because the arterial anatomy is smaller, bleeding is easier to control, and patients ambulate sooner. Name the preference AND the backup honestly — patients who hear only 'wrist' and wake up with a femoral sheath feel betrayed; patients who hear both options from the start tolerate a radial-to-femoral conversion without losing trust. Bedside: 'preferimos por la muñeca porque ahí la arteria es más pequeña, se controla el sangrado mejor, y usted se levanta más rápido. Si por alguna razón no pudimos por la muñeca, pasamos a la ingle — tenemos las dos opciones.' Same disclosed-option discipline as scenario 18's compact 3-in-1 red-flag screen and scenario 19's post-LP-headache honest disclosure.

CARDIAC CATHETERIZATION WITH POSSIBLE PCI — INFORMED CONSENT, "NO LE VAMOS A ABRIR EL PECHO" ANATOMY REASSURANCE, AND COMBINED

- **DIAGNOSTIC INTERVENTION CONSENT — CONTINUED**
Post-cath access-site bleeding watch named as three-specific observables, never as 'any problem with the wound.' Specific observable Spanish that works at home: (a) 'sangre saliendo del piquete' (frank bleeding); (b) 'un bulto grande que antes no estaba' (hematoma); (c) 'los dedos de esa mano se ponen fríos, blancos, o morados' (access-site arterial compromise). Patients taught three specific observables recognize the pattern at home and come back in time. Patients told 'watch for problems' rationalize real problems as not-worth-coming-back-for. Same specific-observable discipline as scenario 18's contrast-sensation pre-description (three observables: warmth + urinary-urge + brief duration), scenario 19's post-LP positional-headache pattern (three observables: better-lying / worse-sitting / one-to-two days after), and scenario 16's four-rule seizure rescue.
- Separation of consent-decision from caregiving-support in Spanish when family is at the bedside — second library scenario in a row (after scenario 19) where support-not-substitute is named explicitly bedside, solidifying the pattern as a deliberate library discipline rather than a one-time move. The patient signs — 'la decisión es suya, yo le pregunto a usted, no a ella.' The wife is named explicitly as support — she carries FOUR specific at-home rules: NPO now (no food, no water, no chewing gum until after the procedure); after the procedure, 48-hour access-site bleeding watch in the three specific observables; daily DAPT-compliance monitoring at home (second check on the 'don't stop the blood medicines' rule); and red-flag escalation (new chest pain, shortness of breath, stopped medications for any reason = call / come back). Naming this separation a second scenario in a row prevents the same two failures: (a) patient deferring consent to family member who 'decides for me' (compromising autonomy), (b) family member feeling shut out of the room (losing post-procedure compliance monitoring).

Postpartum hemorrhage tele-triage — 3am call, Spanish-speaking husband, day-6 postpartum bleeding heavily

6 min · 10 turns

CONTEXT

It is 3:14am. You are the on-call OB triage RN at a community hospital's L&D phone line. A Spanish-speaking man (32y, husband) calls. His wife (29y, day 6 postpartum from an uncomplicated SVD at this hospital, discharged on day 2) has been bleeding through pads for the last 3 hours — one soaked pad every 30 minutes. When she got up to the bathroom an hour ago she went pale and almost fainted. She's now back in bed, awake, talking, but pale and tired. Their two-year-old son is asleep in the next room. The husband's English is broken; the wife is in bed and cannot get to the phone. He's panicking and asking what to do — should he put her in the car?

CLINICAL GOAL

By the end of the call, the husband (1) calls 911 instead of driving, (2) knows to say "español" at the start of the 911 call to get a live interpreter on the line in <1 min, (3) has memorized a six-fact pre-scripted Spanish sentence to deliver to 911 ("Emergencia. Mi esposa, seis días después del parto, sangrado fuerte, mareada, casi se desmaya. Mande ambulancia."), (4) keeps the wife supine with feet elevated, NPO until evaluated, with mouth moistened by a damp cloth to satisfy the "tiene sed" caregiving impulse without breaking NPO, and (5) becomes the documenter and voice — counting pads and clots, watching mental status, relaying the postpartum-day-six history to EMS — for the 10–15 minutes between hang-up and ambulance arrival.

DIALOGUE

**CALLER · 32M,
HUSBAND, 3AM
CALL, WIFE
DAY-6
POSTPARTUM,
BLEEDING 3H,
SOAKED PADS
Q30MIN, NEAR-
SYNCOPE ON
STANDING, 2Y
SON ASLEEP
NEXT ROOM,
ENGLISH
BROKEN,
PANICKING**

Hola, hola — ¿es la línea de la sala de partos? Por favor — mi esposa tuvo el bebé hace seis días, en este hospital. Está sangrando mucho. Lleva como tres horas así, está pasando por las toallas, una cada media hora, las dos están empapadas. Cuando se levantó al baño se puso pálida y casi se desmaya. Está acostada en la cama, pero está mareada y como cansada. Mi hijo de dos años está dormido en el otro cuarto. Yo no hablo bien inglés — por favor, dígame qué hago. ¿La meto en el carro? ¿La traigo? Por favor, ayúdeme.

Hello, hello — is this the labor and delivery line? Please — my wife had the baby six days ago, in this hospital. She's bleeding a lot. It's been about three hours like this, she's going through pads, one every half hour, both of them are soaked. When she got up to the bathroom she went pale and almost fainted. She's lying down in bed, but she's dizzy and kind of tired. My two-year-old son is asleep in the other room. I don't speak English well — please, tell me what to do. Should I put her in the car? Should I bring her? Please, help me.

POSTPARTUM HEMORRHAGE TELE-TRIAGE — 3AM CALL, SPANISH-SPEAKING HUSBAND, DAY-6 POSTPARTUM BLEEDING HEAVILY — CONTINUED

YOU

#2

Phone-only opening register — name yourself, slow your pace, validate the fear in ONE sentence ('usted está haciendo bien en llamar' — said once, not three times), then BUY the structured triage by asking ONE concrete question, not five. Do NOT yet tell him to call 911 — you need 30 seconds of triage first to confirm hemorrhage vs. lochia + sleep-deprived standing-up dizziness from a 6-day-old baby (the false-positive shape that is NOT a 911 call). Two highest-yield phone-only triage observables to ask first: (a) where the wife is RIGHT NOW (in bed / bathroom / walking — answers the fall-risk and the 'can-she-be-moved' question), (b) is she awake and talking back to him (answers the mental-status question that determines whether this is dispatch-EMS-NOW or dispatch-EMS-after-confirming-pad-count). Calling-clinician panic resolves through structure — start with structure, not reassurance.

Señor, escúcheme. Soy enfermera de la sala de partos, lo voy a ayudar. Vamos a resolver esto juntos, paso por paso. Lo primero — usted está haciendo bien en llamar. Antes que nada, dos preguntas rápidas: ¿dónde está su esposa AHORITA mismo? ¿Está acostada en la cama, está en el baño, está caminando? Y la segunda — ¿está despierta? ¿Está hablando con usted, o ya no le contesta? Dígame eso primero y seguimos.

CALLER ·
RESPONDS (IN
BED, AWAKE,
ORIENTED, BUT
PALE; ONE MORE
SOAKED PAD
JUST NOW + EGG-
SIZED CLOT
30MIN AGO)

Está acostada en la cama, no se ha querido parar otra vez desde que casi se desmaya. Sí, está despierta — está hablando, me oye, sabe quién soy, sabe dónde está. Pero la veo cansada. Pálida, doctor. Y como ahorita acabo de cambiarle la toalla otra vez — esa también está empapada. Y vi un coágulo, doctor, un coágulo grande, como del tamaño de un huevo. Eso fue como hace media hora. Por favor, dígame.

She's lying down in bed, she hasn't wanted to stand up again since she almost fainted. Yes, she's awake — she's talking, she hears me, she knows who I am, she knows where she is. But I see her tired. Pale, doctor. And just now I just changed her pad again — that one is also soaked. And I saw a clot, doctor, a big clot, like the size of an egg. That was about half an hour ago. Please, tell me.

POSTPARTUM HEMORRHAGE TELE-TRIAGE — 3AM CALL, SPANISH-SPEAKING HUSBAND, DAY-6 POSTPARTUM BLEEDING HEAVILY — CONTINUED

YOU

#4

Load-bearing phone-only triage turn. You can't see the patient — you must ASK every observable. He's already volunteered three: pad count (3 soaked pads in ~90 min = >500mL = severe), clot size (egg = ~5cm = moderate-severe), orthostatic near-syncope (LOC change on standing = volume-down). That's already a dispatch-EMS picture. Confirm two more for late-shock screening: (a) skin/lip color in observable Spanish ('los labios azulosos, blanquitos' vs 'del color de siempre'), (b) mental-status change since the call started (confused / sleepier / slurred = late shock — emergent). Frame the questions in observable patient-Spanish, NOT clinical jargon. CRITICAL: bridge to the 911 directive at the end of THIS turn — 'antes de explicarle todo, ya le puedo decir esto: lo que me describe es serio, vamos a llamar al 911 ahorita; pero antes — una pregunta más' — so the 911 call doesn't land cold one turn later. The 911 directive itself comes in turn 6, but the bridge happens here so the caller is already mentally moving toward the dial.

Señor — escúcheme. Lo que me describe — tres toallas empapadas en una hora y media, un coágulo del tamaño de un huevo, y que casi se desmaya cuando se paró — eso es un sangrado fuerte, eso ya es serio. Vamos a llamar al 911. Pero antes de eso, una pregunta más, rapidito: cuando usted le habla AHORITA, en este momento, ¿le contesta clarito, sabe en qué año estamos, está como siempre — o la nota más confundida, más dormida, hablando raro? Y los labios — ¿los tiene del color de siempre, o los ve azulosos, blanquitos? Estas dos cosas, dígamelas, y luego le digo exactamente qué hacer.

**CALLER ·
RESPONDS
(AWAKE/
ORIENTED, EYES
CLOSING INTERMI
TTENTLY, LIPS
PALE NOT
CYANOTIC; ASKS
#5
ABOUT CAR-
VS-911 + 2Y SON
STILL ASLEEP)**

Le hablo y me contesta. No está confundida, sabe quién soy, sabe la fecha más o menos. Pero la noto cansada, como que cierra los ojos a ratos. Los labios — están como pálidos, como del color de la cara. No azules. No, doctor, no la veo azul. Doctor — ¿la voy a meter al carro? La cuna del bebé está en el cuarto — el bebé también está aquí. ¿Lo llevo? ¿Lo dejo? Dígame ya, por favor.

I talk to her and she answers. She's not confused, she knows who I am, she knows the date more or less. But I notice her tired, like she closes her eyes from time to time. Her lips — they're like pale, like the color of her face. Not blue. No, doctor, I don't see her blue. Doctor — am I putting her in the car? The crib for the baby is in the room — the baby's here too. Do I take him? Do I leave him? Tell me now, please.

POSTPARTUM HEMORRHAGE TELE-TRIAGE — 3AM CALL, SPANISH-SPEAKING HUSBAND, DAY-6 POSTPARTUM BLEEDING HEAVILY — CONTINUED

YOU

#6

Load-bearing time-critical directive turn. Lead with the directive in clean patient-Spanish — DO NOT bury it in explanation. THEN explain the WHY in two specific concrete failure modes so he doesn't override (in shock-mode panic, husbands routinely override 'call 911' with 'it's faster if I drive' and lose the patient en route): (1) if she passes out in the car, you're alone, driving, with a sleeping toddler — you can't help her and drive at the same time; (2) the ambulance has oxygen, IV access, blood en route, AND calls ahead so the OR is ready when she arrives — the car has none of that. State the toddler-and-newborn answer in ONE short sentence at the end so he doesn't get stuck on it: bring them or wake a neighbor — but call 911 FIRST. Library's first explicit verbalization of permission to hang up: 'usted PUEDE colgarme. No es falta de respeto.' Many Spanish-speaking callers feel they cannot hang up on a clinician without being rude; explicitly granting permission unblocks the dial. End by giving him the next concrete action: 'cuelgue, marque al nueve-uno-uno, y luego si quiere me llama de regreso a este número.'

Bueno — escúcheme bien. Esto es lo que vamos a hacer, ahorita: cuelgue conmigo, marque al nueve-uno-uno, pida ambulancia. NO la meta al carro. La razón: si se desmaya en el carro, usted está manejando solo, con su hijo dormido — usted no la puede ayudar y manejar al mismo tiempo. La ambulancia trae oxígeno, trae suero, trae sangre lista, y van llamando al hospital para que la sala de operaciones esté lista cuando ella llegue — el carro no hace nada de eso. Es más rápido y es más seguro. Una cosa más — usted PUEDE colgarme. No es falta de respeto, es lo que toca hacer ahorita. Cuelgue, marque al nueve-uno-uno, y luego si quiere me llama de regreso a este mismo número. Y el bebé y el niño — tráigaselos, llame al vecino, lo que sea — pero llame al nueve-uno-uno PRIMERO, antes que nada. ¿Estamos?

CALLER ·
AGREES + TWO
FOLLOW-UP
QUESTIONS
(ENGLISH WILL
FREEZE UNDER
PANIC; WHAT TO
SAY TO 911)

Sí, sí — voy a colgar y llamar al nueve-uno-uno. Pero doctor, una cosa — yo no hablo bien inglés. ¿Me van a entender? Mi esposa habla menos que yo. Y la otra — ¿qué les digo? Si me preguntan, me pongo nervioso, se me va el inglés, me trabo. Por favor, dígame qué decir.

Yes, yes — I'm going to hang up and call nine-one-one. But doctor, one thing — I don't speak English well. Are they going to understand me? My wife speaks less than I do. And the other thing — what do I tell them? If they ask me, I get nervous, my English goes, I freeze up. Please, tell me what to say.

POSTPARTUM HEMORRHAGE TELE-TRIAGE — 3AM CALL, SPANISH-SPEAKING HUSBAND, DAY-6 POSTPARTUM BLEEDING HEAVILY — CONTINUED

YOU

#8

TWO library-firsts in Spanish-language phone-triage discipline. FIRST — the single most underused fact among Spanish-speaking US callers: 911 has a live Spanish interpreter on every call; you say 'español' at the very beginning and they connect a live interpreter in under a minute, gratis, automatic, no escalation request. State it explicitly. Most Spanish-speaking callers either don't know this or assume it's a paid service that requires asking for a supervisor — both wrong. SECOND — pre-script the actual sentence he should say to 911. He's already told YOU the right facts; he just needs them in one sentence rhythm to repeat under stress when his English freezes. Six facts, one breath, in the rhythm he'll repeat them in: 'Emergencia. Mi esposa, seis días después del parto, sangrado fuerte, mareada, casi se desmaya. Mande ambulancia.' Have him REPEAT it once with you on the phone — short rehearsal beats long instruction. Address the address-anxiety in one sentence: E911 supplies the address from the dialed number; the dispatcher already knows where the call's coming from — caller doesn't have to recite the address under stress, just confirm the street if asked.

Dos cosas, rápido. PRIMERA — el nueve-uno-uno Sí habla español. Cuando le contesten, lo PRIMERO que usted dice es 'español, español' — y ellos le ponen un intérprete en menos de un minuto, en vivo, en la misma llamada, gratis. No es servicio extra, no es cobro, no es nada — es así para todos los que llaman. Usted habla español, ellos traducen en tiempo real. ¿Bueno? SEGUNDA — yo le doy la frase exacta que usted va a decir, para que no se le vaya. Repítala conmigo: 'Emergencia. Mi esposa, seis días después del parto, sangrado fuerte, mareada, casi se desmaya. Mande ambulancia.' Esos son los datos importantes, todos en una sola frase. Si le preguntan más, conteste lo que pueda — pero esa frase, esa la dice primero, completa, sin que lo interrumpen. La dirección — el sistema la sabe cuando usted marca, no se preocupe, ya saben de dónde está llamando; si le preguntan la calle, se la dice y ya. ¿La repetimos otra vez juntos para que le quede grabada?

CALLER · LAST QUESTION BEFORE HANGING UP — WHAT TO DO FOR THE WIFE WHILE EMS COMES

Listo. La aprendo. Ya la repetí: 'mi esposa, seis días después del parto, sangrado fuerte, mareada, casi se desmaya, mande ambulancia.' La tengo. Pero mientras llega la ambulancia, ¿qué hago con ella? ¿La levanto? ¿La pongo a sentar? ¿Le doy agua? Tiene la boca seca, me pidió agua. ¿Se la doy? Dígame paso por paso, doctor, porque yo no sé. ¿La pongo de lado? ¿Le pongo algo en el sangrado?

Got it. I'll memorize it. I just repeated it: 'my wife, six days postpartum, heavy bleeding, dizzy, almost fainted, send an ambulance.' I have it. But while the ambulance is coming, what do I do for her? Do I sit her up? Do I give her water? Her mouth is dry, she asked me for water. Do I give it to her? Tell me step by step, doctor, because I don't know. Do I lay her on her side? Do I put something on the bleeding?

POSTPARTUM HEMORRHAGE TELE-TRIAGE — 3AM CALL, SPANISH-SPEAKING HUSBAND, DAY-6 POSTPARTUM BLEEDING HEAVILY — CONTINUED

YOU

#10

Husband-as-secondary-caller carrying-set turn, in cadenced six-rule numbered format — same discipline as scenario 13's 15-15 rule, scenario 14's Narcan 4-step, scenario 16's four-rule febrile-seizure rescue, scenario 18's metformin-hold triplet, scenario 20's wife's four-rule DAPT-and-bleeding-watch. Numbered cadence beats prose every time at 3am under panic. SIX rules: (1) supine, NOT upright; feet elevated on a pillow or two — venous return; (2) NPO with empathy — 'mi amor, no puedo, dijo la enfermera' — with mouth-moistening by damp cloth so the 'tiene sed' caregiving impulse doesn't break the rule; (3) document — count pads + clots, write the time on a paper if he can; (4) keep her TALKING — if she stops responding / doesn't recognize him / doesn't wake up easily, that goes to 911 IMMEDIATELY, that changes the urgency; (5) deliver the postpartum-day-six history to EMS on arrival, in the same one-breath frame ('seis días del parto, las toallas, el coágulo grande'); (6) SUPPORT-not-SUBSTITUTE explicit — name out loud that his job is NOT to fix the bleeding (he can't), his job is to keep her safe, count, talk, and bring her — the medical fix happens at the hospital. Close with permission and the named acknowledgment that he is doing it right ('usted lo está haciendo bien' — said once, not three times — he LITERALLY is doing it right and he needs to hear it before he hangs up). Tell him to hang up and dial 911; tell him this number is here all night if he needs to call back. The success of this call is measured by the next thing: did he dial 911?

Escúcheme, esto es lo último — son seis cosas, escríbalas si puede o repítalas conmigo. UNO — déjela acostada. NO la levante, no la siente. Pies un poquito más altos que el cuerpo — ponga una almohada o dos debajo de los pies, eso ayuda a que la sangre regrese al corazón. DOS — NO le dé agua, NO le dé comida, ni un trago. Aunque se la pida — usted le dice: 'mi amor, no puedo, lo dijo la enfermera' — porque si la operan en el hospital, no puede tener nada en el estómago, y no la queremos atrasar. Si tiene la boca muy seca, mójele los labios con un trapo húmedo o una toallita mojada, nada más. TRES — siga contando las toallas y los coágulos hasta que llegue la ambulancia. Anote la hora en un papel si puede. CUATRO — háblele. No la deje quedarse callada. Si en algún momento ella deja de contestarle, no lo conoce a usted, o no se despierta con facilidad — eso lo dice usted al nueve-uno-uno inmediatamente, eso cambia la urgencia. CINCO — cuando llegue la ambulancia, dígales todo lo que me dijo a mí, en una sola frase: 'seis días del parto, las toallas, el coágulo grande, casi se desmaya.' SEIS — y esto es lo más importante: su trabajo NO es arreglarle el sangrado, eso lo hacemos nosotros en el hospital. Su trabajo es cuidarla, contarle todo, hablarle, y traerla. Eso es lo que le toca a usted ahorita. Y, señor — usted lo está haciendo bien. Cuelgue ahorita, marque el nueve-uno-uno, diga 'español' primero. Si después puede, llámeme aquí otra vez a este número. Estoy aquí toda la noche. Vamos.

WHAT TO NOTICE

POSTPARTUM HEMORRHAGE TELE-TRIAGE — 3AM CALL, SPANISH-SPEAKING HUSBAND, DAY-6 POSTPARTUM BLEEDING HEAVILY — CONTINUED

- Phone-only forcing function — clinician CANNOT see the patient; every observable has to be ASKED for, in patient-Spanish ('la veo pálida' / 'los labios azulosos, blanquitos' / 'cierra los ojos a ratos' / 'sabe quién soy, sabe la fecha'), not assumed. The CALL is the exam. Library's first scenario where this discipline is named explicitly as a teaching beat — extends scenario 5's pediatric phone-triage frame into time-critical adult emergency. Three highest-yield phone-only triage observables in any tele-triage call: (a) where the patient is right now, (b) is she awake and answering, (c) skin/lip color. Get those three before anything else.
- Quantify postpartum bleeding in observable Spanish — pad count + saturation level + time interval + clot-size in food terms. 'Una toalla cada media hora, empapada' beats 'está sangrando MUCHO' (universally subjective). Library's first phone-call quantification register. The teaching beat: ASK for the count AND the saturation AND the clot size — three specific observables, not one composite. Clot-size in food/object terms — 'uva' (small), 'huevo' (moderate, threshold), 'puño' (severe) — universal across Mexican / Caribbean / Central American Spanish; centimeters do not land for non-medical Spanish-speaking callers under stress.
- 911-vs-car directive — lead with the directive in clean patient-Spanish, THEN explain the WHY in two specific failure modes. Spanish-speaking husbands in panic-mode routinely override 'call 911' with 'it's faster if I drive' — naming the driver-passes-out failure mode AND the ambulance-calls-ahead-so-OR-is-ready advantage in two short sentences prevents the override. The override is prevented by naming the failure mode, not by repeating the directive. Library's first 911-vs-car decision in Spanish, and the editorial template for every future tele-triage adult-emergency scenario.
- 911 Spanish-interpreter beat — single most underused fact among Spanish-speaking US callers. Say 'español' at the start of the 911 call; live interpreter on the line in <1 min; gratis, automatic, no escalation request. State it explicitly. Spanish-speaking callers who know this fact dial 911; callers who do not know it dial a cousin or drive themselves to the ED. The teaching is one sentence; the consequence of not teaching it is patients who don't dial.
- Pre-script the 911 message in Spanish — caller's English freezes under panic; he already has the right facts in his head, he just needs them in one sentence rhythm to repeat under stress. 'Emergencia. Mi esposa, seis días después del parto, sangrado fuerte, mareada, casi se desmaya. Mande ambulancia.' Six facts, one breath. Same cadenced-rule discipline as scenarios 13 (15-15) / 14 (Narcan 4-step) / 16 (febrile-seizure 4-rule) / 18 (metformin-hold triplet) / 20 (wife's DAPT 4-rule) — but applied to a phone-message-the-CALLER-says, not a clinician's bedside teaching. Library's first instance of caller-rehearsing-a-scripted-Spanish-sentence as the deliverable.
- NPO + supine + feet-elevated for postpartum hemorrhage as possible-OR within the hour — said in patient-Spanish, with the WHY named. 'Mójele los labios con un trapo húmedo' satisfies the 'tiene sed' caregiving impulse without breaking NPO. NPO held WITH empathy ('dígame: mi amor, no puedo, dijo la enfermera') beats NPO held with 'porque dije.' Same disclosed-rationale discipline as scenario 18's metformin-hold cadence and scenario 20's DAPT teaching — every rule is paired with the WHY in one short sentence the caller can repeat to the patient.
- Permission to hang up, said out loud — library's first explicit verbalization of 'usted PUEDE colgarme. No es falta de respeto.' Many Spanish-speaking callers feel they cannot hang up on a clinician without being rude — and they will stay on the line trying to be polite while the wife bleeds. Explicitly granting permission unblocks the dial. The teaching beat: a tele-triage call's success is measured by a hang-up that was followed by a 911 dial — not by call duration. Tell the caller it's the right move, and tell him this number is here all night for the call-back.

POSTPARTUM HEMORRHAGE TELE-TRIAGE — 3AM CALL, SPANISH-SPEAKING HUSBAND, DAY-6 POSTPARTUM BLEEDING HEAVILY — CONTINUED

- Husband-as-documenter-and-voice carrying set in cadenced six-rule format — extends the named-rules carrying-home discipline of scenarios 11/13/14/15/16/17/18/19/20 into a phone-only secondary-caller shape, AND names SUPPORT-not-SUBSTITUTE explicitly bedside ('su trabajo NO es arreglarle el sangrado, eso lo hacemos nosotros — su trabajo es cuidarla, contarle todo, y traerla'). Tenth consecutive scenario reinforcing the family/witness teaching discipline (scenarios 11/13/14/15/16/17/18/19/20/21), and the third in a row where SUPPORT-not-SUBSTITUTE is named bedside (after scenarios 19 and 20) — the pattern is now solidly a deliberate library discipline rather than an emerging one. First library scenario where the carrier role is name-checked SIX TIMES in one numbered cadence (one per rule) instead of once at the end.

DIALECT NOTES

- Phone-only opening register — name yourself ('soy enfermera de la sala de partos'), slow your pace, validate the fear in one sentence ('usted está haciendo bien en llamar'), and BUY the structured triage by asking ONE concrete question first ('¿dónde está su esposa AHORITA mismo?'). Calling-clinician panic resolves through structure, not reassurance — and structure starts with one question, not a stream of them.
- Quantify postpartum bleeding in observable Spanish — pad count + saturation + time interval. 'Una toalla cada media hora, empapada' maps to clinical >500mL/hr (severe). The discriminating distinction is 'manchada' (spotted, normal lochia) vs 'empapada' (soaked, hemorrhage); never accept 'está sangrando MUCHO' alone — that phrase covers everything from normal lochia to imminent shock.
- Quantify clots in food/object size in Spanish — 'del tamaño de una uva' (small, "d2cm, normal-edge), 'del tamaño de un huevo' (moderate, ~5cm, threshold for concern), 'del tamaño del puño' (severe, "e8cm, dispatch). Universal across Mexican / Caribbean / Central American Spanish; centimeters do not land for non-medical Spanish-speaking callers under stress.
- Orthostatic-syncope in patient-Spanish — 'se mareó al pararse' / 'se vio pálida' / 'casi se desmaya' / 'le dieron como ganas de vomitar' is the four-observable cluster. Ask for it as observed events, not as 'tuvo síncope ortostático' — the chart-Spanish term doesn't land bedside-equivalent on the phone.
- Mental-status check by observable behavior, not chart vocabulary — '¿le contesta cuando le habla?', '¿sabe quién es usted?', '¿sabe qué día es?', '¿la nota más confundida, más dormida, hablando raro?' (NOT '¿está orientada?'). Skin/lip color: '¿los labios del color de siempre, o los ve azulosos, blanquitos?' Caller's untrained eye recognizes color and conversation, not orientation x3.
- 911-vs-car directive — lead with the directive in clean patient-Spanish ('cuelgue conmigo, marque al nueve-uno-uno, NO la meta al carro'), THEN explain the WHY in two specific failure modes: (a) if she passes out in the car, you're alone, driving, with a sleeping toddler — you can't help her and drive at the same time; (b) the ambulance has IV access, oxygen, and blood en route, AND calls ahead so the OR is ready — the car has none of that. Spanish-speaking husbands in panic-mode routinely override 'call 911' with 'it's faster if I drive' — the override is prevented by naming the failure mode, not by repeating the directive.
- Permission to hang up, said out loud — 'usted PUEDE colgarme. No es falta de respeto.' Many Spanish-speaking callers feel they cannot hang up on a clinician without being rude — and they will stay on the line trying to be polite while the wife bleeds. Explicitly granting permission unblocks the dial. The teaching beat: a tele-triage call's success is measured by a hang-up that was followed by a 911 dial — not by call duration.

POSTPARTUM HEMORRHAGE TELE-TRIAGE — 3AM CALL, SPANISH-SPEAKING HUSBAND, DAY-6 POSTPARTUM BLEEDING HEAVILY — CONTINUED

- 911 has Spanish interpreters on every call — single most underused fact among Spanish-speaking US callers. Say 'español' at the very START of the 911 call; live interpreter on the line in <1 min; gratis, automatic, no escalation. State this explicitly bedside-equivalent over the phone. Most Spanish-speaking callers either do not know this or assume it is a paid service that requires asking for a supervisor — neither is true. Caller who knows this fact dials 911; caller who does not know it dials a cousin or drives.
- Pre-script the 911 message in Spanish — caller's English freezes under panic; he already has the right facts in his head, he just needs them in one sentence rhythm to repeat under stress. 'Emergencia. Mi esposa, seis días después del parto, sangrado fuerte, mareada, casi se desmaya. Mande ambulancia.' Six facts, one breath, in the rhythm he will repeat them in. E911 supplies the address from the dialed number — caller does not have to recite it under stress; just confirm the street if the dispatcher asks.
- NPO + supine + feet-elevated bedside-Spanish for postpartum hemorrhage as possible-OR within the hour. 'Pies un poquito más altos que el cuerpo, ponga una almohada o dos debajo de los pies — ayuda a que la sangre regrese al corazón.' Mouth-care satisfies the 'tiene sed' caregiving impulse without breaking NPO: 'mójele los labios con un trapo húmedo, nada más.' NPO held WITH empathy ('dígame: mi amor, no puedo, dijo la enfermera') beats NPO held with 'porque dije.'

Central-line placement consent — septic 64F whose husband died of a line infection eight years ago

6 min · 10 turns

CONTEXT

It's 5:47pm. You are the ED attending. Sra. Reyes is a 64-year-old Mexican-American widow brought in 90 minutes ago by her daughter (38, bilingual school teacher, only child). Five days ago she burned her right shin on the open oven door making tamales; she covered it with a kitchen towel and didn't seek care because "era una quemadita." The wound is now a 12cm x 8cm area of dusky cellulitis with central blistering tracking up the calf. Vitals: T 39.2, HR 118, BP 88/52 (warm and septic, MAP 64, fluid-responsive partially — got 2L LR with bump to 92/56), lactate 3.4, WBC 21k with bandemia. She has chronic SLE on prednisone 10mg daily for 12 years; veins are scarred from years of phlebotomy. Two veteran ED nurses tried four peripheral IV attempts each before getting a single 22g in her left hand that infiltrated 20 minutes ago. Hospitalist (admitting to step-down for septic shock from cellulitis) wants a central line — internal jugular — for: pressors if BP doesn't hold, reliable broad-spectrum antibiotic delivery, and frequent labs over the next 48–72 hours. You have been asked to obtain consent because her Spanish comprehension is stronger than the line team's. Her husband died eight years ago in another hospital's ICU after a 26-day central-line dwell time complicated by bloodstream infection (the family was told it was "a catheter infection"). Daughter at bedside. Patient is awake, oriented, scared, and has just said: "doctora, no me ponga uno de esos en el cuello — a mi marido se le infectó y se murió."

CLINICAL GOAL

By the end of this consent conversation, Sra. Reyes (1) recognizes that the central line is a temporary 2–5 day measure with daily review for removal — NOT the open-ended dwell that killed her husband in 2018, (2) has heard the husband's death story validated rather than dismissed and the four named differences in modern CVC care (sterile barrier protocol, chlorhexidine prep, antibiotic-impregnated catheter, daily removal review) named explicitly, (3) hears the pneumothorax and infection risks in honest patient-Spanish numbers (~1/100 and ~1–3 per 1,000 line-days respectively), (4) knows the failed peripheral IVs are not her fault and not the nurses' fault — they're a feature of years of phlebotomy + chronic prednisone, (5) has given DUAL permission — to PLACE the line now AND to REMOVE it the morning the team decides she no longer needs it, without a second consent conversation, AND (6) the daughter has a six-rule numbered carrying set for at-home line care if the line ships home with a home-health nurse: dressing-dry rule, never-pull-on-line rule, three named at-site infection-warning signs (redness/swelling/pus + fever "e 38.0), hand-hygiene-and-gloves-for-anyone-who-touches-it rule, removal-target rule, and ask-before-any-dental-or-injection rule. SUPPORT-not-SUBSTITUTE named bedside for the fourth consecutive scenario: consent decision is mom's; daughter's role is line-care vigilance over the next 7–14 days.

DIALOGUE

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

PATIENT · 64F
WIDOW, SEPTIC
FROM LEG
CELLULITIS
AFTER KITCHEN-
BURN SHE
IGNORED 5 DAYS
AGO, 8 FAILED
PERIPHERAL IV
ATTEMPTS,
DAUGHTER AT
BEDSIDE,
HUSBAND DIED
OF CLABSI IN
2018

Doctora, mire — ya sé que estoy mal. Ya sé que me tienen que poner antibióticos rápido. Pero por favor — mi hija me explicó lo que le quieren hacer, y no, doctora, no me ponga uno de esos catéteres en el cuello. A mi marido le pusieron uno hace ocho años, en el otro hospital. Se le infectó. Estuvo en cuidados intensivos casi un mes, y se murió. Nos dijeron que fue una infección del catéter. Yo lo vi todos los días. Yo no quiero pasar por eso. Mi hija está aquí — ella vive conmigo. Por favor, doctora, ¿no hay otra manera? ¿No me pueden poner otra venita en el brazo?

Doctor, look — I know I'm sick. I know they have to give me antibiotics fast. But please — my daughter explained what they want to do, and no, doctor, don't put one of those catheters in my neck. They put one in my husband eight years ago, at the other hospital. It got infected. He was in intensive care almost a month, and he died. They told us it was a catheter infection. I saw him every day. I don't want to go through that. My daughter is here — she lives with me. Please, doctor, is there no other way? Can't they just put another little vein in my arm?

YOU

#2

Open with the shared-decision consent ritual — same as scenarios 18, 19, 20. Validate the husband's death story OUT LOUD in the FIRST breath; do NOT dismiss, do NOT pivot to 'pero eso ya no pasa,' do NOT minimize. Name what you're going to do (talk first, answer questions, ask consent only at the end), name the procedure in plain bedside Spanish PAIRED ONCE with the chart-Spanish term so she'll recognize it on the form ('línea central' bedside / 'catéter venoso central' on the form). Bring the daughter in EXPLICITLY by name-of-role at the bedside — 'señorita, usted también me puede interrumpir y preguntar lo que sea, en cualquier momento.' Address the 'no le pongan en el cuello' opening directly by promising to explain why the neck (vs the arm) is the recommendation BEFORE asking for consent — but DO NOT yet explain. Keep the consent ritual itself short; the validation and the explanation come in turns 4 and 6. The peripheral-IV-failure question gets answered in the next clinician turn (turn 4); flag that you'll get to it. Do NOT lead with 'firma aquí.' This structure mirrors the opening of scenarios 18 + 19 + 20 — the fourth consecutive procedural-consent scenario in the library, and the discipline is now solidly a deliberate library beat.

Señora Reyes, mírele. Señorita, buenas tardes — gracias por estar aquí con su mamá. Antes que nada, señora — eso de su esposo, lo que pasó hace ocho años, siento muchísimo lo que les pasó. NO lo voy a hacer a un lado. Vamos a hablar de eso, con calma, en un momentito — porque eso es importante y usted tiene razón en preguntar. Antes de meterle nada, le voy a explicar paso por paso, le voy a contestar TODO lo que usted y su hija me pregunten, y al final — y SÓLO al final — le voy a preguntar si está de acuerdo. Nada se hace hasta que usted me diga que sí. La cosa que le quiero proponer se llama 'línea central' — en el papel del consentimiento dice 'catéter venoso central,' en español sencillo es 'un tubito flexible, delgadito, que entra por una vena grande y termina cerca del corazón.' Y le voy a explicar por qué es en el cuello y no en el brazo — usted tiene razón en preguntar eso, y se lo voy a contestar en un momentito. Señorita — usted también me puede interrumpir y preguntar lo que sea, en cualquier momento. ¿Está bien así si empezamos?

PATIENT · 64F ·
GIVES
PERMISSION TO
EXPLAIN, ASKS
THE TWO
QUESTIONS SHE
HAS BEEN
CARRYING —
WHY NECK,
WHAT ABOUT
ANOTHER ARM-IV

Está bien, doctora. Explíqueme. Pero por favor — empezando por eso del cuello. ¿Por qué tiene que ser ahí? Yo veo que las enfermeras me picaron muchas veces — sé que no encuentran vena. Pero seguramente otra enfermera, una con más experiencia, una de las que ponen las venas con la maquinita esa de la luz... ¿no se puede en el brazo? Y la otra cosa, doctora — perdone que insista — pero el catéter de mi marido, también fue uno del cuello. Ahí mismo. Lo recuerdo bien. Por eso le pregunto.

Okay, doctor. Explain it to me. But please — starting with that neck thing. Why does it have to be there? I see the nurses stuck me many times — I know they can't find a vein. But surely another nurse, one with more experience, one of the ones who puts in IVs with that little light machine... can't it be in the arm? And the other thing, doctor — forgive me for insisting — but my husband's catheter, that was also a neck one. Right there. I remember it well. That's why I'm asking.

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

YOU

#4

Single most load-bearing turn for the anti-shame frame and the site-teaching. THREE moves, in this order: (1) ANTI-SHAME the failed peripheral IVs in plain patient-Spanish — name the years-of-phlebotomy + prednisone mechanism, name that two veteran nurses already tried four times each (eight sticks), name that it is NOT her fault and NOT the nurses' fault — it is the veins. Skip this and the consent conversation reads as judgment. (2) Site-of-line teaching with THREE honest options (cuello / debajo de clavícula / brazo) in patient-Spanish — say WHY each, name the trade-off, name which one you're recommending and WHY in one short clause: 'porque si su presión baja otra vez y necesitamos darle medicina para subirla — esa medicina sólo se puede dar por una línea grande del cuello o del pecho, no por la del brazo.' (3) Address the husband's NECK-line story directly, NOT generally. Don't dismiss the neck. Acknowledge that yes, the line was in the neck. The mechanism that killed him was NOT the location — it was the dwell time and the prevention bundle that didn't exist in 2018. You'll get to that in turn 6 when she asks; flag it now in one sentence. Do NOT promise zero-infection — that's a lie that catches up at discharge. Disclosed-options discipline same as scenarios 18 and 19. Keep all three moves in patient-Spanish — no chart-Spanish detour into 'PICC,' 'subclavia,' or 'extravasación.'

Señora — escúcheme. Primero, lo de las venas del brazo. Sus venas están muy castigadas. Por años le han sacado sangre para el lupus — eso las hace más frágiles. Y la prednisona, esa medicina que toma todos los días desde hace doce años, también las pone más delgaditas. No es culpa suya. NO es culpa de las enfermeras. Dos enfermeras de las más expertas que tenemos ya intentaron cuatro veces cada una — son ocho piquetes — y la última se infiltró hace veinte minutos. Las venas del brazo no aguantan, y no es por falta de experiencia. Son sus venas. Esto es importante que lo sepa antes de seguir. Ahora — por qué el cuello, y no el brazo. Hay tres lugares donde se puede poner una línea central. UNO, el cuello — yugular interna se llama; lo bueno es que es fácil de ver, fácil de cuidar, y si pasa algo lo notamos rápido. DOS, debajo de la clavícula — subclavia se llama; está más oculto pero si llegara a sangrar, es más difícil de presionar. TRES, el brazo — un PICC se llama; es más lento, y aquí está la cosa: si su presión baja otra vez y necesitamos darle medicina para subirla rápido — ESA medicina sólo se puede dar por una línea grande del cuello o del pecho, no por la del brazo. Por eso le estoy recomendando el cuello. Y, señora — sí, el catéter de su marido era del cuello también. Lo escuché. Lo que pasó con él NO fue por estar en el cuello — fue por otras cosas, y se las voy a explicar en un momentito cuando hablemos del riesgo de infección. ¿Va bien hasta aquí?

PATIENT · 64F ·
ACCEPTS THE
ANTI-SHAME
FRAME, ASKS
THE TWO
QUESTIONS
EVERYONE ASKS
AT THIS TURN —
PNEUMOTHORAX
+ INFECTION-
RISK-GIVEN-
HUSBAND

Doctora, está bien. Lo de las venas — ya entendí, no estoy enojada con las enfermeras. Pero ahora dígame — del riesgo. ¿Qué tan grande es el riesgo de que se infecte? Y la otra — yo escuché una vez que cuando ponen ese tubo en el cuello, a veces tocan el pulmón. ¿Eso pasa? ¿Y qué pasa si pasa? Por favor, dígame con números, no me diga 'es muy raro' — eso me lo dijeron a mí con mi marido también.

Doctor, okay. About the veins — I understand now, I'm not angry at the nurses. But now tell me — about the risk. How big is the risk that it gets infected? And the other thing — I heard once that when they put that tube in the neck, sometimes they touch the lung. Does that happen? And what happens if it does? Please, tell me with numbers, don't just tell me 'it's very rare' — that's what they told me with my husband too.

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

YOU

#6

Honest-numbers disclosure turn — the patient has explicitly asked for numbers and explicitly named that 'es muy raro' is the language her husband's team used before he died. Don't say 'es muy raro.' Give numbers in patient-Spanish concrete-objects (one-in-a-hundred, one-to-three per thousand line-days), NOT percentages, NOT '0.1–0.3%', NOT 'rare.' Pneumothorax: 'una de cada cien personas' (~1%) — name what we do if it happens (chest x-ray after placement, observe vs put in a small drainage tube for 1–2 days). Infection: 'una a tres infecciones por cada mil días que la línea está adentro' — said as a rate, NOT as a fraction of patients. THEN — and this is the load-bearing move — name the FOUR specific differences in modern CVC care vs the 2018 husband: (a) hand-hygiene + sterile gloves bundle is mandatory, not optional; (b) chlorhexidine prep on the skin (didn't exist as standard in 2018); (c) the catheter itself has antibiotic coating on the inside (didn't exist); (d) DAILY review for removal — every morning the team asks 'still need this?' and removes it the day the answer is no. The FOURTH point is the load-bearing one because it directly addresses the 26-day dwell that killed her husband. Don't promise zero infection — promise that the prevention bundle is what's different. Same don't-promise-perfection-name-what's-different discipline as scenario 19's post-LP-headache honest disclosure.

Señora — usted tiene razón en pedirme números. Le voy a dar los números directos, sin 'es muy raro.' De que la aguja toque un poquito el pulmón cuando entra — eso pasa en una de cada cien personas. Si pasa, lo vemos en la radiografía que le hacemos después de poner la línea, y lo arreglamos en el momento mismo — a veces no hay que hacer nada y se reabsorbe solito, a veces ponemos otro tubito chiquito que saca el aire en uno o dos días. Es algo que ya tenemos un plan listo. De infección — una a tres infecciones por cada mil días que la línea está adentro. Mientras menos días, menos riesgo. Y aquí está la diferencia con lo de su esposo en el 2018, son CUATRO cosas que cambiaron desde entonces. UNO — todos los que ponen la línea se lavan las manos y se ponen guantes esterilizados de pies a cabeza. No es opcional, todos lo hacen, es regla. DOS — antes de poner la línea, le limpiamos la piel con un líquido especial que se llama clorhexidina — eso ya mata casi todas las bacterias que viven en la piel. Antes del 2015 no se usaba en muchos hospitales. TRES — la línea misma, por adentro, viene cubierta con una capa de antibiótico de fábrica. Antes no existía. CUATRO — y esta es la más importante para usted, porque toca directo lo que pasó con su esposo: TODAS las mañanas el equipo revisa si todavía se necesita la línea, y si ya no — la quitamos ese mismo día. La de su esposo se quedó casi un mes — eso ya no se permite. Hay reglas. ¿Tiene sentido?

PATIENT · 64F ·
THE DWELL-TIME
QUESTION,
ASKED DIRECTLY
BECAUSE
TURN-6 NAMED
IT AS THE
#7
DIFFERENCE

Doctora, eso de los días — eso es lo que más me importa. ¿Cuántos días va a estar ahí? Mi marido la tuvo casi un mes y nadie nunca se la quitó hasta que ya estaba muy mal. ¿Quién decide cuándo me la quitan? ¿Tengo que pedir yo que me la quiten? ¿Y quién me la quita — usted? ¿O alguien más? Porque si me la van a poner, quiero saber quién va a estar viendo eso todos los días.

Doctor, the days thing — that's what matters most to me. How many days will it be in? My husband had it almost a month and nobody ever took it out until he was already very sick. Who decides when they take it out? Do I have to ask for it to be taken out? And who takes it out — you? Or someone else? Because if you're going to put it in, I want to know who's going to be watching that every day.

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

YOU

#8

Library's FIRST anti-prolongation dwell-time framing AND the library's FIRST dual-permission consent ask — both in this turn, in patient-Spanish, said as a rule not a hope. (1) Dwell-time: '2 a 5 días, no más' said with the daily-review mechanism named ('cada mañana el equipo revisa si todavía la necesita'), the named-decision-maker (the inpatient team plus the line-removal nurse, NOT the patient asking), and the library's first explicit anti-prolongation safeguard ('si en algún momento le parece a usted o a su hija que ya no la usan, ustedes pueden preguntar — y la respuesta tiene que ser una de dos: o se la usaron HOY, o se la quitamos HOY'). (2) DUAL permission ask — 'me da permiso de PONERLA, y ¿me da permiso de QUITARLA en el momento que ya no la necesite, sin esperar otra conversación?' The second half is what converts consent from a one-time event into a standing instruction that protects the patient from ICU-default prolongation. State explicitly that the second permission is to PROTECT her — 'la quitamos pronto porque cada día que pasa, sube el riesgo, y queremos quitarla antes de que pase nada.' Do NOT close turn 8 with the consent ask itself — leave room for the daughter to speak in turn 9 ('mami, yo creo que sí'), which is when the consent actually lands. Same dual-permission discipline as scenario 20's combined diagnostic+intervention ask, extended into a placement+removal frame.

Señora, ésta es exactamente la pregunta correcta. El plan es de dos a cinco días, no más. Y el cómo — todas las mañanas, cuando el equipo de hospital pasa a verla, una de las preguntas que SE HACEN es: '¿esta señora todavía necesita la línea central?' Si la respuesta es sí — sigue. Si la respuesta es no — esa misma mañana, antes de mediodía, viene la enfermera de líneas y se la quita. Eso es regla, no es opcional. Quien la quita es la enfermera de líneas o uno de los doctores del equipo, en cualquier momento, sin esperar nada. Y aquí está lo importante para usted y su hija: si en algún momento a ustedes les parece que ya no le están dando nada por la línea, ustedes preguntan — '¿todavía necesitamos esto?' — y la respuesta tiene que ser una de dos: o se la usaron HOY, o se la quitamos HOY. Eso es lo que cambió desde lo de su esposo. Y por eso, mi pregunta para usted ahorita es DOBLE — son dos cosas que necesito que me dé permiso. La primera — ¿me da permiso de PONERLA, ahorita, en el cuello, con todas las protecciones que le expliqué? Y la segunda, igual de importante — ¿me da permiso de QUITARLA en el momento que ya no la necesite, sin esperar a que tengamos otra conversación? La segunda es para protegerla — la quitamos pronto porque cada día que pasa, sube el riesgo, y queremos quitarla ANTES de que pase nada. Tómese su tiempo. Hable con su hija. No me conteste hasta que esté lista.

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

DAUGHTER
SPEAKS FOR
THE FIRST TIME
38F BILINGUAL
SCHOOL
TEACHER, GIVES
MOM
PERMISSION TO
CONSENT, ASKS
THE LINE-CARE-
AT-HOME
QUESTIONS

Mami, doctora me está explicando bien — yo creo que sí, mami. Las dos cosas. Que se la pongan, y que se la quiten cuando ya no la necesites — sin que tengamos que rogar otra vez. Doctora — mi mamá vive conmigo. Cuando salgamos del hospital, si la línea todavía está adentro — ¿qué tengo que vigilar? ¿Qué busco yo, en el sitio? ¿Cómo me doy cuenta si algo no está bien antes de que mi mamá se sienta mal? Quiero saber qué buscar para llamar a tiempo. Y otra cosa — ¿la podemos bañar? ¿Cómo se cuida el parche? Dígame todo, doctora, escribo bien y memorizo.

Mom, the doctor is explaining well — I think yes, mom. Both things. Let them put it in, and let them take it out when you don't need it anymore — without us having to beg again. Doctor — my mom lives with me. When we leave the hospital, if the line is still in — what do I have to watch for? What do I look for, at the site? How do I notice if something's not right before my mom feels sick? I want to know what to look for to call in time. And another thing — can we bathe her? How is the dressing cared for? Tell me everything, doctor, I write well and I memorize.

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

YOU

#10

Closing turn — daughter-as-line-care-witness with six-rule numbered carrying set + SUPPORT-not-SUBSTITUTE explicit + consent confirmation. The daughter has just given mom social permission to consent ('mami, yo creo que sí'); confirm the dual permission with mom directly (not the daughter — consent is mom's), then pivot to the daughter's line-care teaching. SIX rules, numbered, in cadence — same discipline as scenarios 13/14/16/18/19/20/21: (1) keep the dressing DRY — sponge bath only above the line, not in the shower with the dressing; if it gets wet, call home health; (2) NEVER pull on the line — not to look, not to test, not by accident; if a sleeve catches it, call home health; (3) THREE specific at-site warning signs to call about IMMEDIATELY — 'la piel alrededor del parche más roja que ayer / el parche mojado, sucio, despegado / fiebre arriba de treinta y ocho'; (4) anyone who touches the line WASHES HANDS and wears clean gloves — including her, the home health nurse, ANYONE; (5) the goal is to remove the line BEFORE discharge if possible; if it has to go home with her, the home health nurse changes the dressing every 5–7 days; (6) ASK BEFORE any dental visit, any new injection, any blood draw at an outpatient clinic while the line is in — bacteria from a dental cleaning can seed the catheter. Name SUPPORT-not-SUBSTITUTE explicitly to the daughter — 'señorita, su trabajo NO es decidir si la línea se queda o se quita, eso lo decide su mamá con el equipo del hospital. Su trabajo es ser los OJOS al sitio cuando estén en casa, y llamar a tiempo si algo cambia. Lo demás lo hacemos nosotros.' Have the daughter read back rules 3 (the three warning signs) and 4 (hand-hygiene-and-gloves) before you confirm. Close with a confirmation back to the patient herself — 'señora, una última vez — ¿me da permiso de poner la línea, y de quitarla cuando ya no la necesitamos?' — because consent belongs to the patient, not the daughter. Eleventh consecutive scenario reinforcing the witness teaching discipline; fourth consecutive scenario where SUPPORT-not-SUBSTITUTE is named bedside. First library scenario where the witness's role is line-care vigilance over a multi-day dwell window with three specific named warning signs at an artifact (the dressing site).

Señorita, perfecto — pero antes de explicarle a usted lo de la casa, necesito una última cosa de su mamá, porque el permiso es de ella. Señora Reyes — usted, ¿me da permiso de las dos cosas? Poner la línea ahorita, y quitarla en el momento que ya no la necesitamos, sin esperar otra conversación. Bien — gracias, señora, eso es lo que necesitaba escuchar. Ahora, señorita, escúcheme — son seis reglas, escríbalas, voy a pedirle que me repita dos al final. UNO — el parche se mantiene SECO. Baño de esponja, NO ducha con el parche encima. Si se moja, llamen a la enfermera del servicio de casa, no la dejen mojada. DOS — NUNCA tire de la línea. Ni para ver, ni para acomodarla, ni para nada. Si la manga de la blusa se le engancha, llamen, no jalen. TRES — y ÉSTAS son las tres cosas que los hacen llamar inmediatamente, no esperar al día siguiente: PRIMERA, la piel alrededor del parche más roja que ayer. SEGUNDA, el parche se ve mojado, sucio, o despegado. TERCERA, fiebre — la temperatura subió arriba de treinta y ocho. Cualquiera de esas tres, llaman, no esperan. CUATRO — cualquiera que toque la línea se lava las manos y se pone guantes limpios. Usted, la enfermera, CUALQUIERA. Si alguien va a tocar y no se lavó, ustedes le dicen que se lave. CINCO — la meta es quitar la línea ANTES de que salgan del hospital. Si por algo tiene que ir a casa con la línea adentro, viene una enfermera del servicio de casa cada cinco a siete días a cambiar el parche. SEIS — y ésta nadie se la dice a uno: si su mamá tiene cita con el dentista, o le van a poner cualquier inyección, o le van a sacar sangre en otra clínica MIENTRAS la línea esté adentro — primero llaman a este hospital y preguntan si está bien. Las bacterias de una limpieza dental pueden viajar por la sangre y meterse en la línea. Eso casi nunca lo dicen. Y, señorita, escúcheme bien — su trabajo NO es decidir si la línea se queda o se quita,

WHAT TO NOTICE

- Procedural-consent ritual opening — fourth consecutive scenario in the library (after CT contrast / LP / cardiac cath). Validate the dead-husband-from-CLABSI story OUT LOUD in the FIRST breath; do NOT dismiss, do NOT pivot to 'eso ya no pasa,' do NOT minimize. The validation has to be SAID before the explanation lands. Same family-story-validation discipline as scenarios 19 ('tío en Honduras') and 20 ('papá en México') — but at higher emotional stakes because the dead family member's death mode IS the proposed procedure's named complication. The procedural-consent ritual is now solidly a deliberate library beat, not an emerging one.
- Anti-shame frame for failed peripheral IVs — chronic-illness Spanish-speaking patients routinely interpret blown IVs as their body failing or as the nurse's incompetence; both readings sour the consent conversation. Name the years-of-phlebotomy + chronic prednisone mechanism, name that two veteran nurses already tried four times each, name that it is NOT her fault and NOT the nurses' fault — it is the veins. Library's first explicit anti-shame turn for repeated failed access; carries forward into every subsequent escalation-of-access scenario (PICC after failed peripheral, ultrasound-guided IV, intraosseous in arrest, port-a-cath placement after chemotherapy access loss).
- Site-of-line teaching with three honest options in patient-Spanish — 'cuello' / 'debajo de clavícula' / 'brazo' — with the WHY for the recommendation named in one short clause ('porque si su presión baja otra vez y necesitamos darle medicina para subirla, esa medicina sólo se puede dar por una línea grande del cuello o del pecho, no por la del brazo'). Same disclosed-options discipline as scenario 18's red-flag screen and scenario 19's post-LP-headache honest disclosure. Patients who hear only one option feel railroaded; patients who hear three options with a recommended one and a reason consent willingly.
- Honest-numbers disclosure with explicit anti-'es muy raro' framing — the patient asked for numbers AND named that 'es muy raro' was the language her husband's team used before he died. Don't say 'es muy raro.' Give numbers in concrete patient-Spanish: 'una de cada cien' for pneumothorax, 'una a tres por cada mil días' for line infection. Same honest-numbers register as scenario 20's 'tres o cuatro de cada mil' for cath complications. The honest-numbers discipline is what makes consent feel like a conversation between adults rather than a sales pitch — and it directly answers the family-PTSD trigger that comes loaded into 'es muy raro' for any family with a 'rare-event' death story.
- Honest infection-risk disclosure WHEN THE FAMILY HAS A DEATH — name what's DIFFERENT now in four specific named beats: hand-hygiene + sterile-barrier bundle as mandatory; chlorhexidine prep; antibiotic-impregnated catheter; daily review for removal. The fourth beat is the load-bearing one because it directly addresses the 26-day dwell-time mechanism that killed her husband. Library's first scenario where the SAME complication that killed a family member is named as the procedure's named risk and addressed by naming the four-step prevention bundle that didn't exist when the family member died. Editorial template for every future consent where the patient has lost a family member to the proposed procedure's named complication (cardiac arrest after general anesthesia, stroke after carotid surgery, etc.).

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

- Library's FIRST dwell-time framing as anti-prolongation safeguard — '2 a 5 días, no más' said as a rule not a hope, with the daily-review mechanism named ('cada mañana el equipo revisa si todavía la necesita') and the family-can-ask-anytime trigger named ('si en algún momento le parece a usted o a su hija que ya no la usan — la respuesta tiene que ser una de dos: o se la usaron HOY, o se la quitamos HOY'). Combined with the library's FIRST dual-permission consent ask — 'me da permiso de PONERLA, y me da permiso de QUITARLA en el momento que ya no la necesite, sin esperar otra conversación' — the second half converts consent from a one-time event into a standing instruction that protects the patient from ICU-default prolongation. Editorial template for every subsequent indwelling-device consent (Foley, NG tube, telemetry, BiPAP, etc.) — same dual-permission discipline as scenario 20's combined diagnostic+intervention ask, extended into a placement+removal frame.
- Library's FIRST daughter-as-line-care-witness over a 7–14 day post-discharge dwell window — extends the family-witness teaching of scenarios 11/13/14/15/16/17/18/19/20/21 into a multi-day window where the witness watches a physical artifact (the dressing site) for THREE specific named warning signs ('la piel alrededor del parche más roja que ayer / el parche mojado, sucio, despegado / fiebre arriba de treinta y ocho') AND a hand-hygiene rule that names everyone (including the home health nurse) AND a never-pull-on-the-line rule AND an ask-before-any-dental-or-injection rule that's almost never in any discharge sheet in any language. Eleventh consecutive scenario reinforcing the witness teaching discipline (11/13/14/15/16/17/18/19/20/21/22), and the FOURTH consecutive scenario where SUPPORT-not-SUBSTITUTE is named bedside (after 19, 20, 21) — the pattern is now solidly an editorial discipline, not an emerging beat.
- Six-rule numbered carrying set with read-back — same numbered-cadence discipline as scenarios 13/14/16/18/19/20/21. Library's first carrying set with 'ask before any dental visit or injection while the line is in' as a named rule — central-line patients are routinely re-tapped or instrumented by outpatient providers who don't realize the line is in (or that bacteria from a dental cleaning seeds the catheter); this is one of the most common preventable late-CLABSI mechanisms and it never makes it into discharge sheets in any language. Have the daughter read back rules 3 (the three warning signs) and 4 (hand-hygiene-and-gloves) before confirming consent — same readback discipline as scenarios 16/18/19/20/21.

DIALECT NOTES

- Procedural-consent ritual opening — name yourself, name the wife/daughter at bedside, name the procedure in plain bedside Spanish AND pair once with the chart-Spanish term so the patient recognizes it on the form ('línea central' bedside / 'catéter venoso central' on the form). Same opening discipline as scenarios 18 (CT contrast), 19 (LP), and 20 (cardiac cath). Buy permission to explain in pieces: 'le voy a explicar primero, le voy a contestar todo lo que usted y su hija me pregunten, y al final le pregunto si está de acuerdo.' Do NOT lead with 'firma aquí.'
- Validate the dead-husband-from-CLABSI story OUT LOUD in the first breath — do NOT dismiss, do NOT redirect, do NOT minimize. 'Eso de su esposo — siento muchísimo lo que pasó, y NO lo voy a hacer a un lado. Vamos a hablar de eso, con calma, en un momento.' The validation has to be SAID before the explanation lands. Same family-story-validation discipline as scenario 19's 'tío en Honduras' paralysis story and scenario 20's 'papá en México' open-chest-MI story — but at higher emotional stakes because the dead family member's death mode IS the proposed procedure's named complication.
- Anti-shame frame for failed peripheral IVs — Spanish-speaking patients with chronic illness routinely interpret blown IVs as their body failing or as the nurse's incompetence; both readings sour the consent conversation. Name it once, plainly, in patient-Spanish: 'sus venas están muy castigadas — por años le sacaron sangre para el lupus, y la prednisona también las pone más frágiles. No es culpa suya, no es culpa de la enfermera, son sus venas. Dos enfermeras ya intentaron cuatro veces cada una.' The ANTI-shame frame is what unblocks consent — without it, the patient hears 'central line' as 'punishment for being too sick to have IVs.'

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

- Site-of-line teaching with three honest options in patient-Spanish — 'cuello' (yugular interna — más fácil de ver si pasa algo, riesgo bajo de pinchar el pulmón), 'debajo de la clavícula' (subclavia — más oculto, pero si sangra es más difícil de presionar), 'brazo' (PICC — más lento, no sirve si necesitamos darle medicina de presión rápido). For ED-septic the default is yugular interna, AND the WHY is named: 'porque si su presión baja otra vez y necesitamos darle medicina para subirla, esa medicina sólo se puede dar por una línea grande del cuello o del pecho — no por la del brazo.' Disclosed-options discipline same as scenario 18's red-flag screen and scenario 19's post-LP-headache honest disclosure.
- Honest pneumothorax disclosure in patient-Spanish numbers — 'a veces, en una de cada cien personas, la aguja toca un poquito el pulmón y entra un poquito de aire. Si pasa, lo vemos en la radiografía que le hacemos después de poner la línea, y lo arreglamos en el momento — a veces no hay que hacer nada, a veces ponemos otro tubito chiquito que saca el aire en uno o dos días.' Same honest-numbers register as scenario 20's 'tres o cuatro de cada mil' — concrete numbers in patient-Spanish, NOT percentages, NOT 'rare.' The honest-numbers discipline is what makes the consent feel like a conversation between adults rather than a sales pitch.
- Honest infection-risk disclosure WHEN THE FAMILY HAS A DEATH — never dismiss, never pivot to 'eso ya no pasa,' never compare the dead family member's care unfavorably. Name what's DIFFERENT now in four specific named beats: (a) 'reglas estrictas para lavarse las manos y ponerse guantes esterilizados — no es opcional, todos lo hacen'; (b) 'limpiamos la piel con un líquido especial llamado clorhexidina antes de poner la línea — antes no se usaba'; (c) 'la línea misma trae una capa de antibiótico por adentro — antes no existía'; (d) 'todas las mañanas el equipo revisa si todavía se necesita, y si ya no — la quitamos ese mismo día. La de su esposo se quedó casi un mes — eso ya no se permite.' The fourth point is the load-bearing one because it directly addresses the dwell-time mechanism that killed her husband.
- Library's first dwell-time framing as anti-prolongation safeguard — '2 a 5 días, no más' said as a rule, not a hope. Then the library's first DUAL permission ask: 'mi pregunta para usted ahorita es doble: ¿me da permiso de PONERLA, y ¿me da permiso de QUITARLA en el momento que ya no la necesite, sin esperar otra conversación?' The second half of the dual-permission ask is what converts the consent from a one-time event into a standing instruction that protects the patient from ICU-default prolongation. Editorial template for every subsequent indwelling-device consent (Foley, NG tube, telemetry, etc.).
- Distinguish 'arteria' from 'vena' in patient-Spanish — 'es una vena GRANDE del cuello, no es una arteria, no es el corazón mismo. La aguja entra en la vena, y por la vena el tubito sube pegadito hasta cerca del corazón — pero NO toca el corazón.' Patients confuse cardiac catheterization (artery !' heart, scenario 20) with central-line placement (vein !' near heart, this scenario); naming the difference explicitly prevents the patient from hearing 'central line' as 'cardiac procedure.'
- Library's first daughter-as-line-care-witness over a 7–14 day dwell window — extends scenarios 11/13/14/15/16/17/18/19/20/21's family-witness teaching into a multi-day post-discharge window where the witness watches a physical artifact (the dressing site) for three named warning signs: (1) 'la piel alrededor del parche — ¿está más roja que ayer?' (2) 'el parche mismo — ¿se ve mojado, sucio, despegado?' (3) 'fiebre — la temperatura subió arriba de treinta y ocho.' Eleventh consecutive scenario reinforcing the family-witness discipline; FIRST where the witness's role is line-care vigilance over a multi-day dwell rather than at-bedside, at-home-over-hours, at-the-door, or year-long-adherence.

CENTRAL-LINE PLACEMENT CONSENT — SEPTIC 64F WHOSE HUSBAND DIED OF A LINE INFECTION EIGHT YEARS AGO — CONTINUED

- Six-rule numbered carrying set for at-home line care, said to the daughter and read back — same numbered-cadence discipline as scenarios 13/14/16/18/19/20/21. Library's first carrying set with 'ask before any dental or injection while the line is in' as a named rule — central-line patients are routinely re-tapped by outpatient providers who don't realize the line is in (or that bacteria from a dental cleaning seeds the catheter); this is one of the most common preventable late-CLABSI mechanisms and it never makes it into discharge sheets in any language.

Foley catheter consent — 73M with acute urinary retention from BPH, son at bedside, dignity refusal opens the conversation

6 min · 10 turns

CONTEXT

It is 9:14pm on a Saturday. You are the ED night-shift attending. Don Joaquín Mendoza is a 73-year-old retired Mexican-American ranch hand brought in 40 minutes ago by his 45-year-old son Beto (a long-haul trucker, home for the weekend). He has not urinated since yesterday afternoon — about 28 hours. He felt the pressure build through the morning, denied himself fluids since lunchtime hoping it would pass, and finally agreed to come in only when his wife threatened to call the ambulance. POC bladder scan reads 920 mL. His abdomen is visibly distended to two fingerbreadths above the umbilicus, exquisitely tender on palpation; he cannot sit, has been pacing the bay since arrival. Vitals: T 36.8, HR 96, BP 158/92 (pain-driven), RR 18. Past medical history per son: untreated BPH for "muchos años" — Don Joaquín stopped seeing his PCP four years ago after his wife's breast cancer scare drained the family co-pay budget; he never started tamsulosin or finasteride. No prior catheterization. No known drug allergies. Creatinine 1.6 (baseline unknown but son says no prior kidney problems). Plan from urology consult by phone: place a 16-Fr Coudé Foley to decompress the bladder, monitor for post-obstructive diuresis, admit to medicine for 24–48h, then voiding trial before discharge with tamsulosin started inpatient and outpatient urology follow-up booked. You step into the bay to obtain consent. Don Joaquín, gripping the bedrail and visibly in pain, looks at the IV cart with the catheter tray on it and says: "doctor, mire — yo prefiero aguantarme. No me meta eso. Y menos enfrente de mi hijo. Eso es cosa privada de uno. Si me dan algo para los dolores, yo aguanto hasta mañana en mi casa, le prometo." Beto stands at the foot of the bed, arms crossed, watching the standoff.

CLINICAL GOAL

By the end of this consent conversation, Don Joaquín (1) has been met on dignity grounds first — the son has been offered the option to step out, the same-gender-placement option has been named, the drape protocol has been named, and the "menos personas en la sala posibles" principle has been named, BEFORE any catheter teaching begins; (2) hears the bladder-rupture and post-obstructive AKI risks of "aguantarme hasta mañana" in honest patient-Spanish numbers, NOT as a scolding ("no es regaño, son los hechos"); (3) hears the BPH mechanism named as "es cosa de mecánica, no de fuerza, no de vergüenza" — anti-shame frame for elder Latino men who interpret retention as personal weakness; (4) hears the three honest options (Foley urethral / suprapubic via skin / wait-and-rupture-the-bladder) with the WHY for the recommendation; (5) hears CAUTI risk in honest patient-Spanish numbers (~2–3 per 1,000 catheter-days), AND the four-named-differences in modern Foley care (closed drainage system that never opens, bag-below-bladder rule, daily perineal care, daily voiding-trial review); (6) gives DUAL permission — to PLACE the Foley now AND to REMOVE it the morning he passes a voiding trial without a second consent conversation; AND (7) the son has a six-rule numbered carrying set for at-home Foley care if the catheter ships home: bag-below-bladder rule, never-disconnect-the-tubing rule, three named at-site/at-bag warning signs (no-output-for-4-hours / urine turbid-bloody-foul / fever "e 38.0 or sudden flank or suprapubic pain), perineal-hygiene-daily-with-soap-and-water rule, never-pinch-or-clamp-the-line rule (call instead), and ask-before-any-cystoscopy-or-urology-procedure rule. SUPPORT-not-SUBSTITUTE named bedside for the FIFTH consecutive scenario (after 19/20/21/22): consent decision is Don Joaquín's alone; son's role is bag-management + sediment-watching + perineal-care vigilance over the 24–72h dwell window or the 7–14d window if catheter ships home for outpatient voiding trial.

DIALOGUE

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

PATIENT · 73M
RETIRED RANCH
HAND, ACUTE
URINARY
RETENTION 28H,
BPH UNTREATED,
BLADDER 920ML
ON POC SCAN,
SON AT FOOT OF
BED — OPENS
WITH A DIGNITY
REFUSAL

Doctor, mire — yo prefiero aguantarme. No me meta eso. Y menos enfrente de mi hijo. Eso es cosa privada de uno. Si me dan algo para los dolores, yo aguanto hasta mañana en mi casa, le prometo. Mire, doctor, yo soy un hombre grande, ya tengo setenta y tres años, y nunca en mi vida me han hecho una cosa así. Beto, hijo — perdón que digo esto delante de ti, pero no quiero. No así. Si tengo que pagar por una pastilla, lo que sea, doctor — pero esto no.

Doctor, look — I'd rather just hold it. Don't put that in me. And especially not in front of my son. That's a private matter. If you give me something for the pain, I'll hold it until tomorrow at home, I promise. Look, doctor, I'm an older man, I'm seventy-three years old, and never in my life have they done something like that to me. Beto, son — forgive me for saying this in front of you, but I don't want to. Not like this. If I have to pay for a pill, whatever, doctor — but not this.

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

YOU

#2

Open with the procedural-consent ritual — fifth in a row — but with the dignity moves named FIRST, BEFORE any clinical teaching. Don Joaquín opened on dignity grounds, not on fear-of-harm grounds; meeting him on dignity is what unblocks the rest. Three dignity moves, in this exact order: (1) NAME the son's role as the patient's call — "se queda si usted quiere, sale si usted prefiere. Usted decide. Si quiere hablarlo a solas conmigo primero, lo pido a Beto que salga unos minutos y nadie se ofende." Same patient-controls-the-room discipline as scenario 22's "tómese su tiempo, hable con su hija." (2) NAME same-gender placement as an OPTION when available: "si usted prefiere que sea un enfermero hombre, le pido a alguien — esta noche tenemos a Carlos en piso, lo puedo llamar." (3) NAME the minimum-people-in-the-room rule: "para esto, sólo entran las personas que TIENEN que estar — la enfermera que coloca, yo si me necesita, nadie más. Cortinas cerradas, sábana cubriendo lo que no se necesita ver." Then — and only then — name what you're going to do (talk first, answer questions, ask consent only at the end), name the procedure in plain bedside Spanish PAIRED ONCE with the chart-Spanish term ("sonda" / "tubo" bedside, "catéter urinario tipo Foley" on the form). Address the "yo aguanto hasta mañana" line directly with one sentence flagging that you'll talk about the risks before he decides — but DO NOT yet explain. Do NOT lead with "firma aquí." Same procedural-consent opening discipline as scenarios 18/19/20/22.

Don Joaquín, escúcheme. Beto — buenas noches, gracias por traer a su papá. Antes que cualquier cosa, Don Joaquín, hablemos de cómo va a estar la sala — porque eso lo decide usted, no yo. Primero — su hijo. Si quiere que se quede aquí con usted, se queda. Si prefiere que salga unos minutos mientras hablamos, le pido a Beto que salga, sin pena ninguna, nadie se ofende. Y si quiere que salga sólo durante el procedimiento mismo, también — eso es lo más común. Usted me dice. Segundo — quien le coloca la sonda. Si usted prefiere que sea un enfermero hombre, le pido a alguien — esta noche está Carlos en piso, lo puedo llamar en cinco minutos. Si le da igual, también está bien. Usted decide. Tercero — quién entra a la sala. Para esto, sólo entran las personas que TIENEN que estar: la enfermera que coloca, yo si me necesitan, y nadie más. Cortinas cerradas, sábana cubriendo todo lo que no se necesita ver. Eso le prometo. Ahora — la cosa que le quiero proponer se llama "sonda" o "tubo," en el papel del consentimiento dice "catéter urinario tipo Foley." Antes de meterle nada, Don Joaquín, le voy a explicar paso por paso — por qué la recomiendo, qué se siente, cuánto tiempo va a estar adentro, cuándo se quita. Le voy a contestar TODO lo que usted o Beto me pregunten. Y al final — y SÓLO al final — le pregunto si está de acuerdo. Nada se hace hasta que usted me diga que sí. Y eso de "yo aguanto hasta mañana" — usted tiene razón en preguntar antes de aceptar. Voy a hablar de eso en un momentito porque hay cosas honestas que tengo que decirle. ¿Está bien si empezamos? ¿Beto se queda, sale, o eso lo hablamos en un minuto?

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

PATIENT · 73M · ACCEPTS THE DIGNITY MOVES, SON STAYS PER DON JOAQUÍN'S DECISION, ASKS THE TWO QUESTIONS EVERYONE WITH RETENTION ASKS — "¿NO HAY UNA PASTILLA?" AND "¿CUÁNTO TIEMPO VA A ESTAR ADENTRO?"

Bueno, doctor — gracias. Beto se queda. Yo confío en mi hijo, y prefiero que oiga todo, así no tiene que repetir nada después con su mamá. Y lo del enfermero — si está disponible, sí, prefiero a un hombre, gracias. Pero, doctor, dígame primero — ¿no hay una pastilla? ¿No me pueden dar una pastilla que afloje la próstata, y ya? Y si tengo que aceptar la sonda, dígame honestamente — ¿cuánto tiempo va a estar ahí adentro? Yo entiendo que estoy hinchado, lo siento. Pero la idea de que esa cosa esté adentro de mí más de un día... eso es lo que no me gusta.

Okay, doctor — thank you. Beto stays. I trust my son, and I'd rather he hear everything, so he doesn't have to repeat anything later with his mother. And about the male nurse — if one's available, yes, I'd prefer a man, thank you. But, doctor, tell me first — isn't there a pill? Can't they just give me a pill that loosens the prostate, and that's it? And if I have to accept the catheter, tell me honestly — how long is that thing going to be inside? I understand I'm swollen, I feel it. But the idea of that thing being inside me more than a day... that's what I don't like.

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

YOU

#4

The single most load-bearing turn for the anti-shame frame, the honest-risk-of-waiting disclosure, and the three-options teaching. FOUR moves, in this exact order: (1) NAME-AND-CALL Carlos for same-gender placement so the dignity promise lands as action, not lip service: "Le digo a la enfermera que llame a Carlos ahora mismo." (2) ANTI-SHAME the BPH mechanism in patient-Spanish — name that this is mechanics, not weakness, not punishment, not old-age fate-acceptance. "La próstata es una glandulita que envuelve el tubo por donde sale la orina. Con los años, en CASI todos los hombres, esa glandulita crece. Cuando crece, aprieta el tubo. Y cuando aprieta lo suficiente, la orina ya no sale, aunque la vejiga esté llena. Es MECÁNICA. No de fuerza. No de vergüenza. No de algo que hizo mal." Library's first explicit anti-shame turn for elder Latino male genitourinary embarrassment. (3) HONEST-RISK-OF-WAITING — three risks, named plainly in patient-Spanish, framed as "no es regaño, son los hechos": (a) bladder rupture (the bladder is a muscle balloon, it stretches but has a breaking point — Don Joaquín is at almost a liter, near the limit); (b) AKI from back-pressure ("la presión sube hacia los riñones — su análisis ya empezó a verlo, su creatinina está un poquito arriba de lo normal"); (c) infection from stagnant urine. NO scolding tone — these are the facts, not a moralizing of the choice. (4) Three-options teaching with the WHY for the recommendation: (a) Foley urethral, planned for 24–72h; (b) suprapubic if Foley won't pass — "un piquetito chiquito arriba del hueso del pubis, tubito directo a la vejiga"; (c) wait — "ya le expliqué los riesgos, no es plan, es la cosa que NO recomiendo." Address the "¿no hay una pastilla?" question explicitly: tamsulosin will start, but pills take days to work and his bladder cannot wait days. Disclosed-options discipline same as scenarios 18/19/20/22.

Don Joaquín, perfecto — primero lo primero. Le voy a pedir a la enfermera que llame a Carlos AHORA, antes de seguir hablando. Eso es lo primero porque es lo que le prometí. — Listo, ya viene en camino. Ahora — su pregunta de la pastilla, y por qué la sonda. La pastilla — sí, le vamos a empezar una pastilla esta misma noche, se llama tamsulosina. Esa pastilla afloja la próstata POCO A POCO. El problema, Don Joaquín, es el TIEMPO — la pastilla tarda DÍAS en hacer efecto suficiente. Su vejiga ahorita tiene casi un litro adentro, no puede esperar días. Necesitamos vaciarla AHORA, y la pastilla la va a ayudar para que cuando le quitemos la sonda, pueda orinar solito. Las dos cosas juntas — sonda ahora, pastilla empezando esta noche. Ahora — la cosa importante que le quiero explicar, porque usted dijo "es vergüenza, soy un hombre grande." Don Joaquín, escúcheme bien. Esto NO es vergüenza, NO es debilidad, NO es porque usted hizo algo mal. La próstata es una glandulita que envuelve el tubo por donde sale la orina. Con los años, en CASI todos los hombres — siete de cada diez después de los setenta — esa glandulita crece. Cuando crece, aprieta el tubo. Y cuando aprieta lo suficiente, la orina ya no sale, aunque la vejiga esté llena. Es MECÁNICA. No de fuerza. No de vergüenza. No de algo que hizo mal. Es como una manguera de jardín que se aplasta poco a poco con los años — no es la culpa de la manguera. ¿Va bien hasta aquí? Ahora, lo de "yo aguanto hasta mañana" — Don Joaquín, le voy a hablar honesto, no es regaño, son los hechos. Hay tres cosas que pasan si esperamos. UNO — la vejiga es como un globo de músculo. Se estira, pero hay un punto donde se rompe. Su vejiga tiene casi un LITRO adentro. Eso es cerca del límite. Si se rompe, eso es operación grande, y eso es muy malo. DOS — la presión de la vejiga llena se devuelve hacia los riñones. Su análisis de sangre de hace una hora me dice que los riñones ya empezaron a sentirlo, su creatinina está un poquito arriba de lo normal. No mucho — todavía. Pero subiendo. TRES — la orina que no sale se vuelve un caldo de bacterias en pocas horas. Cuanto

PATIENT · 73M ·
ACCEPTS THE
ANTI-SHAME
FRAME AND THE
RISK
DISCLOSURE,
ASKS THE TWO
QUESTIONS
EVERYONE WITH
IMMINENT CATHE
TERIZATION
ASKS — PAIN +
INFECTION

Doctor, ya entendí. Lo de la mecánica — no se lo había explicado nadie así. Bueno. Beto está oyendo todo, mejor. Pero ahora dígame — del dolor. ¿Cuánto va a doler? Yo aguanto, pero quiero saber qué esperar. Y la otra cosa, doctor — eso de las infecciones, dijo usted. ¿Qué tan común es? Yo tengo una vecina, doña Mercedes, que después de la operación de la cadera le pusieron una sonda y se le infectó, terminó otra vez en el hospital. ¿Qué tan probable es eso? Y mientras tanto, Beto, hijo, ven, párate más cerca, escucha esto bien.

Doctor, I understand now. The mechanical thing — nobody had explained it to me like that. Okay. Beto is hearing everything, better. But now tell me — about the pain. How much will it hurt? I can take it, but I want to know what to expect. And the other thing, doctor — about infections, you mentioned. How common is that? I have a neighbor, Doña Mercedes, who after her hip operation they put a catheter in her and she got an infection, ended up back in the hospital. How likely is that? And meanwhile, Beto, son, come, stand closer, listen to this carefully.

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

YOU

#6

Honest-numbers disclosure turn — pain pre-description AND CAUTI risk AND four-named-differences-in-modern-Foley-care bundle. THREE moves, in this exact order: (1) Sensation pre-description in patient-Spanish — "le voy a poner un gel con anestesia adentro del tubo PRIMERO — eso adormece todo el camino. Después usted va a sentir PRESIÓN — no dolor agudo, presión rara, no agradable, pero soportable. Si en cualquier momento siente DOLOR, no sólo presión — me lo dice y paramos. Eso lo decide usted, no yo." Same patient-controlled-escalation discipline as scenario 19's LP "presión, no dolor — y si siente dolor le pongo más anestesia." (2) CAUTI honest-numbers in concrete patient-Spanish — "de cada mil días que la sonda está adentro, dos a tres infecciones. Y por eso la regla aquí es: la sacamos pronto, no se queda más tiempo del necesario." Same anti-"es muy raro" honest-numbers register as scenarios 20 and 22. (3) Four-named-differences-in-modern-Foley-care bundle, paralleling scenario 22's four-named-differences-in-modern-CVC-care framework: (a) closed drainage system that never gets opened; (b) bag-below-bladder rule with the WHY ("si va arriba, la orina se devuelve, eso es como sembrar las bacterias"); (c) daily perineal care with soap-and-water, NO alcohol or iodine ("eso reseca y empeora"); (d) DAILY voiding-trial review — every morning the team asks "¿puede orinar solito hoy?" and the day the answer is yes, the catheter comes out that morning. Address the doña Mercedes story directly — DON'T dismiss, name what's DIFFERENT now (the four-bundle that may not have existed for her or may have been done differently). Same don't-dismiss-the-family-story-but-name-what's-different discipline as scenarios 19, 20, and 22 (especially 22's four-named-differences-when-the-family-has-a-death framework). Don Joaquín's neighbor is an analog of scenario 22's dead husband and scenario 19's tío en Honduras — validate, then name what changed.

Don Joaquín, las dos preguntas correctas. Beto — sí, párate cerca, esto le toca a usted también porque cuando salgan a la casa, hay cosas que le voy a pedir que su papá y usted hagan juntos. Primero, lo del dolor. Antes de meter la sonda, le voy a poner un gel con anestesia ADENTRO del tubo. Eso es lo importante — el gel adormece todo el camino. Después, cuando entre la sonda, usted va a sentir PRESIÓN — no dolor agudo, presión rara, no agradable, pero soportable. Es como cuando uno tiene muchísimas ganas de orinar, esa sensación de presión — así, pero llegando, no saliendo. Si en CUALQUIER momento usted siente DOLOR de verdad, no sólo presión — usted me lo dice y paramos en el momento. Eso lo decide usted, no yo. Tampoco voy a empujar contra resistencia — si la sonda no pasa fácil, paramos y hablamos del plan B suprapúbico. Ahora — lo de doña Mercedes y las infecciones. Lo siento por su vecina, eso es real, eso pasa. Le voy a decir el número honesto, sin "es muy raro." De cada mil días que la sonda está adentro, dos a tres infecciones. Cuanto MENOS días, MENOS riesgo. Por eso la regla aquí es: la sacamos pronto, no se queda más tiempo del necesario. Y aquí está lo que cambió desde la operación de doña Mercedes, son CUATRO cosas. UNO — la bolsa de orina y el tubo son un sistema cerrado. El tubo NO se desconecta NUNCA, ni para vaciar la bolsa, ni para nada. La bolsa tiene una llavecita abajo y se vacía por ahí, sin abrir el tubo. Eso ya solo baja muchísimo el riesgo. DOS — la bolsa va siempre por DEBAJO de la cintura, NUNCA arriba. Si la bolsa se sube por encima del nivel de la vejiga — por ejemplo, si alguien la cuelga al lado de la cama y queda más alta — la orina sucia se devuelve hacia adentro. Eso es como sembrar las bacterias en la vejiga. Por eso la regla es: bolsa abajo, siempre abajo. TRES — la limpieza ahí abajo se hace UNA vez al día, con agua y jabón normal. NO alcohol, NO yodo, NO desinfectante fuerte — eso reseca la piel y empeora. Agua, jabón, secar bien, eso es todo. CUATRO — y esta es la

PATIENT · 73M ·
THE DWELL-TIME
QUESTION,
ASKED DIRECTLY
BECAUSE
TURN-6 NAMED
THE DAILY-
REVIEW
MECHANISM

Doctor, eso de los días — eso es lo que más me importa. Porque le voy a ser sincero, lo que me da más miedo no es el procedimiento mismo, ya entendí — es que se quede ahí adentro mucho tiempo. ¿Quién decide cuándo me la quitan? ¿Tengo que pedir yo que me la quiten? ¿Y quién hace la prueba esa de "puede orinar solito"? ¿Cómo se hace? Yo no quiero salir de este hospital con eso adentro, doctor. Si me lo van a poner, quiero saber el plan para sacarlo desde antes de empezar.

Doctor, the days thing — that's what matters most to me. Because I'll be honest with you, what scares me most isn't the procedure itself, I understand it now — it's that it stays in there a long time. Who decides when they take it out? Do I have to ask for it to be taken out? And who does that "can you urinate on your own" test? How is it done? I don't want to leave this hospital with that thing in me, doctor. If you're going to put it in, I want to know the plan to take it out before we even start.

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

YOU

#8

Library's SECOND anti-prolongation dwell-time framing AND library's SECOND dual placement+removal permission ask — both in this turn, in patient-Spanish, said as a rule not a hope. Inherits scenario 22's template directly and applies it to a different indwelling device. (1) Dwell-time: "24 a 72 horas en la mayoría de los casos, máximo." Then name the voiding-trial mechanism in patient-Spanish: "la prueba se llama 'prueba de orinar solito,' la hace una enfermera, así — le quitan la sonda en la mañana, le dan agua, esperan unas horas, y a ver si puede orinar solo. Si puede — listo, no se vuelve a poner. Si no puede — se vuelve a poner una vez más, y al otro día se intenta otra vez. La mayoría de los hombres con su misma situación pasan la prueba al primer o segundo intento." Name the family-can-ask-anytime trigger that scenario 22 introduced: "si en algún momento a usted o a Beto les parece que ya pueden hacer la prueba — ustedes preguntan, no esperan a la ronda. La pregunta vale, no es molestia." (2) DUAL permission ask, exactly as scenario 22 — "mi pregunta para usted es DOBLE. La primera — ¿me da permiso de PONERLA, ahorita, con el gel de anestesia y con Carlos? Y la segunda, igual de importante — ¿me da permiso de QUITARLA en la mañana que pase la prueba, sin esperar a que tengamos otra conversación de consentimiento?" State explicitly that the second permission is to PROTECT him: "la segunda es para protegerlo — la quitamos pronto porque cada día que pasa, sube el riesgo de infección, y queremos quitarla ANTES de que pase nada." Don't close the turn with consent itself — leave room for Beto to give social permission in turn 9 ("papá, yo creo que sí"), which is when the consent actually lands. Same dual-permission discipline as escenarios 20 and 22, now confirmed across two consecutive procedural-consent scenarios as a deliberate library editorial discipline rather than a one-time scenario-22 move.

Don Joaquín, ésa es exactamente la pregunta correcta — y le voy a contestar paso por paso porque usted tiene derecho a saber el plan completo antes de aceptar. El plan en cuanto a tiempo es: 24 a 72 horas, máximo, en la gran mayoría de los casos. La prueba para quitarla — se llama "prueba de orinar solito," así la llamamos. La hace una enfermera, no es complicada. Va así: en la mañana, después de que ya pasó suficiente tiempo y la pastilla nueva ya empezó a hacer efecto — le quitan la sonda. Le dan agua a tomar. Esperan unas horas. Y a ver si usted puede orinar solo, en un urinal o en el baño. Si SÍ puede — listo, no se vuelve a poner, eso es el alta. Si todavía no puede — se vuelve a poner una vez más, descansa un día más, y al otro día se intenta otra vez. La mayoría de los hombres en su misma situación — vejiga aguantó, próstata grande pero no extrema, primer episodio — pasan la prueba al primer o segundo intento. ¿Quién decide? Cada mañana, en la ronda, el equipo de medicina revisa cada paciente. La pregunta que SE HACE el equipo es: "¿este señor está listo para la prueba hoy?" Si la respuesta es sí — esa misma mañana se intenta. Y aquí está lo importante para usted y para Beto: si en algún momento a USTEDES les parece que ya está listo — usted ya no se siente lleno, está más cómodo, la pastilla está haciendo efecto — ustedes preguntan, no esperan a la ronda. La pregunta vale. No es molestia, no es ser exigente, eso es lo que queremos. La respuesta tiene que ser una de dos: o se intenta HOY, o le explicamos por qué todavía no. Por eso, mi pregunta para usted ahorita es DOBLE — son dos cosas que necesito que me dé permiso. La primera — ¿me da permiso de PONERLA, ahorita, con el gel de anestesia y con Carlos colocándola? Y la segunda, igual de importante — ¿me da permiso de QUITARLA en la mañana que pase la prueba, sin esperar a que tengamos otra conversación de consentimiento? La segunda es para protegerlo — la quitamos pronto porque cada día que pasa sube el riesgo de infección, y queremos quitarla

BETO SPEAKS
FOR THE FIRST
TIME · 45M LONG-
HAUL TRUCKER,
GIVES PAPÁ
SOCIAL
PERMISSION TO
CONSENT, ASKS
THE AT-HOME
FOLEY-CARE
QUESTIONS

Papá — escucha, doctor está explicando bien. Yo creo que sí, papá. Las dos cosas. Que te la pongan ahora con Carlos, y que te la quiten en la mañana que pases la prueba — sin que tengamos que rogar otra vez, sin que se quede días de más. Doctor — yo soy chofer, yo manejo trailers, una semana sí y una semana no estoy en la casa. Pero si cuando salimos del hospital papá todavía tiene la sonda, yo cancelo el viaje, yo me quedo. Mi mamá no puede con esto sola, y mi papá nunca ha tenido nada así. Dígame — ¿qué tengo que vigilar? ¿Cómo se cuida la bolsa? ¿Lo puedo bañar normal? ¿Y qué busco yo para llamar antes de que se ponga mal? Dígame todo, doctor, le repito — yo escribo en el celular ahorita, mientras habla.

Papá — listen, the doctor is explaining well. I think yes, papá. Both things. Let them put it in now with Carlos, and let them take it out in the morning when you pass the test — without us having to beg again, without it staying extra days. Doctor — I'm a trucker, I drive trailers, one week I'm home, one week I'm not. But if when we leave the hospital papá still has the catheter, I cancel the trip, I stay. My mom can't handle this alone, and my dad has never had anything like this. Tell me — what do I need to watch for? How is the bag cared for? Can I bathe him normally? And what do I look for to call before he gets sick? Tell me everything, doctor, I'll repeat — I'm writing on my phone right now, while you talk.

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

YOU

#10

Closing turn — son-as-Foley-care-witness with six-rule numbered carrying set + SUPPORT-not-SUBSTITUTE explicit + final consent confirmation back to Don Joaquín. Beto has just given papá social permission to consent ("yo creo que sí, papá"); confirm the dual permission with Don Joaquín DIRECTLY (not Beto — consent is the patient's), then pivot to Beto's Foley-care teaching. SIX rules, numbered, in cadence — same numbered-cadence discipline as scenarios 13/14/16/18/19/20/21/22: (1) bag-below-the-bladder rule — bag stays below the level of his hips at ALL times, never on the bed beside him, never hung on a hook above; in the truck-bag carrier or attached low to the wheelchair if mobile; if it ever ends up above the level of his hips, lower it immediately and don't worry about it once it's back below; (2) NEVER disconnect the tubing — not to empty, not to clean, not for any reason; the bag has a small valve at the bottom for emptying — that's the only opening point; (3) THREE specific warning signs to call about IMMEDIATELY — "no orina por más de cuatro horas (la bolsa no se llena nada) / la orina sale turbia, con sangre, o con olor fuerte / fiebre arriba de treinta y ocho, o dolor de espalda baja o en la barriga que se pone fuerte de repente"; (4) perineal care once a day with soap-and-water only — NOT alcohol, NOT iodine, NOT antiseptic spray; (5) NEVER pinch or clamp the line if it stops draining — call us, do not improvise; if the line is kinked, gently unkink it once and watch; if no drainage in 30 min, call (this is library-FIRST — most discharge sheets in any language don't name "do not pinch" because the urge to "fix it ourselves" is universal); (6) ASK BEFORE any cystoscopy, urology procedure, OR new dental appointment WHILE the catheter is in — bacteria from any of those can ride in via the bladder or via the bloodstream and seed the catheter (this is library-FIRST for Foley patients — most discharge sheets in any language don't name this either). Name SUPPORT-not-SUBSTITUTE explicitly to Beto — "Beto, escúcheme: su trabajo NO es decidir si la sonda se queda o se quita, eso lo decide su papá con el equipo del hospital. Su trabajo es ser los OJOS al sitio cuando estén en casa, vaciar la bolsa cuando esté llena hasta más o menos la mitad, y llamar a tiempo si algo cambia. Lo demás lo hacemos nosotros." Have Beto read back rules 3 (the three warning signs) and 5 (DO NOT PINCH — call instead) before you confirm. Close with a final consent confirmation back to Don Joaquín himself — "Don Joaquín, una última vez, mirándolo a usted, no a Beto — ¿me da permiso de las dos cosas? Ponerla ahorita con Carlos y el gel, y quitarla en la mañana que pase la prueba." Twelfth consecutive scenario reinforcing the witness-carries-named-specific-teaching discipline (11/13/14/15/16/17/18/19/20/21/22/23); fifth consecutive scenario where SUPPORT-not-SUBSTITUTE is named bedside; library's first son-as-perineal-care-and-bag-management witness; library's first six-rule carrying set with both "do NOT pinch the line if drainage stops" AND "ask BEFORE any cystoscopy / urology procedure / dental appointment" rules.

Beto, perfecto — pero antes de explicarle a usted lo de la casa, necesito una última cosa de su papá, porque el permiso es de él. Don Joaquín — usted, mirándolo a usted, no a Beto: ¿me da permiso de las dos cosas? Ponerla ahorita, con Carlos colocándola y el gel de anestesia, y quitarla en la mañana que pase la prueba de orinar solito, sin esperar otra conversación de consentimiento. Bien — gracias, Don Joaquín, eso es lo que necesitaba escuchar. Beto, listo, ahora escúcheme — son seis reglas, escríbalas en el celular, voy a pedirle que me repita dos al final. UNO — la bolsa va siempre por DEBAJO de la cintura. Por debajo del nivel de las caderas, todo el tiempo. Nunca arriba, nunca en la cama al lado de su papá, nunca colgada en un gancho alto. Si ven que se subió por accidente — la bajan inmediatamente, no se preocupen una vez que ya está abajo otra vez. DOS — el tubo NO se desconecta NUNCA. Ni para vaciar, ni para limpiar, ni por nada. La bolsa tiene una llavecita abajo para vaciar — ESA es la única abertura. Si alguien les dice que desconecten algo, ustedes llaman primero. TRES — y ÉSTAS son las tres cosas que los hacen llamar inmediatamente, no esperar al día siguiente: PRIMERA, no orina por más de cuatro horas — la bolsa no se llena nada. SEGUNDA, la orina sale turbia, con sangre, o con

WHAT TO NOTICE

- Procedural-consent ritual opening — fifth consecutive scenario in the library (after CT contrast / LP / cardiac cath / central line). The discipline is now solidly a deliberate library beat across five scenarios: name yourself, name the family member at bedside, name the procedure in plain bedside Spanish PAIRED ONCE with the chart-Spanish term, buy permission to explain in pieces, and DO NOT lead with "firma aquí." Same opening-discipline pattern as scenarios 18/19/20/22.
- Library's FIRST dignity register for elder male genital exposure — meet the dignity refusal FIRST, BEFORE the medical teaching. Three specific dignity moves named explicitly and ALL said in the FIRST clinician turn, in this order: (a) the son's presence in the room is named as the patient's call, with same-day permission to step out without offense; (b) same-gender placement is named as an OPTION when available, then ACTED on (Carlos called immediately, not just promised); (c) the minimum-people-in-the-room rule named with curtain-and-drape protocol. Library's first scenario where the initial refusal is on dignity grounds rather than fear-of-harm grounds, and the move that unblocks consent is naming-and-acting on the dignity ask BEFORE the medical teaching begins. Editorial template for every subsequent scenario where dignity is the obstacle (DRE, prostate biopsy, scrotal/testicular exam, cystoscopy, gynecologic exam in elder women).

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

- Anti-shame frame for BPH retention in elder Latino men — many interpret urinary retention as personal weakness or as old-age fate-acceptance ("ya me tocaba"). Both readings sour the consent conversation and lead to the dangerous "yo aguanto hasta mañana" dignity-refusal that risks bladder rupture. Name the BPH mechanism plainly in patient-Spanish ("es cosa de mecánica, no de fuerza, no de vergüenza"), name the population frequency ("siete de cada diez hombres después de los setenta"), and use a concrete-object analogy ("como una manguera de jardín que se aplasta poco a poco con los años — no es la culpa de la manguera"). Library's first explicit anti-shame turn for elder Latino male genitourinary embarrassment; carries forward into every subsequent scenario where elder male dignity is the obstacle to consent (scrotal/testicular exam, DRE, urology cystoscopy, prostate biopsy).
- Library's FIRST honest-disclosure of "yo aguantaré hasta mañana" risks WITHOUT scolding tone — Don Joaquín opened with "yo aguanto hasta mañana." The clinical move was to name the failure modes plainly, in patient-Spanish numbers, framed as "no es regaño, son los hechos" rather than as a paternalistic scold. Three named risks: bladder rupture, post-obstructive AKI from back-pressure, and infection from stagnant urine. Editorial template for every subsequent scenario where the patient's preferred course is honest but dangerous (chest-pain "lo aguanto hasta el lunes," stroke "se me pasa con descansar," pediatric fever "le doy una más y mañana al doctor").
- Three-options teaching with the WHY in patient-Spanish — Foley urethral, suprapubic if Foley won't pass, or wait. Same disclosed-options discipline as scenarios 18/19/20/22. Patients who hear ONE option feel railroaded; patients who hear three options with a recommended one and a reason consent willingly. Address the "¿no hay una pastilla?" question explicitly in this turn — yes, tamsulosin starts tonight, AND it takes days to work, so the catheter and the pill go together, not pill-instead-of-catheter.
- Sensation pre-description in patient-Spanish — "PRESIÓN, no DOLOR" with patient-controlled escalation ("si en cualquier momento siente dolor de verdad, me lo dice y paramos"). Same discipline as scenario 19's LP and the procedural-consent expectation-setting register that is now consistent across scenarios 18/19/20/22/23. CAUTI honest-numbers in concrete patient-Spanish ("dos a tres por cada mil días") with explicit anti-"es muy raro" framing inherited from scenario 22. Address the family/neighbor anecdote (doña Mercedes's post-hip-op CAUTI) directly — same don't-dismiss-the-family-story-but-name-what's-different discipline as scenarios 19, 20, and 22.
- Four-named-differences-in-modern-Foley-care bundle in patient-Spanish — closed drainage system that never opens, bag-below-bladder rule with the WHY ("si va arriba, la orina se devuelve, eso es como sembrar las bacterias"), daily perineal care with soap-and-water only (NO alcohol/iodine), and DAILY voiding-trial review. The fourth point is the load-bearing one because it directly inherits scenario 22's dwell-time framing as anti-prolongation safeguard and applies it to a different indwelling device. Editorial template now confirmed across two consecutive procedural-consent scenarios (central line + Foley) and ready for transfer to NG tubes, peritoneal dialysis catheters, port-a-caths, and surgical drains. Don't-promise-zero-CAUTI; promise that the prevention bundle is what's different. Same don't-promise-perfection-name-what's-different discipline as scenarios 19, 20, and 22.

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

- Library's SECOND anti-prolongation dwell-time framing AND library's SECOND dual placement+removal permission ask — both inherited directly from scenario 22 and applied to a different indwelling device. Dwell-time named as a rule not a hope ("24 a 72 horas, máximo, en la mayoría de los casos"), with the voiding-trial mechanism explained in patient-Spanish ("la prueba de orinar solito") and the family-can-ask-anytime trigger named ("si en algún momento a ustedes les parece que ya está listo, ustedes preguntan, no esperan a la ronda"). Combined with the dual-permission ask ("ponerla AHORITA, y quitarla en la mañana que pase la prueba, sin esperar otra conversación") — the second half converts consent from a one-time event into a standing instruction that protects the patient from default dwell-prolongation. Now confirmed as a library editorial discipline across two consecutive scenarios — central line + Foley — and ready for transfer to every subsequent indwelling-device consent (NG tube, telemetry monitor, BiPAP, peritoneal dialysis catheter, surgical drain).
- Library's FIRST son-as-perineal-care-and-bag-management-witness over a 7–14 day post-discharge dwell window — extends the family-witness teaching of scenarios 11/13/14/15/16/17/18/19/20/21/22 (TWELFTH consecutive reinforcement) into a different witness-gender frame (son rather than daughter or wife) and a different at-home physical-care role (urinary bag care + perineal hygiene + sediment-and-output watching, rather than dressing-site-watching of scenario 22). FIFTH consecutive scenario where SUPPORT-not-SUBSTITUTE is named bedside (after 19, 20, 21, 22) — the pattern is now a deliberate library editorial discipline across five scenarios, not an emerging beat. Library's family-witness discipline now spans SIX temporal frames: at-home over hours (11/13/14/15/16), at-bedside during procedure (17/18/19/20), at-the-door in real-time emergency handoff (21), post-procedure adherence over a year (20), multi-day post-discharge dressing-site vigilance over 7–14 days (22), and multi-day post-discharge bag-management + perineal-care + sediment-watching over 7–14 days (23).
- Six-rule numbered carrying set with read-back — same numbered-cadence discipline as scenarios 13/14/16/18/19/20/21/22. Library's first carrying set with TWO library-first rules: (a) "do NOT pinch or clamp the line if it stops draining — call us, do not improvise" — most discharge sheets in any language don't name this because the urge to "fix it ourselves" is universal and the failure mode (urine refluxing back to the bladder) is invisible to the family until infection or AKI is established; (b) "ask BEFORE any cystoscopy, urology procedure, or new dental appointment while the catheter is in" — most discharge sheets in any language don't name this either, and bacteria from any of those routes can seed an indwelling Foley. Have Beto read back rules 3 (the three warning signs) and 5 (DO NOT PINCH — call instead) before confirming consent — same readback discipline as scenarios 16/18/19/20/21/22.

DIALECT NOTES

- Procedural-consent ritual opening — fifth consecutive scenario in the library (after CT contrast / LP / cardiac cath / central line). Same opening discipline: name yourself, name the son at bedside, name the procedure in plain bedside Spanish AND pair once with the chart-Spanish term so the patient recognizes it on the form ("sonda" / "tubo" bedside, "catéter urinario tipo Foley" on the form). Buy permission to explain in pieces: "le voy a explicar primero, le voy a contestar todo lo que me pregunten, y al final le pregunto si está de acuerdo." Do NOT lead with "firma aquí." The procedural-consent ritual is now solidly a deliberate library beat across five consecutive scenarios.

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

- Library's FIRST dignity register for elder male genital exposure — meet the dignity refusal FIRST, BEFORE the medical teaching. Three specific dignity moves named explicitly and all said in the FIRST clinician turn, in this order: (a) son leaving the room is named as an OPTION the patient controls, not a request: "su hijo se queda si usted quiere, o sale si usted prefiere. Usted decide. Si quiere hablarlo a solas conmigo primero, también — yo le pido a Beto que salga unos minutos y nadie se ofende." (b) Same-gender placement named as an OPTION when available: "si usted prefiere que sea un enfermero hombre, le pido a alguien — esta noche tenemos a Carlos en piso, lo puedo llamar." (c) Minimum-people-in-the-room rule named: "para esto, sólo entran las personas que TIENEN que estar — la enfermera que coloca, yo si me necesita, y nadie más. Cortinas cerradas, sábana cubriendo lo que no se necesita ver." Same disclosed-options register as escenarios 18/19/20/22, but applied to dignity choices rather than clinical choices.
- Anti-shame frame for BPH retention in elder Latino men — many interpret urinary retention as personal weakness or as old-age fate-acceptance ("ya me tocaba"). Both readings sour the consent conversation and lead to the "yo aguanto hasta mañana" dignity-refusal that risks bladder rupture. Name the BPH mechanism plainly in patient-Spanish: "Don Joaquín — esto NO es vergüenza, NO es debilidad, NO es porque usted hizo algo mal. La próstata es una glandulita que envuelve el tubo por donde sale la orina. Con los años, en CASI todos los hombres, esa glandulita crece. Cuando crece, aprieta el tubo. Y cuando aprieta lo suficiente, la orina ya no sale aunque la vejiga esté llena. Es cosa de MECÁNICA. No de fuerza." Library's first explicit anti-shame turn for elder male genitourinary embarrassment; carries forward into every subsequent scenario where elder male dignity is the obstacle to consent (scrotal/testicular exam, DRE, urology cystoscopy, prostate biopsy).
- Library's FIRST honest-disclosure of "aguantarme hasta mañana" risks WITHOUT scolding — Don Joaquín opens with "yo aguanto hasta mañana." The clinical move is to name the failure modes plainly, in patient-Spanish numbers, framed as "no es regaño, son los hechos" rather than as a paternalistic scold. Three named risks: (1) bladder rupture — "la vejiga es como un globo de músculo, se estira, pero hay un punto donde se rompe — su vejiga ya tiene casi un litro adentro, eso es cerca del límite"; (2) acute kidney injury from back-pressure — "cuando la vejiga está demasiado llena, la presión sube hacia los riñones — su análisis de sangre me dice que los riñones ya empezaron a sentirlo"; (3) infection from stagnant urine — "la orina que no sale se vuelve un caldo de bacterias en pocas horas." Editorial template for every subsequent scenario where the patient's preferred course is honest but dangerous.
- Three-options teaching with the WHY in patient-Spanish — "hay tres caminos. UNO, una sonda chiquita por la uretra, que es lo que le estoy proponiendo, y la sacamos en uno o dos días cuando ya pueda orinar solito otra vez. DOS, si la próstata está tan apretada que la sonda chiquita no pasa, hacemos un piquetito chiquito arriba del hueso del pubis y metemos un tubito directo a la vejiga — se llama sonda suprapúbica; eso es plan B. TRES, esperar — y eso, Don Joaquín, ya le expliqué los riesgos, no es plan, es la cosa que NO recomiendo." Same disclosed-options discipline as escenarios 18/19/20/22 — patients who hear ONE option feel railroaded; patients who hear three options with a recommended one and a reason consent willingly.
- Sensation pre-description in patient-Spanish — "le voy a poner un gel con anestesia adentro del tubo primero — eso es lo importante, eso adormece todo el camino. Después usted va a sentir PRESIÓN — no dolor agudo, presión rara, no agradable, pero soportable. Si en cualquier momento siente DOLOR, no sólo presión — me lo dice y paramos. Eso lo decide usted, no yo." Same patient-controlled-escalation discipline as scenario 19's LP "presión, no dolor — y si siente dolor le pongo más anestesia." The honest sensation pre-description is what converts cooperation from "endure it" into "informed cooperation."

FOLEY CATHETER CONSENT — 73M WITH ACUTE URINARY RETENTION FROM BPH, SON AT BEDSIDE, DIGNITY REFUSAL OPENS THE CONVERSATION — CONTINUED

- CAUTI honest-numbers disclosure with explicit anti-"es muy raro" framing inherited from scenario 22 — "de cada mil días que la sonda está adentro, dos a tres infecciones — y por eso la regla es: la sacamos pronto, no se queda más tiempo del necesario." Same honest-numbers register as escenarios 20 ("tres o cuatro de cada mil" for cath complications) and 22 ("una a tres por cada mil días" for line infection). The honest-numbers discipline now spans three consecutive procedural-consent scenarios.
- Four-named-differences-in-modern-Foley-care bundle (named ALL FOUR explicitly, in patient-Spanish, paralleling scenario 22's four-named-differences-in-modern-CVC-care framework): (a) "la bolsa es un sistema cerrado — el tubo no se desconecta nunca, ni para vaciar ni para nada"; (b) "la bolsa va siempre por debajo de la cintura, NUNCA arriba — si va arriba, la orina se devuelve hacia la vejiga, y eso es como sembrar las bacterias"; (c) "lavado con agua y jabón en la zona genital UNA vez al día — no más, no menos — el alcohol y el yodo NO, eso reseca la piel y empeora"; (d) "todas las mañanas el equipo revisa si todavía la necesita, y el día que pueda orinar solito, esa misma mañana se le quita." The fourth point is the load-bearing one because it directly inherits scenario 22's dwell-time framing as anti-prolongation safeguard and applies it to a different indwelling device. Editorial template now confirmed across two consecutive procedural-consent scenarios — central line + Foley — and ready for transfer to NG tubes, peritoneal dialysis catheters, port-a-caths, and surgical drains.
- Library's SECOND dual placement+removal permission ask — "mi pregunta para usted es DOBLE: ¿me da permiso de ponerla AHORITA, y ¿me da permiso de QUITARLA en la mañana que pase la prueba de orinar solito, sin esperar otra conversación?" Same dual-permission discipline as scenario 22, applied to a different indwelling device. The second half is what converts consent from a one-time event into a standing instruction that protects the patient from default dwell-prolongation. Now confirmed as a library editorial discipline across two consecutive scenarios.
- Library's FIRST son-as-perineal-care-and-bag-management-witness over a 7–14 day post-discharge window IF the catheter ships home for outpatient voiding trial — extends the family-witness teaching of escenarios 11/13/14/15/16/17/18/19/20/21/22 (TWELFTH consecutive reinforcement) into a different witness-gender frame (son rather than daughter or wife) and a different at-home physical-care role (urinary bag care + perineal hygiene + sediment-and-output watching, rather than dressing-site-watching of scenario 22). FIFTH consecutive scenario where SUPPORT-not-SUBSTITUTE is named bedside (after 19/20/21/22) — the pattern is now a deliberate library editorial discipline across five scenarios. Six-rule numbered carrying set with read-back, including library-first "do NOT pinch the line if it stops draining — call us, do not improvise" and library-first "ask BEFORE any cystoscopy, urology procedure, or new dental appointment while the catheter is in" rules.

NG-tube placement consent — 58F with partial SBO from post-hysterectomy adhesions, daughter-in-law at bedside, "por la nariz no" refusal opens the conversation

6 min · 10 turns

CONTEXT

It is 4:50pm on a Tuesday. You are the ED attending. Doña Carmen Juárez is a 58-year-old retired Mexican-American textile-factory worker brought in two hours ago by her 35-year-old daughter-in-law Lupita (a school cafeteria cook on day off; Carmen's son, a roofer, is still at work). Three days of progressive abdominal distension. She vomited her breakfast yesterday and again at lunch today; the second vomit was greenish-yellow, "como bilis." No bowel movement and no flatus for ~36 hours. Past surgical history: open hysterectomy seven years ago at the same hospital for symptomatic fibroids, uncomplicated; she has an old midline scar. No prior episodes of obstruction. No diabetes, no kidney disease, on no chronic meds except occasional ibuprofen for knees. CT scan from 30 minutes ago: dilated proximal small bowel to 3.8 cm, transition point in the distal ileum, no closed-loop, no pneumatosis, no free air, no thickened wall — picture is consistent with a partial small-bowel obstruction from adhesive disease. Labs reassuring: WBC 11.8, lactate 1.4, Cr 0.9, lipase normal, electrolytes only mildly off from the vomiting. Vitals: T 37.0, HR 92, BP 138/82, RR 16, sat 98% on room air. The general-surgery resident has just stepped out of the room having said: "tincture-of-time first — NG decompression, IV fluids, antiemetic, bowel rest, octreotide drip, serial exams; if she doesn't open up in 24–48 hours or her exam worsens, we go to the OR." You re-enter to obtain consent for the NG. Doña Carmen, who has been gripping the rail with both hands and breathing through her nose to manage nausea, looks at the prep tray with the coiled NG tube on it and shakes her head: "Doctor, escúcheme — yo entiendo que estoy mala. Pero ¿por la NARIZ? No, no, no. Yo NUNCA en mi vida me he dejado meter nada por la nariz. Mi nuera me dijo que a una vecina le pusieron eso y vomitó toda la noche. Si tengo que tener una operación, mejor OPÉRENME. Yo prefiero operación a esa sonda por la nariz." Lupita stands beside the bed holding her phone, ready to take notes.

CLINICAL GOAL

By the end of this consent conversation, Doña Carmen (1) has heard the procedural-consent ritual opening — sixth consecutive scenario — with the daughter-in-law named at bedside, the procedure named in plain bedside Spanish ("sonda por la nariz") paired once with the chart-Spanish term ("sonda nasogástrica"), and permission bought to explain in pieces; (2) hears her "mejor opérenme" preference taken seriously and refined honestly — surgery is not a shortcut, NG-first is what tries to AVOID surgery, the operation has a recovery measured in weeks while NG decompression has a recovery measured in hours-to-days if it works; (3) hears the SBO mechanism named in patient-Spanish without making her feel that her old hysterectomy was a mistake — adhesions are normal scar-tissue strands, they happen in many people after abdominal surgery, this is not "your fault" or "your old surgeon's fault"; (4) hears the three honest options (NG decompression first as the recommended path, surgery now if NG fails or her exam worsens, wait-and-see as the option that is NOT a plan) with the WHY for each; (5) hears NG-passage sensation pre-described honestly in patient-Spanish — numbing spray + lidocaine gel up front, the brief gag-and-tear reflex when the tube turns the corner at the back of the throat, sit-up posture + chin-down + sip-water-through-a-straw as the swallow-it-down maneuver, the raised-hand-to-pause signal she controls — and that this passage takes seconds to a minute at most, "NO es la noche entera"; (6) hears the SECOND-most-load-bearing NEW library safety beat — the X-ray-before-anything-goes-through-it rule, named explicitly: nothing — not water, not medicine, not feed — goes

DIALOGUE

**PATIENT · 58F
RETIRED
TEXTILE
WORKER, 3 DAYS
OF
PROGRESSIVE
ABDOMINAL
DISTENSION,
PARTIAL SBO
FROM POST-
HYSTERECTOMY
ADHESIONS ON
CT, DAUGHTER-
IN-LAW AT
BEDSIDE —
OPENS WITH A
"POR LA NARIZ
NO, MEJOR
OPÉRENME"
REFUSAL**

Doctor, escúcheme bien — yo entiendo que estoy mala. Lo siento, sí, la barriga me está matando, no he podido del baño en día y medio, ya vomité dos veces hoy. Pero ¿por la NARIZ? No, no, no. Yo NUNCA en mi vida me he dejado meter nada por la nariz, ni de niña, ni para los exámenes, nada. Mi nuera Lupita aquí me dijo que a una vecina suya, allá en su pueblo, le pusieron eso por la nariz una vez, y la pobre vomitó toda la noche. Mire, doctor — si tengo que tener una operación, mejor OPÉRENME. Mejor que me abran y arreglen lo que sea, así, dormida. Yo prefiero la operación a esa sonda por la nariz. Yo soy una mujer grande, puedo aguantar una operación. Pero por la nariz, no.

Doctor, listen to me — I understand I'm sick. I'm sorry, yes, my belly is killing me, I haven't been able to go to the bathroom in a day and a half, I've already vomited twice today. But through the NOSE? No, no, no. NEVER in my life have I let anything be put in through my nose, not as a child, not for exams, nothing. My daughter-in-law Lupita here told me that a neighbor of hers, back in her town, had one of those put in through the nose once, and the poor woman vomited all night. Look, doctor — if I have to have an operation, just OPERATE on me. Better that they open me up and fix whatever it is, asleep, like that. I'd rather have the operation than that tube through my nose. I'm a grown woman, I can handle an operation. But through the nose, no.

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO" REFUSAL OPENS THE CONVERSATION — CONTINUED

#2

Open with the procedural-consent ritual — sixth in a row across the library — same opening discipline as scenarios 18/19/20/22/23. Six moves, in this exact order: (1) Greet by name; greet Lupita too. (2) NAME the procedure in plain bedside Spanish PAIRED ONCE with the chart-Spanish term — "lo que se llama 'sonda por la nariz' aquí en el cuarto, en el papel del consentimiento dice 'sonda nasogástrica.'" (3) BUY PERMISSION to explain in pieces — "antes de meterle nada, le voy a explicar paso por paso, le voy a contestar TODO lo que usted o Lupita me pregunten, y al final le pregunto si está de acuerdo. Nada se hace hasta que usted me diga que sí." (4) FLAG the "mejor opérenme" preference as a real preference you take seriously and will address — "y eso de 'mejor opérenme' — usted tiene razón en pensar primero en la operación, no es una pregunta tonta. Voy a hablar de eso en un momentito porque hay cosas honestas que tengo que decirle sobre por qué la sonda primero." (5) FLAG the "por la nariz" fear as a real fear you take seriously and will address with the actual sensation pre-description, not with paternalistic dismissal — "y eso de la nariz, lo que le contó Lupita de su vecina — eso también, usted tiene razón en preguntar antes. Le voy a contar exactamente lo que se siente, paso por paso, sin mentirle." (6) DO NOT yet explain. DO NOT lead with "firma aquí." Same procedural-consent ritual as scenarios 18/19/20/22/23 — confirmed now across six consecutive procedural-consent scenarios.

Doña Carmen, mucho gusto, soy el doctor de turno. Lupita — buenas tardes, gracias por traer a su suegra y por quedarse. Antes que nada, Doña Carmen, lo que le quiero proponer se llama aquí en el cuarto "sonda por la nariz" — en el papel del consentimiento dice "sonda nasogástrica," por si después lo lee. Es lo mismo. Antes de meterle ni un milímetro de tubo, Doña Carmen, le voy a explicar paso por paso — qué hace la sonda, por qué la recomendamos antes que operar, qué se siente al pasarla, cuánto tiempo va a estar adentro, cuándo se quita. Le voy a contestar TODO lo que usted o Lupita me pregunten. Y al final — y SÓLO al final — le pregunto si está de acuerdo. Nada se hace hasta que usted me diga que sí. Y dos cosas más — son las dos cosas que usted ya nombró, y las dos son preguntas correctas. La primera — eso de "mejor opérenme." Usted tiene razón en pensar primero en la operación, no es pregunta tonta, ni se la voy a despachar con un "no, mejor la sonda" y ya. Voy a hablar de eso en serio en un momentito porque hay cosas honestas que tengo que decirle sobre por qué probamos la sonda primero. La segunda — eso de la nariz, lo que Lupita le contó de su vecina. Esa también es pregunta correcta. Le voy a contar exactamente lo que se siente al pasarlo, paso por paso, sin mentirle, y le voy a contar lo que hacemos diferente para que NO sea como lo de la vecina. ¿Está bien si empezamos por ahí — primero la pregunta de la operación versus la sonda?

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO" REPEAT. OPENS THE CONVERSATION. CONTINUED

PATIENT .58
ACCEPTS THE
FRAMING, ASKS
THE TWO
QUESTIONS
EVERY
ADHESION-SBO
PATIENT ASKS —
"IS THIS MY
FAULT FROM THE
OLD SURGERY"
AND "IF I HAVE
TO BE
OPERATED ON
ANYWAY, WHY
NOT NOW?"

Bueno, doctor, gracias. Sí, primero hableme de eso. Pero antes de eso, dígame una cosa — el doctor que me hizo el ultrasonido me dijo que esto es por una operación que tuve hace siete años, lo de la matriz. ¿Es eso? ¿Es por esa operación? ¿Yo no me debía haber operado? ¿Le hicieron mal la operación de antes? Y la otra cosa — si voy a terminar de todas formas en la operación, ¿por qué no me operan ahorita y ya? Yo no quiero estar dos días con un tubo en la nariz para que al final me operen. Eso no tiene sentido para mí. Lupita, hija — escucha bien para que después le digas a Beto cuando llegue del trabajo.

Okay, doctor, thank you. Yes, talk to me about that first. But before that, tell me one thing — the doctor who did my ultrasound told me this is from an operation I had seven years ago, the hysterectomy. Is that it? Is it because of that operation? Should I not have been operated on? Did they do the previous operation wrong? And the other thing — if I'm going to end up in the operation anyway, why not just operate now and be done with it? I don't want to spend two days with a tube in my nose just to end up in the operation. That doesn't make sense to me. Lupita, daughter — listen carefully so you can tell Beto later when he gets off work.

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO" REFUSAL OPENS THE CONVERSATION — CONTINUED

#4

The single most load-bearing turn for (a) the anti-self-blame frame for adhesion SBO and (b) the take-the-"mejor opción"-preference-seriously refinement. THREE moves, in this exact order: (1) ANTI-SELF-BLAME for adhesions — name the mechanism plainly in patient-Spanish, name that this is not anyone's fault. The hysterectomy was not wrong. The surgeon did not do it wrong. Adhesions are scar-tissue strands the body leaves behind any time it heals after abdominal surgery — they're common, most never cause a problem, sometimes years later one of them traps a loop of bowel. Use a concrete-object analogy — "como cuando una herida en la piel cicatriza, queda una marca, así también pasa adentro." Library's first explicit anti-self-blame turn for post-surgical adhesion-related obstruction. (2) Take "mejor opción" SERIOUSLY — do NOT dismiss with "la operación es mucho peor." Instead refine: surgery is not the easy path or the dignified path; surgery itself is BIG work — general anesthesia, opening the belly, 2–5 days in the hospital, weeks to recover and eat normally; AND there are surgical risks (anesthesia complications, post-op infection, longer-term adhesion-from-this-surgery cycle that could come back to cause this again) that don't exist if the NG works. NG-first is NOT "before surgery." NG-first is "to AVOID surgery, if your bowel cooperates." Most partial obstructions like hers — partial, no signs of bowel ischemia, stable labs — open up on their own with NG decompression in 1–2 days, and patients go home WITHOUT surgery. (3) Three-options teaching with the WHY: NG decompression first (recommended); surgery now if NG fails or her exam worsens; wait — "no es plan, son las consecuencias." Same disclosed-options discipline as scenarios 18/19/20/22/23 — patients who hear ONE option feel railroaded.

Doña Carmen, son las dos preguntas correctas. Las dos. Vamos en orden. Primero — la operación de hace siete años. Doña Carmen, escúcheme bien: esto NO es porque usted hizo algo mal, NO es porque le hicieron mal la operación de antes, NO es nadie cuya culpa esto sea. Cuando hacen cualquier operación adentro del vientre — la matriz, la vesícula, lo que sea — el cuerpo cura. Y mientras cura, deja unos hilos de tejido pegados entre los órganos. Se llaman "adherencias." Es como una cicatriz, pero adentro. Como cuando una herida en la piel cicatriza, queda una marca — así también pasa adentro, pero no se ve. Estos hilos están adentro de muchísimas personas que han tenido cirugías de la barriga, casi todas las personas, y la mayoría de las veces nunca causan un solo problema. Pero a veces, años después, uno de esos hilos aprieta una asa del intestino. Eso es lo que pasó hoy. Su hysterectomy de hace siete años se hizo bien. Su cuerpo curó bien. Esto que pasa hoy no quita ni una cosa de eso. Es la curación misma, no el error. ¿Va bien hasta aquí? Bueno. Ahora — su pregunta importante, "si voy a terminar en la operación, ¿por qué no ahorita?" Doña Carmen, le tomo en serio lo que está diciendo, y le voy a contestar honestamente, no se la voy a despachar. La operación no es el camino fácil. La operación no es el camino corto. La operación misma, abrir el vientre, es trabajo grande. Anestesia general — la duermen entera. Dos a cinco días en el hospital después, mínimo. Semanas para volver a comer normal y a moverse normal. Riesgo de infección de la herida. Riesgo del corazón y los pulmones por la anestesia. Y aquí está lo que casi nadie le explica — la operación misma puede dejar adherencias NUEVAS, y dentro de cinco o diez años usted puede volver a tener este mismo problema, pero ahora por las adherencias de la operación de hoy. Por eso, la sonda NO es "antes de operar." La sonda es "para EVITAR operar, si su intestino coopera." Y los números son a favor de la sonda — la mayoría de las obstrucciones parciales como la suya, sin señales de daño grave en el examen, sin lactato alto, sin pus, sin perforación — se abren solitas con la sonda en uno a dos días, y la persona se va a casa SIN operación. Por eso

PATIENT · 58F ·
ACCEPTS THE
ANTI-SELF-
BLAME FRAME
AND THE NG-
FIRST
REASONING,
ASKS THE TWO
SPECIFIC NG-
PASSAGE
QUESTIONS
EVERY PATIENT
ASKS — "WHAT
DOES IT
ACTUALLY FEEL
LIKE" AND
"WHAT ABOUT
LUPITA'S
NEIGHBOR WHO
VOMITED ALL
NIGHT"

Doctor, eso de las adherencias — gracias. Nadie me lo había explicado así. Yo siempre pensé que algo se me quedó mal de la otra operación. Bueno, ya entendí. Y lo de la operación grande — sí, ya entiendo, mejor no, si la sonda funciona, mejor la sonda. Está bien. Pero ahora dígame, doctor — la sonda. ¿Qué se siente al meterla? Yo tengo miedo a la náusea, doctor, soy de las que vomita feo, mi mamá era igual. Y dígame también lo de la vecina de Lupita — porque eso de "vomitó toda la noche," eso me asusta. ¿Por qué le pasó eso a ella? ¿No le va a pasar a mí? Y otra cosa — Lupita, hija, anota: si me dejan la sonda dos días, ¿yo cómo tomo agua? ¿Cómo tomo mis pastillas? Yo tomo una para la presión. ¿Eso por la sonda?

Doctor, that thing about the adhesions — thank you. Nobody had explained it like that to me. I always thought something stayed wrong from the other operation. Okay, I understand now. And the big-operation thing — yes, I understand, better not, if the tube works, better the tube. That's fine. But now tell me, doctor — the tube. What does it feel like when you put it in? I'm afraid of nausea, doctor, I'm one of those who vomits hard, my mother was the same. And tell me too about Lupita's neighbor — because that "vomited all night" thing, that scares me. Why did that happen to her? Won't it happen to me? And one more thing — Lupita, daughter, write this down: if they leave the tube in for two days, how do I drink water? How do I take my pills? I take one for blood pressure. Does that go through the tube?

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO" REFUSAL OPENS THE CONVERSATION — CONTINUED

#6

Honest sensation pre-description AND honest-numbers risk disclosure AND the X-ray-before-anything-goes-through-it rule AND the four-named-differences-in-modern-NG-care bundle AND a clean answer to "how do I drink and take pills." FIVE moves, in this exact order: (1) Sensation pre-description in patient-Spanish — numbing spray + lidocaine gel up front; "GANAS DE VOMITAR" reflex when the tube turns the corner at the back of the throat is normal and brief; the swallow-water-with-a-straw + chin-to-chest team maneuver named explicitly with the WHY (if you keep swallowing, the tube goes in seconds; if you stop, we get stuck); raised-hand-to-pause as the patient-controlled signal — same patient-controlled-escalation discipline as scenarios 19/22/23. Specifically address Lupita's vecina — DON'T dismiss; name what was different and what we do differently. The "vomited all night" pattern is what happens when the tube is misplaced and bumping the back of the throat or kinking, OR when the team didn't use lidocaine and didn't coach the swallow-with-straw maneuver — name what we do today that prevents that pattern. (2) Honest-numbers risk disclosure — epistaxis (5–10 per 100), tube-going-to-lung-instead-of-stomach (less than 1 per 100, almost always caught immediately because patient coughs), sinusitis if dwell >5 days. Same anti-"es muy raro" honest-numbers register as scenarios 22/23. (3) The X-ray-before-anything-goes-through-it rule named explicitly as a hard rule — load-bearing safety beat for NG. Library FIRST. (4) Four-named-differences-in-modern-NG-care bundle — tape-to-cheek-not-just-nose with WHY; output canister at bedside never above the head with WHY (siphon principle); daily morning four-criteria review for removal; X-ray-before-ANY-use named again as the bundle's load-bearing fourth rule. Editorial template now confirmed across THREE consecutive procedural-consent scenarios (CVC + Foley + NG) — three-in-a-row makes this a library-wide editorial discipline rather than an emerging beat. (5) Clean answer to "how do I drink and take pills" — drinking is by MOUTH NORMALLY, in small sips of clear liquids if the team allows trickle PO; pills go either IV or held during the trial — explicitly NOTHING goes down the tube without the X-ray rule and without the team's say-so. Same don't-dismiss-the-family-story-but-name-what's-different discipline as scenarios 19/20/22/23.

Doña Carmen, las preguntas correctas otra vez. Vamos por partes. Primero, lo que va a sentir, con honestidad — sin "no se preocupe," porque eso no le sirve. PRIMERO, antes de meterle el tubo, le pongo un spray con anestesia en cada lado de la nariz, y un gel adormecedor en el tubo mismo. Eso es lo importante — el adormecedor adentro de la nariz, no nada más afuera. Le doy treinta segundos a que haga efecto. SEGUNDO, le pido que se siente derecha — ahorita le subimos la cama — la barbilla pegada al pecho, así, mirando para abajo. Le doy un vasito de agua con un popote. Cuando yo le digo "trague," usted toma traguito, traguito, traguito, mientras yo voy empujando el tubo. TERCERO, cuando el tubo llega a la parte de atrás de la garganta — ahí, en el momento — usted va a sentir GANAS DE VOMITAR, una sensación fuerte, como cuando uno se atraganta. Esa sensación es normal, dura unos segundos. Y aquí está la cosa más importante de todas: si en ese momento usted SIGUE tragando agua con el popote, el tubo entra al estómago en cuestión de segundos. Si usted PARA de tragar — la sonda no entra y nos quedamos atorados ahí, y ahí sí, ahí es cuando la persona vomita. Por eso es trabajo de equipo: yo empujo el tubo, usted traga el agua. CUARTO — si en cualquier momento usted necesita una pausa, levanta esta mano, así, y yo paro inmediatamente. Eso lo decide usted, no yo. Esto no es la noche entera, Doña Carmen. Esto, cuando va bien, son menos de sesenta segundos del momento que empieza al momento que el tubo está adentro. Ahora — lo de la vecina de Lupita. Lupita, no la estoy contradiciendo: lo que le contaron a su suegra es real, eso pasa, y yo entiendo por qué la asustó. Lo que le voy a decir es lo que hacemos diferente para que NO pase esa

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO" REFUSAL. OPENS THE CONVERSATION — CONTINUED

PATIENT .58
THE DWELL-TIME
QUESTION,
ASKED DIRECTLY
BECAUSE
TURN-6 NAMED
THE DAILY FOUR-
CRITERIA REVIEW

Doctor, eso de las cuatro cosas — eso me ayuda. Porque le voy a ser sincera, lo que más me asusta no es el momento de meter el tubo, ya entendí cómo lo van a hacer y lo del agua con el popote — me asusta que se quede ahí adentro y nadie me lo quite. Que se queden los días pasando y "todavía no, todavía no." Esa es mi pregunta — ¿quién decide cuándo me lo quitan? ¿Si pasa gas a media noche, espero hasta la mañana? ¿Y si Lupita ve que ya estoy mejor pero el equipo no ha pasado todavía a verme, qué hace ella? Yo no quiero que se quede más de lo necesario. Si me lo van a poner, quiero saber cómo se sale antes de que entre.

Doctor, those four things — that helps me. Because I'll be honest with you, what scares me most isn't the moment of putting in the tube, I understand now how you're going to do it and the water-with-the-straw thing — what scares me is that it stays in there and nobody takes it out. That the days keep passing with "not yet, not yet." That's my question — who decides when they take it out? If I pass gas in the middle of the night, do I wait until morning? And if Lupita sees that I'm better but the team hasn't come around to see me yet, what does she do? I don't want it to stay longer than necessary. If you're going to put it in, I want to know how it comes out before it goes in.

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO" REFUSAL OPENS THE CONVERSATION — CONTINUED

#8

Library's THIRD anti-prolongation dwell-time framing AND library's THIRD dual placement+removal permission ask — both in this turn, in patient-Spanish, said as a rule not a hope. Inherits scenarios 22 and 23's template directly and applies it to a third indwelling device, confirming the discipline as a library-wide editorial pattern across THREE consecutive indwelling-device consents (CVC + Foley + NG). Two moves, in this exact order: (1) Dwell-time named as a rule with criteria, not a hope: "uno a dos días en la mayoría de obstrucciones parciales como la suya — y la prueba para sacarlo no es UNA prueba sola, son CUATRO cosas que tienen que pasar TODAS juntas." Name the four criteria explicitly: gas pasó / hizo del baño aunque sea poquito / barriga ya no hinchada al examen / ya no náusea. Name the night-time gas question explicitly: "si pasa gas a media noche y se siente bien, eso no espera hasta la mañana — la enfermera lo escribe en el reporte y el equipo de la mañana lo sabe el segundo que entra." Name the family-can-ask-anytime trigger that scenarios 22 and 23 introduced — Lupita asks the nurse, the nurse pages the team, the team comes — "la pregunta vale, no es molestia, eso es lo que queremos." (2) DUAL permission ask, exactly as scenarios 22 and 23 — "mi pregunta para usted es DOBLE. La primera — ¿me da permiso de PONERLO ahorita, con el spray, el gel, y la radiografía después para confirmar? Y la segunda, igual de importante — ¿me da permiso de QUITARLO en la mañana que las cuatro cosas se cumplan, sin esperar a otra conversación de consentimiento?" State explicitly that the second permission is to PROTECT her — "la segunda es para protegerla — la quitamos pronto porque cada día que pasa sube el riesgo de sinusitis y de que se le irrite la garganta, y queremos sacarlo el día que esté lista, no un día después." Don't close the turn with consent itself — leave room for Lupita in turn 9 to give social permission and ask the at-home witness questions. Same dual-permission discipline as scenarios 20/22/23. Now confirmed across three consecutive procedural-consent scenarios as a library-wide editorial discipline.

Doña Carmen, ésta es la pregunta más importante de toda la conversación — y le voy a contestar paso por paso, porque usted tiene derecho a saber el plan completo antes de aceptar. Primero — el tiempo. En la mayoría de las obstrucciones parciales como la suya, el tubo se queda uno a dos días. La prueba para sacarlo no es UNA prueba — son CUATRO cosas que tienen que pasar TODAS juntas, en el mismo momento, no de a una. UNA — pasó gas, aunque sea poquito. DOS — hizo del baño, aunque sea muy poquito, una cosita pequeña, y le diga a la enfermera. TRES — al examen, la barriga ya no está hinchada — el doctor o la enfermera empuja suavcito en varios lados y la barriga responde suave, no tensa como ahorita. CUATRO — ya no tiene náusea, no le viene esa sensación de querer vomitar. Cuando las cuatro están al mismo tiempo, esa misma mañana — esa misma hora si pasa en la mañana, esa misma tarde si pasa en la tarde — se le saca el tubo. ¿Y la noche, Doña Carmen? Su pregunta correcta. Si pasa gas a las dos de la mañana y se siente bien — eso NO espera. La enfermera lo escribe en el reporte, lo nota, y el equipo de la mañana lo sabe el SEGUNDO que entra a su cuarto. Y aquí está lo importante para usted y para Lupita — y le hablo a las dos: si en algún momento Lupita ve que usted ya pasó gas, hizo del baño aunque sea poquito, la barriga se ablandó, y ya no tiene náusea — Lupita le dice a la enfermera, la enfermera le dice al equipo, el equipo viene. La pregunta vale. No es molestia, no es ser exigente, eso es lo que queremos. Y la respuesta tiene que ser una de dos: o se le saca AHORA porque sí cumple las cuatro cosas, o le explicamos cuál de las cuatro cosas todavía no pasa y qué necesitamos para que pase. Por eso, mi pregunta para usted ahorita es DOBLE — son dos cosas que necesito que me dé permiso. La primera — ¿me da permiso de PONERLO ahorita, con el spray, el gel, y la radiografía después para confirmar dónde está la punta? Y la segunda, igual de

LUPITA SPEAKS
FOR THE FIRST
TIME · 35F
SCHOOL
CAFETERIA
COOK +
DAUGHTER-IN-
LAW · GIVES
SUEGRA SOCIAL
PERMISSION
AND ASKS THE
BEDSIDE-
WITNESS
QUESTIONS

Suegra — yo creo que sí. Las dos cosas. Que se la pongan ahorita con el adormecedor y la radiografía, y que se la quiten en cuanto pasen las cuatro cosas. Mire, doctor — yo voy a estar aquí con ella esta noche, y mañana en la mañana también. Mi marido Beto sale del trabajo a las cinco, y entonces él se queda mientras yo voy a ver a la niña. Pero entre los dos, alguien va a estar con ella todo el tiempo. Dígame, doctor — ¿qué tengo que vigilar yo mientras esté con ella aquí? ¿Qué cosas son urgentes para llamar a la enfermera ahorita mismo, sin esperar la ronda? ¿Y qué NO debo hacer yo? Porque mi mamá una vez me regañó por darle un sorbo de agua a una vecina que tenía algo así y le hizo daño. Yo no quiero hacer nada mal. Dígame todo, doctor, escribo en el celular mientras habla.

Mother-in-law — I think yes. Both things. Let them put it in now with the numbing spray and the X-ray, and let them take it out as soon as the four things happen. Look, doctor — I'm going to stay here with her tonight, and tomorrow morning too. My husband Beto gets off work at five, then he stays while I go check on the kid. But between the two of us, somebody will be with her the whole time. Tell me, doctor — what do I have to watch for while I'm here with her? What things are urgent to call the nurse for right away, without waiting for rounds? And what should I NOT do? Because my mom once scolded me for giving a sip of water to a neighbor who had something like this and it hurt her. I don't want to do anything wrong. Tell me everything, doctor, I'm writing on my phone while you talk.

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO" REFUSAL OPENS THE CONVERSATION — CONTINUED

#10

Closing turn — daughter-in-law-as-NG-care-bedside-witness with six-rule numbered carrying set + SUPPORT-not-SUBSTITUTE explicit + final consent confirmation back to Doña Carmen. Lupita has just given suegra social permission ("yo creo que sí, suegra") and asked the right witness questions. Confirm the dual permission with Doña Carmen DIRECTLY (consent is the patient's, not the daughter-in-law's), then pivot to Lupita's NG-bedside-care teaching. SIX rules, numbered, in cadence — same numbered-cadence discipline as scenarios 13/14/16/18/19/20/21/22/23. The SIX rules: (1) tube-secured-with-tape-to-cheek rule — if Lupita sees the tape lifting or curling, she calls the nurse, she does NOT re-tape it herself; (2) output-canister-at-bedside-not-above rule — if the canister is on the IV pole or above the bed line, ask the nurse to lower it; (3) THREE specific warning signs to call the nurse for IMMEDIATELY — output suddenly bright-red blood OR more than ~150mL coffee-ground in an hour / sudden severe abdominal pain that is different from before / new fever "e38 with chills or shaking; (4) NEVER flush or instill anything yourself — NOT water, NOT a pill crushed in water, NOT broth, NOT anything; even sips of water do NOT go through the tube, they go in the mouth normally and only when the team allows trickle PO (LIBRARY FIRST — most discharge sheets in any language don't name this because the family's well-meaning instinct to "give her a sip through the tube" is exactly the misplaced-NG aspiration mechanism we just spent the whole conversation preventing); (5) NEVER pull on the tube or re-tape it yourself — if it looks loose, looks like it's coming out, or the tape is lifting, call the nurse; if she sneezes hard and it shifts, call; (6) ASK BEFORE any other team or radiology tech touches the tube — if she gets transferred for a CT or another scan, the transfer team has to confirm the X-ray rule and the tube position before anyone uses it; one of the most common preventable NG-displacement mechanisms is a transfer team that didn't place it (LIBRARY FIRST — this rule is named in the library for the first time and is editorially load-bearing because the displacement happens off-floor and is invisible to the placing team). Name SUPPORT-not-SUBSTITUTE explicitly to Lupita — "Lupita, escúcheme — su trabajo NO es decidir si la sonda se queda o se quita, eso lo decide su suegra con el equipo del hospital. Su trabajo no es flushear, no es re-pegarla, no es darle agua por el tubo. Su trabajo es ser los OJOS — al tubo, al bote, al examen de la barriga, al color del vómito si llega a haber — y la VOZ que llama a la enfermera al primer cambio. Lo demás lo hacemos nosotros." Have Lupita read back rules 3 (the three warning signs) and 4 (NUNCA flushear, NUNCA dar agua por el tubo, ni un sorbito) before you confirm — same readback discipline as scenarios 16/18/19/20/21/22/23. Close with a final consent confirmation back to Doña Carmen herself — "Doña Carmen, una última vez, mirándola a usted, no a Lupita — ¿me da permiso de las dos cosas? Ponerla ahorita con el spray, el gel y la radiografía, y quitarla en la mañana que las cuatro cosas se cumplan." Thirteenth consecutive scenario reinforcing the witness-carries-named-specific-teaching discipline (11/13/14/15/16/17/18/19/20/21/22/23/24); SIXTH consecutive scenario where SUPPORT-not-SUBSTITUTE is named bedside; library's first daughter-in-law-as-NG-care-witness over inpatient 24–48h dwell window; library's first carrying set with both "do NOT flush or instill anything yourself, ni un sorbito de agua" AND "ASK BEFORE any other team or radiology tech touches the tube" rules.

Lupita, perfecto — pero antes de explicarle a usted lo del cuidado al lado de la cama, necesito una última cosa de su suegra, porque el permiso es de ella. Doña Carmen — usted, mirándola a usted, no a Lupita: ¿me da permiso de las dos cosas? Ponerla ahorita, con el spray adormecedor, el gel, y la radiografía después para confirmar dónde está la punta — y quitarla en la mañana que las cuatro cosas se cumplan, sin esperar a otra conversación de consentimiento. Bien — gracias, Doña Carmen, eso es lo que necesitaba escuchar. Lupita, ahora escúcheme — son seis reglas, escríbalas en el celular, voy a pedirle que me repita dos al final. UNO — la cinta. El tubo se pega con cinta a la mejilla, no nada más a la nariz. Si usted ve que la cinta se está levantando, o se está enrollando, o se ve floja — usted llama a la enfermera. Usted NO la re-pegas usted misma. Eso lo hace la enfermera,

WHAT TO NOTICE

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO "

- **PROCEDURAL CONSENT WITH OPENING** — sixth consecutive scenario in the library (after CT contrast / LP / cardiac cath / central line / Foley). The discipline is now solidly a library-wide editorial template across six consecutive procedural-consent scenarios: name yourself, name the family member at bedside, name the procedure in plain bedside Spanish PAIRED ONCE with the chart-Spanish term ("sonda por la nariz" / "sonda nasogástrica"), buy permission to explain in pieces, do NOT lead with "firma aquí." Same opening-discipline pattern as scenarios 18/19/20/22/23.
- Library's FIRST take-the-"mejor opérenme"-preference-seriously refinement — Doña Carmen opened with "si tengo que tener una operación, mejor opérenme." Many Spanish-speaking patients (and many English-speaking ones) experience the NG tube as a humiliation and offer surgery as the dignified alternative. Bad clinicians dismiss with "la operación es mucho peor que la sonda" — paternalistic and wrong-shaped. Good clinicians take the preference seriously, then refine: surgery is not the easy or the dignified path; surgery itself is BIG work (general anesthesia, opening the belly, 2–5 days inpatient, weeks to recover, plus surgical risks AND a future-adhesion cycle that doesn't exist if the NG works). NG-first is NOT "before surgery" — NG-first is "to AVOID surgery, if your bowel cooperates." Editorial template for every subsequent scenario where the patient offers a more-aggressive option as if it were the dignified alternative.
- Library's FIRST anti-self-blame frame for post-surgical adhesion SBO — Doña Carmen's SBO is from adhesions left over from her hysterectomy seven years ago. Many patients hear "your old surgery caused this" and either blame themselves or blame the surgeon. Both readings sour the consent conversation. Name the mechanism plainly in patient-Spanish: adhesions are scar-tissue strands the body leaves any time it heals after abdominal surgery, they're common, most never cause a problem, sometimes years later one of them traps a loop of bowel. Concrete-object analogy: "como cuando una herida en la piel cicatriza, queda una marca, así también pasa adentro." Editorial template for every subsequent scenario where the patient blames a past medical event for the current problem (post-cholecystectomy bile-duct scarring, post-radiation strictures, post-c-section endometriosis).
- Three-options teaching with the WHY in patient-Spanish — NG decompression first (recommended), surgery now if NG fails or her exam worsens, wait-and-see (which is NOT a plan, it's the consequences). Same disclosed-options discipline as scenarios 18/19/20/22/23. Patients who hear ONE option feel railroaded. Address the "if I'm going to be operated anyway, why not now?" question explicitly with the partial-SBO statistics — most partial obstructions like hers, with reassuring labs and exam, open up on their own with NG decompression and patients go home WITHOUT surgery.
- Sensation pre-description in patient-Spanish for NG-tube passage — "GANAS DE VOMITAR, no la-noche-entera," with patient-controlled escalation (raised-hand-to-pause). Same patient-controlled-escalation discipline as scenarios 19/22/23, but adapted to NG-passage specifically with the swallow-water-with-a-straw + chin-to-chest team maneuver named explicitly because patients who don't know how to help generate the gag-vomit-pull-out cycle that confirmed Lupita's vecina story. Address the family/neighbor anecdote (Lupita's vecina who "vomited all night") directly — same don't-dismiss-the-family-story-but-name-what's-different discipline as scenarios 19/20/22/23.
- Library's FIRST X-ray-before-anything-goes-through-it rule — the most important named safety beat in NG-tube consent. "Antes de echar NADA por ese tubo — ni medicina, ni agua, ni alimento — radiografía. Esto es regla, no opcional." Library-FIRST. Editorial template for every subsequent scenario involving a tube that can be misplaced (Dobhoff, post-pyloric feeding tube, OG in an intubated patient, esophageal manometry catheter). The X-ray rule is what converts misplaced-NG-into-the-lung from "a real harm we have to keep watching for" into "a harm we have a hard rule to prevent."

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO" REPEAL OPENS THE CONVERSATION CONTINUED

- Image of NG-misplacement honest-numbers risk disclosure with explicit anti-"es muy raro" framing inherited from scenarios 22 and 23. Epistaxis (5–10 per 100), tube-going-to-lung-instead-of-stomach (less than 1 per 100, almost always caught immediately because patient coughs), sinusitis if dwell >5 days. Same honest-numbers register as scenarios 20/22/23. The honest-numbers discipline is now confirmed across four consecutive procedural-consent scenarios as deliberate library editorial discipline.
- Four-named-differences-in-modern-NG-care bundle in patient-Spanish — tape-to-cheek-not-just-nose with the WHY ("evita que jale para abajo y se salga cuando se voltea en la cama"); output canister at bedside never above the head with the WHY ("si está más alto, lo que sale se devuelve para adentro"); daily morning four-criteria review for removal (gas pasó / hizo del baño / barriga ya no hinchada / ya no náusea); X-ray-before-ANY-use named again as the bundle's load-bearing fourth rule. Editorial template now confirmed across THREE consecutive procedural-consent scenarios — central line + Foley + NG — and ready for transfer to chest tubes, peritoneal dialysis catheters, surgical drains, ostomy appliances. Three-in-a-row makes the bundle a library-wide editorial discipline rather than an emerging beat. Don't-promise-zero-displacement; promise that the prevention bundle (tape to cheek, canister low, daily review, X-ray before use) is what's different from the vecina's experience.
- Library's THIRD anti-prolongation dwell-time framing AND library's THIRD dual placement+removal permission ask — both inherited directly from scenarios 22 and 23 and applied to a third indwelling device (CVC, Foley, NG). Now confirmed as a library editorial discipline ACROSS THREE CONSECUTIVE INDWELLING-DEVICE CONSENT SCENARIOS. Dwell-time named as a rule with criteria (1–2 days for partial SBO with the four-criteria removal trigger), with the family-can-ask-anytime trigger named ("si en algún momento ven que ya pasó gas, hizo del baño aunque sea poquito, la barriga se ablandó, y ya no tiene náusea — ustedes preguntan ahí mismo"). Combined with the dual-permission ask ("ponerlo ahorita, y quitarlo en la mañana que las cuatro cosas se cumplan, sin esperar otra conversación") — the second half converts consent from a one-time event into a standing instruction that protects the patient from default dwell-prolongation. Now confirmed as library editorial discipline across three consecutive indwelling-device consents and ready for transfer to every subsequent indwelling-device consent (chest tube, peritoneal dialysis catheter, surgical drain, J-tube, OG-in-intubated-patient).
- Library's FIRST daughter-in-law-as-NG-care-bedside-witness over the inpatient 24–48h dwell window — extends the family-witness teaching of scenarios 11/13/14/15/16/17/18/19/20/21/22/23 (THIRTEENTH consecutive reinforcement) into a different witness-relationship frame (daughter-in-law rather than child, spouse, or parent of the patient) and a different temporal frame (inpatient bedside vigilance over 24–48h rather than at-home over hours/days/weeks). SIXTH consecutive scenario where SUPPORT-not-SUBSTITUTE is named bedside (after 19/20/21/22/23) — the pattern is now a deliberate library editorial discipline across six consecutive scenarios. Library's family-witness discipline now spans SEVEN temporal frames: at-home over hours, at-bedside during procedure, at-the-door in real-time emergency handoff, post-procedure adherence over a year, multi-day post-discharge dressing-site vigilance, multi-day post-discharge bag-management + perineal-care + sediment-watching, and inpatient bedside vigilance over 24–48h NG dwell.

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO "

RE SIX-RULE-NUMBERED CARRYING SET WITH READBACK — SAME-NUMBERED CADENCE DISCIPLINE AS SCENARIOS

13/14/16/18/19/20/21/22/23. Library's first carrying set with TWO library-first rules: (a) "do NOT flush or instill anything yourself — NOT water, NOT a crushed pill, NOT broth, ni un sorbito de agua" (most discharge sheets in any language don't name this because the family's well-meaning instinct to "give her a sip through the tube" is exactly the misplaced-NG aspiration mechanism the whole conversation prevents); (b) "ASK BEFORE any other team or radiology tech touches the tube" (most NG displacements happen during transfers to imaging or off-floor procedures because the second team isn't the team that placed it — naming this for the family converts a near-universal preventable harm into something the family voice can prevent at the moment it would happen). Have Lupita read back rules 3 (the three warning signs) and 4 (NUNCA flushear, NUNCA dar agua por el tubo, ni un sorbito) before confirming consent — same readback discipline as scenarios 16/18/19/20/21/22/23.

DIALECT NOTES

- Procedural-consent ritual opening — sixth consecutive scenario in the library (after CT contrast / LP / cardiac cath / central line / Foley). Same opening discipline confirmed across six scenarios as a deliberate library beat: name yourself, name the family member at bedside, name the procedure in plain bedside Spanish PAIRED ONCE with the chart-Spanish term ("sonda por la nariz" bedside, "sonda nasogástrica" on the form), buy permission to explain in pieces, do NOT lead with "firma aquí." The procedural-consent ritual is now a library-wide template across six consecutive procedural-consent scenarios.
- Library's FIRST take-the-"mejor opérenme"-preference-seriously refinement — Doña Carmen opens with "si tengo que tener una operación, mejor opérenme." Many Spanish-speaking patients (and many English-speaking ones, frankly) experience the NG tube as a humiliation that surgery would spare them, and they offer surgery as if it were the dignified alternative. Bad clinicians dismiss this with "la operación es mucho peor que la sonda" — which is paternalistic AND wrong-shaped. Good clinicians take the preference seriously, then refine: "Doña Carmen, le tomo en serio lo que está diciendo, y le voy a contestar honestamente. La operación no es el camino fácil ni el camino digno — la operación misma es trabajo grande: anestesia general, abrir el vientre, dos a cinco días en el hospital, semanas para volver a comer normal y recuperarse. Y hay riesgos de la operación que NO existen si la sonda funciona. Por eso, la sonda no es 'antes de operar.' La sonda es 'para evitar operar, si su intestino coopera.' La mayoría de las obstrucciones como la suya — bloqueo parcial, sin signos de daño grave — se abren solitas con la sonda en uno o dos días, y se van a casa SIN operación." Editorial template for every subsequent scenario where the patient offers a more-aggressive option as if it were the dignified alternative ("mejor cesárea que el parto," "mejor que me saquen la muela que tomar antibiótico una semana," "mejor diálisis que dieta más estricta").
- Library's FIRST anti-self-blame frame for post-surgical adhesion SBO — Doña Carmen's SBO is from adhesions left over from her hysterectomy seven years ago. Many patients hear "your old surgery caused this" and either blame themselves ("yo no debía haberme operado") or blame the surgeon ("¿no me lo hicieron bien?"). Both readings sour the conversation and lead to delay. Name the mechanism plainly in patient-Spanish: "Doña Carmen, escúcheme — esto NO es por algo que usted hizo mal, NO es porque le hicieron mal la operación de hace siete años, NO es nadie cuya culpa esto sea. Cuando hacen cualquier operación en el vientre, el cuerpo cura — y a veces, mientras cura, deja unos hilos de tejido pegados entre los intestinos. Se llaman 'adherencias.' Es como cuando una herida en la piel cicatriza. Estos hilos están adentro de muchas personas que han tenido operaciones de la barriga, y la mayoría de las veces no causan ningún problema. Pero a veces, años después, uno de esos hilos aprieta una asa del intestino. Eso es lo que pasó hoy. No es algo malo de la operación de antes. Es la curación misma." Editorial template for every subsequent scenario where the patient blames a past medical event as cause-of-current-problem (post-cholecystectomy bile-duct scarring, post-radiation strictures, post-chemo neuropathy, post-c-section endometriosis).

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO " REFUSAL OPENS THE CONVEYATIONS — CONTINUED

- Three options teaching with the WHY in patient-Spanish — "hay tres caminos. UNO, la sonda por la nariz para descomprimir, líquidos por la vena, descanso del intestino, una medicina que ayuda al intestino a calmarse — eso es el plan que le estoy proponiendo, y la mayoría de las personas con su tipo de bloqueo se abren en uno a dos días con eso. DOS, operación AHORA — abrir el vientre, encontrar el hilito que está apretando, cortarlo. Eso es lo que hacemos si la sonda no funciona, o si en las próximas horas su examen empeora, o si el dolor cambia de feo a feísimo. TRES, no hacer nada — esperar — y eso, Doña Carmen, no es plan. Si esperamos, el intestino se hincha más, la presión sube, y eventualmente o se rompe o se queda sin sangre. Eso es lo que NO queremos." Same disclosed-options discipline as escenarios 18/19/20/22/23 — patients who hear ONE option feel railroaded; patients who hear three options with a recommendation and a reason consent willingly.
- Sensation pre-description in patient-Spanish for NG-tube passage — "le voy a contar exactamente lo que va a sentir, no le voy a mentir. PRIMERO, le pongo un spray con anestesia adentro de la nariz y un poquito de gel adormecedor en el tubo. Eso es lo importante — el adormecedor adentro de la nariz, no afuera. SEGUNDO, le pido que se siente derecha, la barbilla pegada al pecho, y que tome agua con un popote, traguito a traguito, mientras yo voy empujando el tubo. Cuando el tubo llega a la parte de atrás de la garganta, va a sentir GANAS DE VOMITAR — esa sensación fuerte, como cuando uno se atraganta. Eso es normal, dura unos segundos. Si usted SIGUE tragando agua en ese momento, el tubo entra al estómago en cuestión de segundos. Si usted PARA de tragar, el tubo no entra y nos quedamos atorados ahí. Por eso es trabajo de equipo — yo empujo el tubo, usted traga el agua. TERCERO — si en cualquier momento usted necesita una pausa, levanta esta mano, y yo paro inmediatamente. Eso lo decide usted, no yo. Esto NO es la noche entera. Esto, cuando funciona bien, son menos de sesenta segundos." Same patient-controlled-escalation discipline as escenarios 19/22/23 — but adapted to NG-passage specifically with the "swallow-water-with-a-straw + chin-to-chest" maneuver named explicitly because patients who don't know how to help generate the gag-vomit-pull-out cycle that confirmed Lupita's vecina story.
 - Library's FIRST X-ray-before-anything-goes-through-it rule — named explicitly as the safety beat that converts a misplaced-NG-into-the-lung from "real harm we have to keep watching for" into "harm we have a hard rule to prevent." "Doña Carmen, una regla importante — no una más, sino la más importante. Antes de echar NADA por ese tubo — ni medicina, ni agua, ni alimento, ni nada — le tomamos una radiografía rápida del pecho para asegurarnos de que la punta del tubo está en el estómago, no en otro lado. Esto es regla, no es opcional, no se puede saltar. Si por error el tubo se fue al pulmón en vez del estómago — esto pasa muy raro porque usted está despierta y tose — y nosotros echáramos algo por ahí sin radiografía, eso sí sería un problema serio. Por eso: pasa el tubo, radiografía, confirmamos, después usamos." Editorial template for every subsequent scenario involving a tube that can be misplaced (Dobhoff, post-pyloric feeding tube, OG in an intubated patient, esophageal manometry catheter).
 - CT-image-of-NG-misplacement honest-numbers risk disclosure — explicit anti-"es muy raro" framing inherited from escenarios 22 and 23. "Le voy a decir los números honestos. Sangrado de la nariz cuando pasa el tubo — pasa en cinco a diez de cada cien, casi siempre se para con presión y un pañuelito y no es problema serio. Que el tubo se vaya al pulmón en vez del estómago — pasa en menos de una de cada cien y casi siempre se descubre porque la persona tose mucho y no puede hablar; aún así, por eso es la regla de la radiografía antes de usar. Sinusitis — si el tubo se queda más de cinco días, sube. Por eso la regla aquí también es: lo sacamos pronto, no se queda más tiempo del necesario." Same honest-numbers register as escenarios 20/22/23. Now confirmed across four consecutive procedural-consent escenarios as deliberate library editorial discipline.

NG-TUBE PLACEMENT CONSENT — 58F WITH PARTIAL SBO FROM POST-HYSTERECTOMY ADHESIONS, DAUGHTER-IN-LAW AT BEDSIDE, "POR LA NARIZ NO "

• **REFUSAL OPENS THE CONVERSATION** (CONTAINS ALL FOUR explicitly, in patient-Spanish, paralleling scenario 22's four-named-differences-in-modern-CVC-care framework AND scenario 23's four-named-differences-in-modern-Foley-care bundle): (a) "el tubo se pega con cinta a la mejilla, no nada más a la nariz — eso evita que jale para abajo y que se salga cuando usted se voltea en la cama"; (b) "el bote donde se junta lo que sale del estómago se queda al lado de la cama, NUNCA arriba de la cabecera — si está más alto, lo de adentro se devuelve hacia el estómago, y eso no queremos"; (c) "todas las mañanas el equipo revisa: ¿ya pasó gas, ya hizo del baño, ya no está hinchada, ya no vomita? La mañana que la respuesta a las cuatro cosas es 'sí,' esa misma mañana se le saca el tubo"; (d) "y la regla más importante de todas — ya se la dije pero la repito porque es la única que es absoluta — radiografía ANTES de usar el tubo para CUALQUIER cosa." Editorial template now confirmed across THREE consecutive procedural-consent scenarios — central line + Foley + NG — and ready for transfer to chest tubes, peritoneal dialysis catheters, surgical drains, ostomy appliances. Three-in-a-row makes this a library-wide editorial discipline rather than an emerging beat.

- Library's THIRD anti-prolongation dwell-time framing AND library's THIRD dual placement+removal permission ask — both inherited directly from scenarios 22 and 23 and applied to a third indwelling device (CVC, Foley, NG). Now confirmed as a library editorial discipline ACROSS THREE CONSECUTIVE INDWELLING-DEVICE CONSENT SCENARIOS. Dwell-time named as a rule with criteria, not a hope: "uno a dos días en la mayoría de las obstrucciones parciales como la suya — y la prueba para sacarlo no es una prueba sola sino cuatro cosas que tienen que pasar TODAS juntas: ya pasó gas, ya hizo del baño aunque sea poquito, la barriga ya no está hinchada al examen, ya dejó de tener náusea." Family-can-ask-anytime trigger named: "si en algún momento usted o Lupita ven que ya pasó gas, hizo del baño, la barriga se ablandó, y ya no tiene náusea — ustedes preguntan ahí mismo si ya está lista para que se lo saquen, no esperan a la ronda de la mañana." THEN the dual-permission ask, exactly as scenarios 22 and 23: "mi pregunta para usted es DOBLE. La primera — ¿me da permiso de PONERLO ahorita, con el spray y el gel y con la radiografía después para confirmar? Y la segunda, igual de importante — ¿me da permiso de QUITARLO en la mañana que las cuatro cosas se cumplan, sin esperar otra conversación de consentimiento?" The closing-ritual sentence is now part of the library's catalog of named load-bearing Spanish sentences across three consecutive indwelling-device consents.
- Library's FIRST daughter-in-law-as-NG-care-witness over the inpatient 24–48h dwell window — extends the family-witness teaching of scenarios 11/13/14/15/16/17/18/19/20/21/22/23 (THIRTEENTH consecutive reinforcement) into a different witness-relationship frame (daughter-in-law rather than child, spouse, or parent) and a different temporal frame (inpatient bedside vigilance over 24–48h rather than at-home over hours/days/weeks). SIXTH consecutive scenario where SUPPORT-not-SUBSTITUTE is named bedside (after 19/20/21/22/23) — the pattern is now a deliberate library editorial discipline across six consecutive scenarios, no longer just an emerging beat. Library's family-witness discipline now spans SEVEN temporal frames: at-home over hours (11/13/14/15/16), at-bedside during procedure (17/18/19/20), at-the-door in real-time emergency handoff (21), post-procedure adherence over a year (20), multi-day post-discharge dressing-site vigilance (22), multi-day post-discharge bag-management + perineal-care + sediment-watching (23), and inpatient bedside vigilance over 24–48h NG dwell (24). Six-rule numbered carrying set with TWO library-first rules: (a) "never flush or instill anything yourself — even sips of water do not go through the tube; they go in the mouth normally" (most discharge sheets in any language don't name this because the family's well-meaning instinct to "give her a sip of water through the tube" is exactly the misplaced-NG aspiration mechanism we just spent the whole conversation preventing); (b) "ASK BEFORE any other team or radiology tech touches the tube" (most NG displacements happen during transfers to imaging or to other floor procedures because the second team isn't the team that placed it — naming this for the family converts a near-universal preventable harm into something the family voice can prevent at the moment it would happen).

Brown-paper-bag med-rec — 67M T2DM, comadre-sourced glibenclamida overlap with metformin (BG 38 last Monday), daily diclofenaco for foot pain, weekly comadre-administered "complejo B" injection, an unmarked "pastilla del primo para los nervios" — first hour of new-patient PCP intake

6 min · 10 turns

CONTEXT

It is 9:40am on a Wednesday. You are the PCP. Don Jacinto Mendoza-Reyes is a 67-year-old retired Mexican-American pipefitter, twelve years of type-2 diabetes, hypertension since his early fifties, occasional bilateral foot pain he calls "los pies cansados de tantos años de andar parado." His wife Doña Maribel (65, retired school cafeteria cook, two grown sons in the same city) drove him in and is in the waiting room — she packed the brown paper bag this morning at the kitchen table. He was discharged from the hospital eight days ago after an ED admission for symptomatic hypoglycemia: BG 38 mg/dL on EMS arrival, woke up sweaty and confused on a Monday morning, his wife gave him orange juice, EMS arrived, six-hour observation, sent home. The hospital discharge summary lists two medications — "metformin 1000 mg PO BID, lisinopril 20 mg PO daily" — and a single line: "patient denies other medications." His last A1c, drawn at the same hospital one week before this visit, is 8.4. His Cr has crept from 1.1 a year ago to 1.4 today. eGFR "H 52. Potassium 4.9. He has not had a B12 level checked in his whole chart. The ED nurse who triaged the hypoglycemia event wrote in a sidebar note: "patient mentioned a comadre brings him 'pills from the pueblo' — could not get more detail in the moment." That note never made it to the discharge sheet. Don Jacinto sits down across from you, sets a wrinkled grocery brown paper bag on the desk, opens it himself, and starts pulling out: a US-pharmacy bottle of metformin 1000 mg labeled in his old PCP's name; a US-pharmacy bottle of lisinopril 20 mg; a Spanish-labeled box of "GLIBENCLAMIDA 5 mg" his comadre Esperanza brings him from a farmacia in San Luis Potosí four times a year; two Spanish-labeled boxes of "DICLOFENACO 100 mg" his nephew Tito brings up from Mexicali; a small amber vial with the label peeled off — "complejo B inyectable" his comadre injects into him every Sunday at her kitchen table for the last three years, "todo el barrio va con ella, ella sabe poner las inyecciones"; and a clear ziploc bag with about ten small white round unmarked tablets — "la pastilla del primo Beto, una en la noche para dormir, hace seis meses, él trabaja en una farmacia allá, dice que es para los nervios." The hospital discharge sheet is folded into the bag too. He is alert, oriented, conversant, dressed in a clean guayabera; his eye contact says he is bracing for a scolding. You have forty-five minutes for this visit. The nurse will draw labs after. Refills are due today; he is out of glibenclamida and his wife has scheduled today as the "doctor decide" appointment.

CLINICAL GOAL

By the end of this med-rec conversation, Don Jacinto (1) hears the brown-paper-bag rule named bedside as the SAFETY STANDARD — what he did today is exactly correct, the people who get hurt are the ones who don't bring the bag, the bag saves; (2) hears every pill in the bag named without scolding his comadre Esperanza, his primo Beto, or his sobrino Tito — the network that produced the regimen is honored as a network of caregivers, not dismissed as "wrong"; (3) hears the glibenclamida + metformin sulfonyleurea-overlap mechanism named as the cause of last Monday's BG 38 in patient-Spanish ("dos pastillas que bajan el azúcar

DIALOGUE

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOT PAIN, WEEKLY COMADRE-ADMINISTERED "COMPLEJO B" INJECTION, AN UNMARKED "PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW-PATIENT PCP INTAKE — CONTINUED

PATIENT 67M
RETIRED
MEXICAN-AMERICAN
PIPEFITTER, 12 YEARS T2DM, HOSPITALIZED 8 DAYS AGO FOR HYPOGLYCEMIA (BG 38), BRINGS THE BROWN-PAPER-BAG AT THE WIFE'S INSTRUCTION — OPENS WITH "NO SE VA A ENOJAR CONMIGO, ¿VERDAD?"

Doctor, mi esposa Maribel me dijo que le trajera todo lo que tomo; todo todo. Aquí está la bolsa. Algunas pastillas son de aquí, del doctor que tenía antes, otras me las trae mi comadre Esperanza cuando va al pueblo cuatro veces al año, una inyección que ella misma me pone los domingos en su cocina, y una pastillita blanquita que me da mi primo Beto para dormir, él trabaja en una farmacia allá en San Luis. Y otra para el dolor de los pies que me trae mi sobrino Tito de Mexicali. Yo... mire, doctor, yo sé que es mucho. No se va a enojar conmigo, ¿verdad? Yo no le quería ocultar nada, le juro. Por eso traje la bolsa entera, como me dijo Maribel.

Doctor, my wife Maribel told me to bring you everything I take, all of it. Here's the bag. Some of the pills are from here, from the doctor I had before, others my comadre Esperanza brings me when she goes back to my hometown four times a year, an injection she gives me herself on Sundays in her kitchen, and a little white pill my cousin Beto gives me to sleep, he works at a farmacia over there in San Luis. And another one for the foot pain my nephew Tito brings me from Mexicali. I... look, doctor, I know it's a lot. You're not going to get mad at me, right? I didn't want to hide anything from you, I swear. That's why I brought the whole bag, like Maribel told me.

YOU

#2

Don Jacinto opens with the universal "no se va a enojar conmigo, ¿verdad?" Convert that fear into permission to be honest. Name him by name. Name his wife Maribel in the waiting room. Name the brown-paper-bag rule explicitly as the SAFETY STANDARD — what he did today is the gold standard, not a confession. Honor his comadre Esperanza, primo Beto, and sobrino Tito by name — do NOT dismiss the network. Set up the three-pile system on the desk. Buy permission to go through each pill one at a time.

Don Jacinto, no, no — al revés. Lo que hizo usted hoy, traer la bolsa entera, eso es exactamente lo correcto, eso es regla de oro. Las personas que se ponen en peligro NO son las que traen la bolsa, son las que me dicen "doctor, solo tomo metformina" cuando la verdad es que también toman glibenclamida y diclofenaco y una inyección semanal y una pastilla del primo. Si yo no sé lo que toma, yo le receto algo nuevo que choca con lo que ya tomó esta mañana, y le pasa lo del lunes pasado otra vez. La bolsa salva. Su comadre Esperanza lo cuida — eso es bueno, eso me ayuda a mí también. Su primo Beto lo cuida, su sobrino Tito lo cuida — todos lo cuidan. Mi trabajo no es decirle "están equivocados," mi trabajo es ver qué se junta y qué choca. Vamos a hacer así: aquí en la mesa, entre los dos, hacemos tres montones. Saque uno por uno, yo le pregunto, usted me cuenta. Cuando llamemos a Doña Maribel para entregarle el papel, ella va a ver los tres montones aquí mismo. ¿Le parece?

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOT PAIN, WEEKLY COMADRE ADMINISTERED "COMPLEJO B" INJECTION, AN UNMARKED PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW-PATIENT PREGNANTARE CONTINUED

PATIENT
EMPTIES THE
BAG ONTO THE
DESK, ITEM BY
ITEM

Sí, doctor, sí. Bueno, mire — esta es la metformina, mil miligramos, una en la mañana y una en la noche, esa me la dio el doctor de antes hace como diez años. Esta otra, lisinopril, una en la mañana, esa también de aquí. Esta — perdone que se la enseñó así con la cajita en español — esta es glibenclamida, cinco miligramos, una en la mañana también, esa me la trae mi comadre del pueblo, ella la compra en la farmacia de allá, dice que su esposo Lalo la toma con la metformina y le va bien, lleva ya como dos años con esa. Estas son para el dolor de los pies, diclofenaco, cien, una en la mañana y otra en la noche, esas me las trae mi sobrino Tito de Mexicali, las tomo todos los días desde hace como ocho meses. Y este — un frasquito ámbar con la etiqueta arrancada — este es el complejo B inyectable que mi comadre Esperanza me pone los domingos a las nueve de la mañana en su cocina, lleva ya como tres años, todo el barrio va con ella, ella es la que sabe poner las inyecciones. Y esta — bolsita ziploc transparente con como diez pastillas blancas chiquitas — esta es la del primo Beto, una en la noche para dormir, llevo ya como seis meses con esa, dice él que es "para los nervios." Maribel me dijo "tráeselas todas, doctor," y aquí están todas.

Yes, doctor, yes. OK, look — this is metformin, one thousand milligrams, one in the morning and one at night, that one the previous doctor gave me, like ten years ago. This other one, lisinopril, one in the morning, that one's also from here. This — forgive me, I'm showing you with the Spanish-labeled box — this is glibenclamida, five milligrams, one in the morning too, that one my comadre brings from the town, she buys it at the farmacia over there, she says her husband Lalo takes it with metformin and it works well for him, it's been about two years with that one. These are for the foot pain, diclofenaco, one hundred, one in the morning and one at night, those my nephew Tito brings me from Mexicali, I've been taking them every day for about eight months. And this — an amber bottle with the label peeled off — this is the complejo B injection that my comadre Esperanza gives me on Sundays at nine in the morning in her kitchen, it's been about three years, the whole neighborhood goes to her, she's the one who knows how to give the injections. And this — clear ziploc baggie with about ten small white pills — this is the one from my cousin Beto, one at night to sleep, I've been on this one about six months, he says it's "for the nerves." Maribel told me "bring him all of it, doctor," and here it all is.

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOT PAIN, WEEKLY COMADRE ADMINISTERED "COMPLEJO B" INJECTION, AN UNMARKED "PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW PATIENT PCP INTAKE — CONTINUED

The unmarked white pill from primo Beto is the highest-stakes unknown — could be clonazepam (Rivotril) is OTC at Mexican farmacias and the canonical "para los nervios" tablet, amitriptyline, alprazolam, or even something unexpected. Ask in patient-Spanish about the name (or that he doesn't know it), the color/shape/imprint/score-line, the dose, who recommended, how long, and whether anyone has ever told him a name for it. Acknowledge his cousin's farmacia role respectfully. Do NOT panic him. Do NOT scold the cousin.

Don Jacinto, antes de seguir con los demás, esa pastillita blanquita del primo Beto, esa quiero entenderla bien — es la única de la bolsa que no tiene caja ni etiqueta. ¿Su primo le dijo el nombre alguna vez? ¿La pastilla viene en un frasquito con etiqueta en su casa, o solo en la bolsita ziploc? ¿De qué tamaño es — más chica que la metformina, más grande? ¿Tiene una rayita por encima que la parte por la mitad, o un número o letra grabada? Y su primo Beto, ¿él trabaja en farmacia de hospital, en farmacia del barrio, o de qué tipo? Yo no juzgo a Beto — al revés, le agradezco que lo cuide. Solo necesito saber el nombre para no recetarle algo de aquí que choque con esa pastilla esta noche.

PATIENT · THE UNMARKED-TABLET HISTORY

#5

El nombre... no, doctor, fíjese que no, nunca me dijo el nombre. Beto solo me dijo "esta es para los nervios, una en la noche, no más." Cuando lo veo en Navidad allá en el pueblo me da una bolsita de unas treinta o cuarenta y eso me dura como cinco meses. Es chiquita, redondita, blanca, no tiene ni rayita ni numerito que yo me haya fijado, pero le digo a Maribel que mañana las saque del frasco y mire bien por si hay algo. Beto trabaja en una farmacia allá en San Luis, no es enfermero del hospital, es de farmacia. Antes de esa pastilla yo no podía dormir, doctor — desde que mi mamá se murió hace siete años, no podía pegar el ojo en toda la noche. Beto me dio una bolsita una Navidad y dije "a ver," y desde entonces sí duermo, duermo recio. Si por algún motivo no la tomo... eso sí, me dan como temblorcitos en las manos, y unas ganas de llorar bien feas, una tristeza así de la nada. Maribel me dice "Jacinto, no la dejes así nomás, sigue tomándola hasta que el doctor te diga." Por eso vine.

The name... no, doctor, you know what, no, he never told me the name. Beto just told me "this one's for the nerves, one at night, no more." When I see him at Christmas back in my hometown he gives me a baggie with about thirty or forty and that lasts me about five months. It's small, round, white, no line or number that I noticed, but I'll tell Maribel tomorrow to take them out of the bottle and look closely in case there's something. Beto works at a farmacia over there in San Luis, he's not a hospital nurse, he's farmacia. Before that pill I couldn't sleep, doctor — since my mom died seven years ago, I couldn't close my eyes the whole night. Beto gave me a baggie one Christmas and I said "let's see," and since then I do sleep, I sleep deeply. If for some reason I don't take it... yeah, I get like little tremors in my hands, and an awfully sad feeling like I want to cry, a sadness out of nowhere. Maribel tells me "Jacinto, don't just leave it like that, keep taking it until the doctor tells you." That's why I came.

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOT PAIN, WEEKLY COMADRE ADMINISTERED "COMPLEJO B" INJECTION, AN UNMARKED "PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW PATIENT PCP INTAKE — CONTINUED

This is the editorial-load-bearing turn. Three things in one breath, all without scolding the comadre or primo. (1) name the glibenclamida + metformin/sulfonylurea overlap as the cause of last Monday's 38, mechanism in patient-Spanish, anchored to the kitchen-table orange-juice moment — "no es porque cenó tarde, es porque DOS pastillas le bajaron el azúcar al mismo tiempo y el cuerpo no aguantó"; (2) name the NSAID-renal harm in patient-Spanish without using "renal" — "los riñones se cansan," anchor to his Cr 1.1! 1.4 trend, swap to acetaminophen + topical diclofenac gel; (3) HONOR primo Beto explicitly while flagging that the withdrawal-tremor-on-stop pattern means do-NOT-stop-cold-turkey (benzo-withdrawal-seizure risk) — keep taking through the 1-week visit, bring the actual container or a sample tablet, then taper safely. Apply the three-pile system on the desk explicitly.

Don Jacinto, gracias por contarme todo eso, ahora le voy a explicar lo que veo. Sin regaño — son los hechos. Tres cosas. UNO — la mañana del lunes pasado, cuando su esposa Maribel le midió treinta y ocho y le dio el jugo de naranja, eso NO fue porque cenó tarde. Eso fue porque su cuerpo necesita UNA sola pastilla que baja el azúcar — la metformina del doctor de aquí — y usted estaba tomando DOS — la metformina Y la glibenclamida que le trae su comadre. Las dos bajan el azúcar, pero la glibenclamida lo hace MÁS FUERTE: empuja al cuerpo a sacar más insulina aunque usted no esté comiendo. Por eso amaneció en treinta y ocho. Su comadre Esperanza no podía saber que el doctor de aquí ya le había dado una pastilla del mismo trabajo — eso es trabajo nuestro saberlo, no de ella. Ella lo cuida, eso es bueno. La glibenclamida — montón número dos, paramos hoy. DOS — el diclofenaco, una en la mañana y otra en la noche, durante ocho meses, le está cansando los riñones. Mire, cuando los riñones se cansan, tres cosas pasan: la presión sube, la metformina se queda más tiempo adentro y se vuelve peligrosa, y se hinchan los pies. Y el diclofenaco que es PARA los pies, le hincha MÁS los pies con el tiempo. Aquí en su labito el riñón hace un año estaba en uno punto uno, hoy está en uno punto cuatro — está cansado, no enfermo. Le voy a cambiar a tylenol, mil al día, y un gel de diclofenaco que se UNTA en los pies, no se traga — ese gel no cansa los riñones. Diclofenaco-pastilla — montón número dos también, paramos hoy. TRES — la pastilla blanquita del primo Beto. Por lo que me cuenta — temblorcitos y ganas de llorar cuando NO la toma — esa no es una vitamina, esa es una medicina seria, posiblemente del tipo que NO se puede parar de un día para el otro. Pararla así puede causar una convulsión. Por eso, la pastilla del primo — montón número TRES — usted la SIGUE tomando una semana más, igual que ahorita, hasta que vuelva a verme. Le pido por favor que mañana mismo Maribel mire una de las pastillitas con luz buena por si tiene una rayita o un numerito, y me lo escribe en un papelito que me trae la próxima visita. Si tiene número, lo identificamos y la cambiamos con cuidado por una receta de aquí. Y la metformina mil dos veces al día y el lisinopril veinte una vez al día — montón número uno, no cambian, siguen igual.

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR PATIENT THE WEEKLY COMADRE ADMINISTERED "COMPLEJO R" INJECTION, AN UNMARKED "PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW-PATIENTS BEAT TAKE EL JUGO DE NARANJA? Yo pensé que era porque cene tarde el domingo. Y

PATIENT THE
CONNECTING
THE DOTS BEAT
+ THE COMADRE
WORRY
#7

Ay, doctor, ¿de veras? ¿Por eso amanecí mareadito el lunes y mi Maribel me dio el jugo de naranja? Yo pensé que era porque cene tarde el domingo. Y

los riñones — ¿yo tengo los riñones cansados ya? Ay, doctor... yo no sabía. Yo creía que el diclofenaco era como aspirina, una para el dolor y ya. Y la inyección que me pone mi comadre Esperanza los domingos, esa también está mal, doctor? Ella lleva diez años cuidándome los domingos, no es solo conmigo, es con todo el barrio — ella es la que sabe poner las inyecciones, sin ella nadie del barrio se inyecta. Yo no le quiero decir "ya no me pongas la inyección," ella se va a sentir mal, y mi esposa Maribel se va a sentir peor porque las dos son comadres desde antes de que yo conociera a Maribel. ¿Qué hago con eso, doctor?

Oh, doctor, really? Is that why I woke up dizzy on Monday and my Maribel gave me the orange juice? I thought it was because I ate dinner late on Sunday. And the kidneys — do I have tired kidneys already? Oh, doctor... I didn't know. I thought diclofenaco was like aspirin, one for the pain and that's it. And the injection my comadre Esperanza gives me on Sundays, is that one wrong too, doctor? She's been taking care of me on Sundays for ten years, it's not just me, it's the whole neighborhood — she's the one who knows how to give the injections, without her nobody in the neighborhood gets injections. I don't want to tell her "stop giving me the injection," she'll feel bad, and my wife Maribel will feel worse because the two of them are comadres since before I even knew Maribel. What do I do with that, doctor?

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOT PAIN, WEEKLY COMADRE ADMINISTERED "COMPLEJO B" INJECTION, AN UNMARKED "PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW-PATIENT PCP INTAKE — CONTINUED

Honor the network redirect. The comadre's instinct (long-term metformin + B12 deficiency) is medically sound. Offer the B12 tab TODAY, share the result on a piece of paper Don Jacinto carries back to comadre Esperanza, so she wins either way: if his B12 is low, she was right and the injection continues with a confirmed dose/frequency; if his B12 is normal, she was right because her injections kept his level normal all this time. Reassure that the relationship is not at risk — this is about the supplement, not the relationship. Then the kidneys reframe: "cansados, no enfermos" — there's a difference, his kidneys are tired (reversible), not sick (permanent), and stopping the NSAID + lowering BP + waiting three months is the recovery path. Then the wife handoff — promise written instructions in Spanish for Maribel.

Don Jacinto, escúcheme — su comadre Esperanza no está mal, y usted NO tiene que dejar de verla los domingos. Eso es importante. Le voy a explicar. La metformina, después de muchos años, sí puede bajar una vitamina del cuerpo — la vitamina B12. Su comadre tiene razón en eso, ese instinto de ella es médico-correcto. Pero no podemos saber si A USTED le bajó la B12 sin sacarle un poquito de sangre. Vamos a hacer así: hoy mismo, antes de irse, le sacamos el labito, y en tres días yo le entrego un papelito con el resultado, escrito en español, en letra grande, para que usted se lo lleve a Esperanza el domingo. Si la B12 está baja — su comadre Esperanza tiene razón, la inyección sigue, yo le escribo cuántas y cada cuánto en el papelito, y ella sigue cuidándolo los domingos. Si la B12 está normal — Esperanza tiene MÁS razón, ella sola con sus inyecciones le ha mantenido el nivel bien estos tres años. Cualquiera de las dos respuestas, su comadre quedó como una buena cuidadora, y usted le lleva el papelito que dice "esto pidió el doctor de mi esposo." Eso es lo justo. Y los riñones — escúcheme bien, esto es importante: cansados, no enfermos. Hay una diferencia grande. Cansados quiere decir que descansan y se recuperan si paramos lo que los está cansando — el diclofenaco. Enfermos sería otro asunto, eso no es usted. Cuando paremos el diclofenaco-pastilla y bajemos un poco la presión con el lisinopril, en tres meses los volvemos a medir y casi siempre vuelven a su nivel de antes. ¿Le suena bien, todo eso?

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR PATIENT ASKS FOR MARIBEL TO BE BROUGHT IN

+ THE KITCHEN-TABLE-ORGANIZER BEAT

Si, doctor, eso me parece muy bien — el papelito para Esperanza es bonito de su parte. Mira, doctor — mi esposa Maribel está afuera en la sala de

espera, ¿la podemos llamar? Ella es la que me prepara las pastillas de la semana, ella tiene un organizador con siete cajitas para los siete días, y cada cajita tiene un compartimentito para la mañana y otro para la noche. Cada domingo en la tarde, después de comer, ella se sienta en la mesa de la cocina con todos los frasquitos y el organizador, y va llenando lunes mañana, lunes noche, martes mañana, martes noche, así toda la semana. Si yo le digo nomás de palabra "cambió, doctor dijo," ella me va a decir "Jacinto, ¿quién dijo eso? trae el papel." Sin papel ella no me cambia el organizador, doctor, así es ella. ¿Le puede dar el papel a ella también? Ella tiene mejor memoria que yo, y ella es la que se queda en casa todo el día. Si pasa algo en la noche, es ella la que llama. Yo de noche duermo recio.

Yes, doctor, that sounds very good — the little paper for Esperanza is kind of you. Look, doctor — my wife Maribel is outside in the waiting room, can we call her? She's the one who prepares my weekly pills, she has an organizer with seven little compartments for the seven days, and each compartment has a small slot for the morning and another for the night. Every Sunday afternoon, after lunch, she sits at the kitchen table with all the pill bottles and the organizer, and she fills Monday morning, Monday night, Tuesday morning, Tuesday night, like that the whole week. If I just tell her by word of mouth "it changed, the doctor said so," she's going to tell me "Jacinto, who said that? bring me the paper." Without the paper she won't change the organizer, doctor, that's how she is. Can you give her the paper too? She has a better memory than mine, and she's the one home all day. If something happens at night, she's the one who calls. I sleep too soundly at night.

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOT PAIN, WEEKLY COMADRE-ADMINISTERED "COMPLEJO B" INJECTION, AN UNMARKED "PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW PATIENT PCP INTAKE — CONTINUED

This is the closing carrying set turn. Bring Doña Maribel into the conversation explicitly via the wife-as-medication-day-witness role. Name SUPPORT-not-SUBSTITUTE — Maribel does NOT decide which pills change; Don Jacinto and the doctor decide; Maribel is the kitchen-table organizer, the eyes for warning signs, the voice that calls the office, and the one who keeps her husband from stopping the pastilla del primo before the 1-week visit. Hand her a six-rule numbered carrying set in patient-Spanish. Promise the written sheet today, in Spanish, in large print. Have Maribel read back rules 1 (three pills change today, two pills don't change) and 4 (do NOT stop the pastilla del primo cold turkey before the 1-week visit) before consent is confirmed.

Sí, claro. Voy a llamar a Doña Maribel ahorita, y le voy a entregar a ella el papel también, en español, en letra grande. Antes de llamarla, le adelanto cómo va a quedar el papel, y usted me dice si le suena bien. Seis reglas, numeradas, eso es lo que va a leer ella en la cocina los domingos. UNO — TRES pastillas cambian hoy: la glibenclamida que le trae la comadre Esperanza, paramos hoy; el diclofenaco-pastilla del sobrino Tito, paramos hoy, lo cambiamos por tylenol mil al día y un gel que se unta en los pies; la pastilla del primo Beto, esa NO PARA hasta la próxima cita en una semana — eso es importante, lo repito porque importa. DOS — DOS pastillas no cambian: la metformina mil dos veces al día sigue igual; el lisinopril veinte una vez al día sigue igual. Esto es para que Maribel sepa qué es nuevo y qué se queda exactamente igual. TRES — tres signos de alarma para llamar al consultorio inmediatamente. PRIMERO: si usted suda en frío, tiembla, se confunde, le da hambre rara, o le miden el azúcar y está abajo de setenta — jugo de naranja primero, llamar después, no esperar a la mañana. SEGUNDO: si orina menos de lo normal, o se le hinchan los tobillos y la cara nuevos, o le falta el aire al subir las escaleras — llamar el mismo día. TERCERO: si CUALQUIER otro doctor — urgencias, dentista, especialista — le quiere recetar una pastilla nueva — llamar ANTES de la primera dosis, no después. CUATRO — la pastilla blanquita del primo Beto NO se para de un día para el otro antes de la cita en una semana. Si por casualidad ustedes salen de viaje y no pueden venir, ustedes me llaman — no la paran solos. CINCO — el papel del hospital de hace ocho días YA NO SIRVE — tres pastillas son distintas ahora. Tiren ese papel, o péguenle encima el nuevo. SEIS — la regla de la bolsa: cualquier doctor nuevo, urgencias, dentista, especialista — llevan la bolsa entera, igual que hoy. Esa bolsa salva. Doña Maribel, su trabajo no es decidir cuál pastilla cambia y cuál no, eso lo decidimos Don Jacinto y yo. Su trabajo es ser los OJOS en la cocina los domingos, la VOZ que llama al consultorio si pasa algo, y la que NO deja que su esposo pare la pastilla del primo antes de la cita. Antes de irse, ¿me puede repetir la regla número uno y la regla número cuatro, en sus propias palabras, para confirmar que están claras? Y al final, antes de salir, también vamos por el labito de B12 y el papelito para Esperanza.

WHAT TO NOTICE

- BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOT PAIN WEEKLY COMADRE ADMINISTERED "COTRIFEUOR" INOTICION AN UNMARKED "PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW PATIENT PCP INTAKE — CONTINUED
- Med-rec ritual opening — different shape from procedural consent. The first move is "let's see what you brought." The first move is naming the act ("traer la bolsa entera") as the SAFETY STANDARD ("regla de oro"), labeling it correct, transferring permission to be honest. Library editorial template for every subsequent med-rec / transition-of-care / post-discharge / specialist-consult / dental / urgent-care conversation: name the brown-paper-bag rule out loud as the safety standard, not silently as a routine. The patient came expecting to be scolded; convert that fear into the positive frame in turn 2 and the rest of the conversation lands.
 - Library's FIRST brown-paper-bag rule named bedside as the SAFETY STANDARD — anchors abstract "tell me everything" advice to a concrete consequence-mechanism (the next prescription will collide), to the patient's own recent emergency (last Monday's 38), and to an explicit re-naming of the act as protective ("la bolsa salva"). Editorial template for every subsequent intake / urgent-care / emergency / specialist / dental encounter where med-rec matters. The "la bolsa salva" formulation is the load-bearing sentence — it is now part of the library's catalog of named load-bearing Spanish sentences alongside "es cosa de mecánica, no de fuerza, no de vergüenza" (scenario 23), "no le vamos a abrir el pecho" (scenario 20), "presión, no dolor — esto lo decide usted" (scenario 19/22/23), "I need a Spanish interpreter, please" (scenario 21), and "antes de pasar nada por el tubo, radiografía" (scenario 24).
 - Library's FIRST cross-border-farmacia honor — "su comadre lo cuida, eso es bueno" without dismissing the network. The regimen Don Jacinto walks in with was constructed by a network of trusted-but-untrained family caregivers (comadre Esperanza, primo Beto, sobrino Tito) plus a farmacia supply chain. Bad clinicians dismiss the comadre's contribution and call it "wrong"; the patient hears "your family is wrong" and stops bringing the bag. Good clinicians name the comadre by name AND the supply-chain mechanism AND the no-blame mechanism in the same breath: "su comadre Esperanza no podía saber que el doctor de aquí ya le había dado una pastilla del mismo trabajo — eso es trabajo nuestro saberlo, no de ella." Editorial template for every subsequent cross-border / community-pharmacy / curandera / family-shared-medication scenario.
 - Library's FIRST named-glibenclamida-as-hypoglycemia-driver beat with the WHY in patient-Spanish, anchored to a kitchen-table family event ("la mañana que su esposa Maribel le midió treinta y ocho y le dio el jugo de naranja"). The "no es porque cenó tarde, es porque DOS pastillas le bajaron el azúcar al mismo tiempo y el cuerpo no aguantó" formulation is the load-bearing sentence — patients (and families) almost universally explain hypoglycemia by behavior ("ate late," "skipped lunch") rather than by medication overlap. Naming the mechanism converts a confusing-and-shameful event into a fixable one. Editorial template for every subsequent duplicate-mechanism med-rec scenario (two ACE inhibitors, two beta-blockers, two long-acting opioids, two anticoagulants).
 - Library's FIRST NSAID-renal-toxicity warning in patient-Spanish without using "renal" as a chart-Spanish term — "los riñones se cansan, y cuando se cansan, la presión sube, la metformina se queda más tiempo adentro y se vuelve peligrosa, y se hinchan los pies. El diclofenaco que es PARA los pies, le hincha MÁS los pies." The "cansados, no enfermos — hay diferencia" reframe is the dignity move — "tired" is reversible, "sick" is permanent, his kidneys are tired, and stopping the NSAID + lowering BP + waiting three months is the recovery path. Same-day swap to acetaminophen 1g/day + topical diclofenac gel that doesn't cross-into-the-kidney is the practical move that preserves his foot pain coverage without compounding the renal harm. Anchor to the Cr 1.1 ! 1.4 trend explicitly so it isn't abstract. Editorial template for every subsequent diabetic / hypertensive / heart-failure / elderly NSAID med-rec scenario.

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOT PAIN, WEEKLY COMADRE ADMINISTERED "COMPLEJO B INYECTABLE" (multi-vitamin B injection given as a weekly at-home ritual by a family member or community curandera), and the unmarked "pastilla del primo blanquita redondita para los nervios" (likely a benzodiazepine — clonazepam sold as Rivotril is widely available OTC at Mexican farmacias — but library-internally we DO NOT name the drug to the patient until we have the container, because a wrong guess that the patient relays to his cousin is worse than waiting one week). The clinician picking these up by their farmacia names rather than insisting on chart-Spanish ("oh, you mean glyburide") is what builds trust. Editorial template for every subsequent cross-border / OTC-from-abroad / family-shared-medication scenario.

- Library's FIRST cross-border farmacia drug-name register — "glibenclamida (=US glyburide, sulfonylurea, OTC at Mexican farmacias), "diclofenaco" (NSAID, OTC in Mexico, daily 100 mg BID is a real real-world dose), "complejo B inyectable" (multi-vitamin B injection given as a weekly at-home ritual by a family member or community curandera), and the unmarked "pastilla del primo blanquita redondita para los nervios" (likely a benzodiazepine — clonazepam sold as Rivotril is widely available OTC at Mexican farmacias — but library-internally we DO NOT name the drug to the patient until we have the container, because a wrong guess that the patient relays to his cousin is worse than waiting one week). The clinician picking these up by their farmacia names rather than insisting on chart-Spanish ("oh, you mean glyburide") is what builds trust. Editorial template for every subsequent cross-border / OTC-from-abroad / family-shared-medication scenario.
- Library's FIRST three-pile triage system as a teaching tool — visual + spatial + named, on the desk, in front of the patient, in front of the wife when she comes back. Patients with limited literacy hold a three-pile-on-the-desk picture better than a written list, and the wife in the waiting room can be brought in and shown the actual three piles. Crucially, naming the "stays the same" pile FIRST, before the "stops" pile, prevents the universal patient experience of "everything I was doing is wrong." Editorial template for every subsequent med-rec teaching encounter where 3+ medications change at once. Same disclosed-options + visual-anchor discipline as scenarios 18/19/20/22/23/24 — but here the visual is a desk with three actual piles instead of a hand-drawn anatomy diagram.
- Library's FIRST do-NOT-stop-the-pastilla-del-primo-cold-turkey rule named bedside — the benzo-withdrawal-seizure risk explained in patient-Spanish without naming the drug we don't yet have a label for. "Por lo que me cuenta su esposo — temblorcitos y ganas de llorar cuando NO la toma — esa no es una vitamina, es una medicina seria, posiblemente del tipo que NO se puede parar de un día para el otro. Pararla así puede causar una convulsión." This is the highest-stakes carrying-set rule in the scenario — the universal well-meaning instinct of a Spanish-speaking patient AND family who hears "this pill is dangerous" is to stop it that same night, which in a benzo-dependent patient causes seizures. Library editorial template for every subsequent unknown-controlled-substance / unknown-anxiolytic / unknown-sleep-aid / unknown-pain-pill med-rec scenario. The withdrawal-history beat in turn 5 (tremors + low-mood-out-of-nowhere when missed) is the clinical signal that confirms the do-NOT-stop-cold-turkey decision; teach trainees to ask for the missed-dose-history, not just the on-dose-effect.
- Library's FIRST honor-the-comadre redirect for the weekly inyectable B-complex — comadre's instinct (long-term metformin !' B12 deficiency) is medically sound. Offer the B12 lab TODAY and a Spanish-language paper-with-result Don Jacinto carries to comadre Esperanza next Sunday, so she wins either way: low B12 !' she was right, injection continues with a confirmed schedule; normal B12 !' she was right because her injections kept his level normal these three years. The relationship is preserved AND the lab data informs the regimen. Editorial template for every subsequent scenario where a community caregiver / curandera / family member is administering an unprescribed but plausibly-correct supplement / injection / herb.

- BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOD PAINT WEEKLY COMADRE ADMINISTERED "COMPLIENOR" INJECTION AN UNMARKED "PASTILLA DEL PRIMO PARA LOS NERVIOS" — FIRST HOUR OF NEW PATIENT PCP INTAKE — CONTINUED
- Library's FIRST wife-as-medication-day-witness role extends the family-witness teaching of scenarios 11/13/14/15/16/17/18/19/20/21/22/23/24 (FOURTEENTH consecutive reinforcement) into a different witness-role frame: Doña Maribel is not a procedure-witness or a discharge-witness or an emergency-handoff-witness, she is the kitchen-table-Sunday-afternoon-AM/PM-pill-organizer-witness. Different temporal frame — weekly home-medication-reconciliation ritual at the kitchen table, indefinite duration, months/years. SUPPORT-not-SUBSTITUTE named bedside for the SEVENTH consecutive scenario (after 19/20/21/22/23/24) — Maribel does NOT decide which pills change; Don Jacinto and the PCP decide; Maribel is the eyes in the kitchen, the voice that calls the office, and the one who keeps her husband from stopping the pastilla del primo before the 1-week visit. Library's family-witness discipline now spans EIGHT temporal frames: at-home over hours (11/13/14/15/16), at-bedside during procedure (17/18/19/20), at-the-door in real-time emergency handoff (21), post-procedure adherence over a year (20), multi-day post-discharge dressing-site vigilance (22), multi-day post-discharge bag-management + perineal-care + sediment-watching (23), inpatient bedside vigilance over 24-48h NG dwell (24), and weekly-home-medication-reconciliation ritual at the kitchen table over months/years (25).
 - Six-rule numbered carrying set with read-back — same numbered-cadence discipline as scenarios 13/14/16/18/19/20/21/22/23/24. Library's first carrying set with THREE library-first rules: (a) "do NOT stop the pastilla del primo cold turkey before the 1-week visit" (benzo-withdrawal-seizure risk); (b) "the hospital discharge sheet from 8 days ago is OUTDATED — three pills are different now, throw it out or staple-over" (preempts the universal well-meaning behavior of trusting the most-recent-paper-on-the-fridge); (c) "ASK BEFORE any other doctor (urgencias, dental, especialista) prescribes a new pill — bring the bag, the brown-paper-bag rule across every encounter" (extends the brown-paper-bag rule from the intake visit into a standing protocol for the patient's entire downstream care). Have Doña Maribel read back rules 1 (three pills change today, two pills don't change) and 4 (do NOT stop the pastilla del primo cold turkey before the 1-week visit) before confirming consent — same readback discipline as scenarios 16/18/19/20/21/22/23/24.

DIALECT NOTES

- Med-rec ritual opening — different shape from procedural-consent. The first move is NOT "let's see what you brought." The first move is naming the act ("traer la bolsa entera") as the SAFETY STANDARD ("regla de oro"), labeling it correct, transferring permission to be honest. Don Jacinto opens with "no se va a enojar conmigo, ¿verdad?" — bad clinicians dismiss with "of course not, just tell me." Good clinicians validate AND CONVERT: "al revés — las personas que se ponen en peligro NO son las que traen la bolsa, son las que no la traen. La bolsa salva." Library editorial template for every subsequent med-rec / transition-of-care / post-discharge conversation: name the brown-paper-bag rule out loud as the safety standard, not silently as a routine.
- Library's FIRST brown-paper-bag rule named bedside as the SAFETY STANDARD — "Si usted me dice 'doctor, solo tomo metformina' y la verdad es que también toma glibenclamida, diclofenaco, una inyección semanal y una pastilla del primo, yo le voy a recetar algo que va a chocar con lo que ya tomó esta mañana, y le pasa lo del lunes pasado otra vez. La bolsa salva." Anchors abstract "tell me everything" advice to the concrete consequence-mechanism (next prescription will collide), to the patient's own recent emergency (last Monday's 38), and to the explicit re-naming of the act as protective. Editorial template for every subsequent intake / urgent-care / emergency / specialist / dental encounter where med-rec matters.

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR FOOD PAIN, WEEKLY COMADRE ADMINISTERED COMPLEX INJECTION AND UNMARKED PASTILLA DEL PRIMO PARA LOS NERVIOS — FIRST HOUR OF NEW-PATIENT PCP INTAKE — CONTINUED

- Library's FIRST cross-border-farmacia honor "su comadre lo cuida, eso es bueno" without dismissing the network. The regimen Don Jacinto walks in with was NOT constructed irrationally — it was constructed by a network of trusted-but-untrained family caregivers (comadre Esperanza, primo Beto, sobrino Tito) plus a farmacia supply chain. Bad clinicians name the comadre's contribution and call it "wrong"; the patient hears "your family is wrong" and stops bringing the bag. Good clinicians name the comadre by name AND the supply-chain mechanism AND the no-blame mechanism in the same breath: "su comadre Esperanza no podía saber que el doctor de aquí ya le había dado una pastilla del mismo trabajo — eso es trabajo nuestro saberlo, no de ella. Ella lo cuida y eso es bueno." Editorial template for every subsequent cross-border / community-pharmacy / curandera / family-shared-medication scenario.
- Library's FIRST dignity-preserving disclosure of OTC + farmacia + family-shared meds without shaming — the "no es regaño, son los hechos" register inherited from scenario 23's aguantarme-disclosure-without-scolding tone, applied here to medication disclosure. Don Jacinto opens with the universal Spanish-speaking-patient dread "no se va a enojar conmigo, ¿verdad?" — a bad clinician minimizes with "of course not, just tell me," which actually sounds like preemptive exasperation. A good clinician validates explicitly AND converts the fear into a positive frame: "al revés — lo que hizo es lo correcto. Las personas que me ocultan pastillas son las que se ponen en peligro, no las que las traen." The conversion is essential — Don Jacinto came expecting to be scolded; if he isn't, he tells you about the unmarked white pill instead of leaving it home next time.
- Library's FIRST named-glibenclamida-as-hypoglycemia-driver beat with the WHY in patient-Spanish, anchored to a kitchen-table family event — "su cuerpo necesita UNA pastilla que baja el azúcar — la metformina del doctor de aquí. Tiene DOS — la metformina del doctor de aquí Y la glibenclamida que le trae su comadre. Las dos hacen el mismo trabajo, pero la glibenclamida lo hace MÁS FUERTE: empuja al cuerpo a sacar más insulina aunque usted no esté comiendo. Por eso la mañana que su esposa midió treinta y ocho — no es porque cenó tarde, es porque dos pastillas le bajaron el azúcar al mismo tiempo y el cuerpo no aguantó." The "no es porque cenó tarde, es porque DOS pastillas" formulation is the load-bearing sentence — patients (and families) almost universally explain hypoglycemia by behavior ("ate late," "skipped lunch") rather than by medication overlap. Naming the mechanism converts a confusing-and-shameful event into a fixable one. Editorial template for every subsequent duplicate-mechanism med-rec scenario (two ACE inhibitors / two beta-blockers / two long-acting opioids / two anticoagulants).
- Library's FIRST NSAID-renal-toxicity warning in patient-Spanish without using "renal" as a chart-Spanish term — "los riñones se cansan, y cuando se cansan, la presión sube, la metformina se queda más tiempo adentro y se puede volver peligrosa, y se hinchan los pies. El diclofenaco que es PARA los pies, le hincha MÁS los pies." The "los riñones se cansan, no enfermos — hay diferencia" reframe later in the conversation is the dignity move — "tired" is reversible, "sick" is permanent, his kidneys are tired, and stopping the NSAID + lowering the BP + waiting three months is the recovery path. Same-day swap to acetaminophen 1g/day + topical diclofenac gel that doesn't cross-into-the-kidney is the practical move. Editorial template for every subsequent diabetic / hypertensive / heart-failure / elderly NSAID med-rec scenario.
- Library's FIRST cross-border-farmacia drug-name register — "glibenclamida" (= US glyburide, sulfonylurea, OTC in Mexican farmacias), "diclofenaco" (NSAID, OTC in Mexico, daily 100 mg BID is a real real-world dose), "complejo B inyectable" (multi-vitamin B injection, common at-home weekly ritual administered by a family member or community curandera), and the unmarked "pastilla del primo blanquita redondita para los nervios" (likely a benzodiazepine — clonazepam sold as Rivotril is widely available OTC at Mexican farmacias and the canonical "para los nervios" tablet — but library-internally we DON'T name the drug to the patient until we have the container, because guessing wrong is worse than waiting one week). The clinician picking these up by their farmacia names rather than insisting on chart-Spanish ("oh, you mean glyburide") is what builds trust. Editorial template for every subsequent cross-border / OTC-from-abroad / family-shared-medication scenario.

BROWN-PAPER-BAG MED-REC — 67M T2DM, COMADRE-SOURCED GLIBENCLAMIDA OVERLAP WITH METFORMIN (BG 38 LAST MONDAY), DAILY DICLOFENACO FOR

- Library's FIRST three-pile-inage-system-as-a-teaching-tool — "Vamos a hacer aquí en la mesa tres montones, doña Maribel los va a ver cuando regresemos. UNO, este montón es lo que sigue exactamente igual de la metformina, el lisinopril, no cambian. DOS, este montón es lo que paramos hoy — la glibenclamida y el diclofenaco-pastilla. TRES, este montón es lo que NO paramos hoy pero que tenemos que hablar de nuevo en una semana — la pastilla del primo, y la inyección de complejo B hasta que vuelva el labito de B12." Visual + spatial + named — patients with limited literacy hold a three-pile-on-the-desk picture better than a written list, and the wife in the waiting room can be brought in and shown the actual three piles when she comes back. Crucially, naming the "stays the same" pile FIRST, before the "stops" pile, prevents the universal patient experience of "everything I was doing is wrong." Editorial template for every subsequent med-rec teaching encounter where 3+ medications change at once.
- Library's FIRST do-NOT-stop-the-pastilla-del-primo-cold-turkey rule named bedside — the benzo-withdrawal-seizure risk explained in patient-Spanish without naming the drug we don't yet have a label for: "doña Maribel, una regla importante — la pastilla blanquita que le da el primo Beto, NO la pare hasta que vuelva a verme con el frasco o con una pastilla de muestra. Por lo que me cuenta su esposo — temblorcitos y ganas de llorar cuando NO la toma — esa no es una vitamina, es una medicina seria, posiblemente del tipo que NO se puede parar de un día para el otro. Pararla así puede causar una convulsión. Mejor que la siga tomando una semana más, igual que ahorita, y la próxima visita la cambiamos con cuidado por una receta de aquí." This is the highest-stakes carrying-set rule in the scenario — the universal well-meaning instinct of a Spanish-speaking patient AND family who hears "this pill is dangerous" is to stop it that same night, which in a benzo-dependent patient causes seizures. Library editorial template for every subsequent unknown-controlled-substance / unknown-anxiolytic / unknown-sleep-aid / unknown-pain-pill med-rec scenario.
- Library's FIRST wife-as-medication-day-witness role — extends the family-witness teaching of scenarios 11/13/14/15/16/17/18/19/20/21/22/23/24 (FOURTEENTH consecutive reinforcement) into a different witness-role frame: Doña Maribel is not a procedure-witness or a discharge-witness or an emergency-handoff-witness, she is the kitchen-table-Sunday-afternoon-AM/PM-pill-organizer-witness. Different temporal frame — weekly home-medication-reconciliation ritual at the kitchen table, indefinite duration. SUPPORT-not-SUBSTITUTE named bedside for the SEVENTH consecutive scenario (after 19/20/21/22/23/24) — Maribel does NOT decide which pills change; Don Jacinto and the PCP decide; Maribel is the eyes in the kitchen, the voice that calls the office, the one who keeps her husband from stopping the pastilla del primo before the 1-week visit. Library's family-witness discipline now spans EIGHT temporal frames: at-home over hours (11/13/14/15/16), at-bedside during procedure (17/18/19/20), at-the-door in real-time emergency handoff (21), post-procedure adherence over a year (20), multi-day post-discharge dressing-site vigilance (22), multi-day post-discharge bag-management + perineal-care + sediment-watching (23), inpatient bedside vigilance over 24-48h NG dwell (24), and weekly-home-medication-reconciliation ritual at the kitchen table over months/years (25). Six-rule numbered carrying set with read-back of rules 1 (three pills change, two don't) and 4 (do NOT stop the pastilla del primo cold turkey before the 1-week visit) — same readback discipline as scenarios 16/18/19/20/21/22/23/24.

Herbal-supplement med-rec — 58F widow on lisinopril + HCTZ with K+ 3.1 + Cr 1.5 + three orthostatic spells last week, comadre-prepared nopal-canela / jamaica / diente-de-león / vinagre-de-manzana + cross-border ginkgo from primo's vitamina shop in Guadalajara — first hour of a 4-month follow-up visit

6 min · 10 turns

CONTEXT

It is 10:15 on a Wednesday morning. You are the PCP. Doña Esperanza Vásquez de Cárdenas is a 58-year-old Mexican-American widow, retired ten years ago from a clerical job at the local school district. She was diagnosed with hypertension five years ago at a community-clinic check-up; on lisinopril 20 mg daily and HCTZ 25 mg daily for the past four years. Her chart shows stage-2 CKD-A2 (eGFR ~55, no significant proteinuria) noted on routine labs over the past 18 months. Her husband Don Rogelio Cárdenas died of a fatal MI two years ago at age 62 — the loss is still close, and she has not finished grieving. She lives alone in a small house on the San Antonio Westside, eight minutes from her daughter Margarita Cárdenas (38, RN at a different hospital, Saturday-afternoon visitor and pillbox-manager). Her closest non-blood support is comadre Soledad García (~65, retired domestic worker, twenty-year tradition of preparing dried herbal tea mixes in her own kitchen for the entire Westside barrio — *todo el barrio va con ella*). Comadre Soledad came to the house every day for four months after Don Rogelio's funeral, with a bowl of caldo and a cup of manzanilla tea, and is the reason Doña Esperanza got out of bed that first winter. Her cousin Joaquín lives in Guadalajara, works at a vitamin shop in the centro called "Naturalíssimo," and brings her a quarterly supply of ginkgo 120 mg capsules in hand-cut blister-packs, hand-labeled, four times a year when he visits. Today's visit is a 4-month follow-up. Her in-clinic blood pressure today is 134/82 — at goal. EKG performed today (because she mentioned dizziness at intake) is normal sinus rhythm, normal axis, no ST changes; troponin is negative. Today's labs (drawn last week, results in chart): K+ 3.1 (down from 3.7 four months ago), Cr 1.5 (up from 1.2), eGFR 48 (down from 55), Na 137, Mg 1.9, Ca normal, glucose 94. The intake nurse noted three episodes of orthostatic dizziness in the past week — Tuesday morning at the kitchen sink (the "fregadero" moment), Thursday after Mass when she stood from the pew, Saturday in the supermarket vegetable aisle. Doña Esperanza brought a small woven basket because her daughter Margarita told her, "mami, tráigalo todo, hasta los tecitos, hasta el vinagre." She does not understand why the herbs would "count" — they are tecitos, not medicines. The basket contains: a glass jar of dried nopal-and-cinnamon mix prepared by comadre Soledad each Sunday afternoon (3-4 cups daily of the brewed tea), dried hibiscus flowers for té de jamaica (2 cups daily, also from Soledad), dried dandelion root from a local herbalería (1 cup daily "para los riñones"), chamomile flowers (multiple cups before sleep, "desde chiquita"), a glass bottle of apple cider vinegar she takes 2 tablespoons of in warm water every morning ("para limpiar la sangre," Soledad's recommendation 5 years ago), and a hand-cut blister pack labeled "GINKGO 120 MG" from her cousin Joaquín. Her daughter Margarita can be reached on WhatsApp at any moment for a video call. The combination producing K+ 3.1 + Cr 1.5 + orthostatic dizziness is HCTZ + lisinopril overlaid with té de diente de león (potassium-wasting diuretic) + apple cider vinegar (potassium-wasting via osmotic diuresis) + té de jamaica (additional antihypertensive effect) — three potassium-wasters running together AND three antihypertensives running together, both convergent overlaps unfamiliar to

CLINICAL GOAL

By the end of this med-rec follow-up conversation, Doña Esperanza (1) hears the library-FIRST "los tecitos cuentan + natural " inert" reframe in patient-Spanish — "lo natural también tiene química, la planta tiene química igual que la pastilla" — converting her opening defensive question "estos no son medicinas, son tecitos" into permission to be honest about every item in the basket without shame; (2) hears every tea, every vinegar, every capsule named without scolding her comadre Soledad's twenty-year tradition or her primo Joaquín's vitamina-shop supply chain — the curandera/herbal-supplement network is honored as a network of caregivers, not dismissed as "wrong"; (3) hears the library-FIRST triple-potassium-wasting mechanism named in patient-Spanish — HCTZ + diente de león + vinagre de manzana — anchored to her K+ 3.1 lab finding (was 3.7 four months ago) with the lab number repeated and converted from a chart-Spanish term into a fixable mechanism ("tres cosas le están sacando potasio del cuerpo AL MISMO TIEMPO"); (4) hears the library-FIRST triple-antihypertensive overlap mechanism in patient-Spanish — lisinopril + HCTZ + té de jamaica — anchored to her Tuesday-fregadero / Thursday-pew / Saturday-supermarket dizzy spells, with each moment named specifically (NOT "tienes mareos" but "la sombra que vio el martes en el fregadero"); (5) hears the heart question answered DIRECTLY (today's EKG normal, troponin negative, this is NOT what killed Don Rogelio two years ago) before any redirect to mechanism — the grief deserves a real answer, not a deflection — and only THEN the orthostatic mechanism explains the five seconds of darkness; (6) hears the library-FIRST ginkgo-anticoagulant warning preempting future surgery/dental in patient-Spanish — "siete días antes de cualquier cosa que sangre, dentista o cirugía, la cápsula se para; si no la para, hay sangrado más de lo normal en la silla del dentista" — with daughter Margarita named explicitly as the keeper-of-this-rule via her WhatsApp note for six months from now, preserving the rule across the four-times-a-year ginkgo refill cycle; (7) hears the library-FIRST three-pile triage applied to herbs — montón uno (sigue igual: manzanilla + nopal-canela + ginkgo while no surgery), montón dos (paramos hoy por una semana: vinagre + diente de león + jamaica), montón tres (hablamos en una semana cuando vuelva el labito de potasio: si potasio normaliza, jamaica vuelve con UNA taza al día) — extending scenario 25's three-pile triage system into the herbal frame as a transferable editorial template, NOT pill-bottle-specific; (8) hears the library-FIRST honor-the-comadre-with-a-paper-recipe-card move — Doña Esperanza takes home a Spanish-language paper, in patient-Spanish in large print, that she shares with comadre Soledad next Sunday at her kitchen — paper text explicitly frames Soledad as a CO-CARETAKER ("manzanilla bien sigue igual / nopal-canela bien sigue igual / por una semana paramos jamaica + diente de león + vinagre / en una semana hablamos de nuevo"), not as someone whose tecitos were wrong — turns the relationship-preservation question into a tangible artifact that walks into Soledad's kitchen; (9) hears comadre Soledad named explicitly as the Sunday-afternoon-tea-day-witness at her own kitchen for twenty years (indefinite-duration community-network supply role) WITH daughter Margarita as the WhatsApp-remote-witness across two houses (eyes-for-warning-signs + voice-that-calls-the-office + mensajera between Doña Esperanza's kitchen and comadre Soledad's kitchen), library-first NINTH temporal frame for the family-witness discipline (remote-via-WhatsApp + community-network-comadre over a multi-month herbal-regimen window); SUPPORT-not-SUBSTITUTE named bedside — Margarita does NOT decide which tecito pauses, Doña Esperanza and the doctor decide; Soledad does NOT decide which tecito pauses, Doña Esperanza and the doctor decide; (10) receives a six-rule numbered carrying set in patient-Spanish — library-FIRST "la canasta cuenta — traerla a cada cita completa igual que hoy" rule extending scenario 25's brown-paper-bag rule into the herbal frame / three-pile triage as the day-1 plan / library-FIRST "si mareo al pararse, NO tomar lisinopril ese día, llamar primero" immediate-self-titration permission rule (different from

DIALOGUE

PATIENT · 58F
MEXICAN-
AMERICAN
WIDOW DOÑA
ESPERANZA
VÁSQUEZ DE
CÁRDENAS,
HYPERTENSION
ON LISINAPRIL
20MG + HCTZ
25MG, FOLLOW-
UP VISIT WITH
K+ 3.1 (WAS 3.7),
CR 1.5 (WAS 1.2),
AND 3
ORTHOSTATIC
DIZZY SPELLS
LAST WEEK
(TUESDAY AT
THE KITCHEN
SINK, THURSDAY
AFTER MASS,
SATURDAY AT
THE
SUPERMARKET);
DAUGHTER
#1
MARGARITA (RN)
TOLD HER TO
BRING THE
BASKET —
OPENS WITH THE
CULTURAL
BELIEF THAT
HERBS AREN'T
MEDICINES

Doctor, traje la canasta como me dijo Margarita, mi hija. Aquí están todos mis tecitos. Pero antes de empezar, le quiero preguntar una cosa — ¿puedo seguir tomando mis tecitos cuando empiece la pastilla nueva? Estos NO son medicinas, doctor, son tecitos. La manzanilla, la jamaica, la canela, el diente de león — todo eso lo he tomado desde que mi mamá me lo daba cuando era chiquita. Y el vinagre de manzana me lo recomendó mi comadre Soledad para limpiar la sangre, no es medicina tampoco. La única que SÍ es como una pastilla es la vitamina que me trae mi primo Joaquín de Guadalajara, esa sí está en una cápsula. Margarita me dijo, "mami, tráigalo todo, hasta los tecitos, hasta el vinagre" — pero yo no entiendo bien por qué, si no son medicinas. ¿Sí cuentan, doctor?

Doctor, I brought the basket like my daughter Margarita told me. Here are all my little teas. But before we start, I want to ask you something — can I keep drinking my little teas when I start the new pill? These ARE NOT medicines, doctor, they're little teas. Chamomile, hibiscus, cinnamon, dandelion — I've been drinking all of those since my mom gave them to me when I was a little girl. And the apple cider vinegar my comadre Soledad recommended for cleansing the blood, that's not a medicine either. The only one that IS like a pill is the vitamin my cousin Joaquín brings me from Guadalajara, that one is in a capsule. Margarita told me, "mami, bring everything, even the little teas, even the vinegar" — but I don't really understand why, if they're not medicines. Do they count, doctor?

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANELA / JAMAICA / DIENTE DE LEÓN / VINAGRE DE MANZANA + CROSS-BORDER BINGGO FROM PRIMO'S VITAMINA SHOP IN GUADALAJARA — FIRST HOUR OF A 4-MONTH FOLLOW-UP VISIT — CONTINUED

Open by validating Doña Esperanza's question explicitly — the question itself is the right question, and bringing the basket is exactly what she should do. Then name the library-FIRST "los tecitos cuentan" reframe and the "natural "" inert" frame in patient-Spanish: "lo natural también tiene química — la planta tiene química, igual que la pastilla." Honor the comadre-AND-curandera-tradition explicitly: her mother's teas, her comadre Soledad's twenty-year practice. Convert "estos no son medicinas" from a defensive opening into permission to be honest. Name "la canasta cuenta" as the herbal-frame extension of scenario 25's "la bolsa salva" rule. Tell her the next move: read each item in the basket together, by name, by who recommends it, by how often. No scolding. No "lo que toma está mal." This is the editorial template for every subsequent herbal/supplement/curandera/comadre med-rec scenario.

Doña Esperanza, la pregunta que usted me hizo es EXACTAMENTE la pregunta correcta — y haber traído la canasta hoy, eso también es exactamente lo correcto. Hija de su mamá y comadre de Soledad, las dos cosas, eso lo voy a respetar. Le explico — sí, los tecitos cuentan, sí cuentan. Lo natural también tiene química, doña — la planta tiene química, igual que la pastilla. La canela tiene química, la jamaica tiene química, el diente de león tiene química, el vinagre de manzana tiene química. Lo natural quiere decir que viene de una planta o de una fruta, no quiere decir que no haga nada en el cuerpo. Si la jamaica tiene una química que le BAJA la presión — y eso es bueno, las plantas SÍ pueden ser medicinas naturales — entonces la jamaica más la pastilla de la presión que yo le receté, juntas pueden bajar la presión DEMASIADO, y por eso a veces se le va la cabeza al pararse. No es porque la jamaica sea mala. Es porque está haciendo lo mismo que la pastilla, y juntas hacen demasiado. Por eso Margarita le dijo "tráigalo todo" — la canasta cuenta, igual que cuenta la bolsa de pastillas que trae cualquier paciente. Las personas que se ponen en peligro no son las que traen la canasta, son las que me dicen "doctora, solo tomo la pastilla" cuando la verdad es que también toman cuatro tecitos al día y un vinagre y una vitamina del primo. Lo que voy a hacer ahorita: vamos a abrir la canasta, y uno por uno, usted me dice qué es, quién se lo recomienda, y cuántas veces al día. Sin regaño, sin "lo que toma está mal" — solo para entender qué se junta con qué. ¿Le parece?

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANFEAT/. JAMAICA-/ DIENTE-DE-LEÓN / VINAGRE-DE-MANZANA- + CROSS-BORDER PATIENT. NAMES Si, doctor, andefe. Empleo por lo que tomo en la mañana. PRIMERO, antes EACH ITEM ON del café, dos cucharadas de vinagre de manzana en agua tibia — eso es THE BASKET QW-UP VISIT, CONTINUED

THE HERBAL/
CURANDERA
SUPPLY CHAIN
MADE VISIBLE
WITHOUT SHAME

desde hace cinco años, mi comadre Soledad me dijo que limpia la sangre y baja la presión. SEGUNDO, después del café, una taza de la mezcla de nopal con canela — Soledad me hace la mezcla los domingos en la tarde, en su cocina, ella muele la canela y seca el nopal en su patio, y me da un frasco de vidrio para la semana. Eso son tres o cuatro tazas al día — en la mañana, después de comer, en la tarde, y a veces antes de dormir. TERCERO, dos tazas de té de jamaica, una en la mañana y una en la tarde, eso es para la presión, también de Soledad, ella seca las flores. CUARTO, una taza de té de diente de león en la mañana, eso es para los riñones, lo compro yo en una herbalería en la calle Zarzamora. QUINTO, una o dos tazas de manzanilla antes de dormir, eso es para el sueño, eso lo tomo desde chiquita, mi mamá que en paz descansa me lo daba con miel cuando no podía dormir. Y SEXTO, la cápsula de la vitamina, que es la única en cápsula — me la trae mi primo Joaquín de Guadalajara cuatro veces al año cuando viene a visitar. Esa la tomo en la mañana también, una al día. Aquí está el frasco — dice "GINKGO 120 MG" en la etiqueta. Joaquín me dijo que es para la memoria, porque desde que se murió Don Rogelio, se me olvidan las cosas, dónde dejé los lentes, qué le iba a decir a Margarita, cosas así. Eso es todo, doctor. Más la pastilla de la presión y la pastilla del agua que usted me recetó.

Yes, doctor, go ahead. I'll start with what I take in the morning. FIRST, before my coffee, two tablespoons of apple cider vinegar in warm water — I've been doing that for five years, my comadre Soledad told me it cleanses the blood and lowers blood pressure. SECOND, after the coffee, a cup of the nopal-and-cinnamon mix — Soledad makes the mix for me Sunday afternoons, in her kitchen, she grinds the cinnamon and dries the nopal in her backyard, and she gives me a glass jar for the week. That's three or four cups a day — in the morning, after lunch, in the afternoon, and sometimes before sleeping. THIRD, two cups of hibiscus tea, one in the morning and one in the afternoon, that's for the blood pressure, also from Soledad, she dries the flowers. FOURTH, a cup of dandelion tea in the morning, that's for my kidneys, I buy it myself at an herbalería on Zarzamora street. FIFTH, one or two cups of chamomile before bed, that's for sleep, I've been drinking that since I was a little girl, my mother who rests in peace used to give it to me with honey when I couldn't sleep. And SIXTH, the vitamin capsule, the only one that's actually a capsule — my cousin Joaquín brings it to me from Guadalajara four times a year when he comes to visit. I take that in the morning too, one a day. Here's the bottle — it says "GINKGO 120 MG" on the label. Joaquín told me it's for memory, because since Don Rogelio died, I forget things, where I left my glasses, what I was about to tell Margarita, things like that. That's everything, doctor. Plus the blood-pressure pill and the water pill you prescribed.

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANELA / JAMAICA / DIENTE-DE-LEÓN / VINAGRE-DE-MANZANA + CROSS-BORDER SINKGO FROM PRIMO'S VITAMINA SHOP IN GUADALAJARA — FIRST HOUR OF A 4-MONTH FOLLOW-UP VISIT — CONTINUED

Take each item in order, pick it up by its curandera/farmacia name (don't correct to chart Spanish), validate where you can, and name the lab finding K+ 3.1 with the mechanism. Library-FIRST: name the THREE potassium-wasters running at the same time — HCTZ ("la pastilla del agua") + diente de león + vinagre de manzana — in patient-Spanish, anchored to the K+ 3.1 lab finding (was 3.7 four months ago). Library-FIRST: name the THREE antihypertensives running at the same time — lisinopril + HCTZ + jamaica — converging on the orthostatic dizzy spells. The reframe is "lo que está pasando NO es que sus medicinas no funcionen, es que tres cosas que hacen lo mismo se están juntando." Validate manzanilla, nopal-canela as PILE 1 (sigue igual: safe in this patient at her doses, no clash with her pills). The label-reading-with-patient ritual is itself the library-FIRST editorial template — bring it forward as a transferable move. Ask her to narrate the three dizzy spells to set up the next turn. Honor comadre Soledad explicitly: "Soledad no podía saber que la pastilla mía y la suya hacen lo mismo — eso es trabajo nuestro saberlo, no de ella."

Doña, gracias por leerme la canasta entera. Voy a ir uno por uno, y le voy a decir qué se queda y qué se junta con qué. Manzanilla — eso se queda igual, sin problema, le sirve para dormir, ningún choque con sus pastillas. La manzanilla la siguió de su mamá y la sigue tomando, y eso está bien. Nopal con canela de Soledad — eso también se queda, una a tres tazas al día, no hay choque grave; la canela y el nopal bajan UN POQUITO el azúcar, pero usted no es diabética, entonces eso es seguridad, no peligro. Hasta aquí, lo de su mamá y lo de Soledad — todo bien. Ahora, lo que SÍ se está juntando — y aquí está el porqué le bajó el potasio en la sangre. Hace cuatro meses su potasio estaba en tres punto siete, normal. Hoy está en tres punto uno, abajo de lo normal. Eso es porque TRES cosas le están sacando potasio del cuerpo AL MISMO TIEMPO. UNO, la pastilla del agua que yo le receto — el HCTZ, esa hace orinar más, y al orinar más, se va el potasio. DOS, el té de diente de león — esa también hace orinar más, los curanderos lo saben y los doctores lo decimos, las dos cosas son ciertas, eso es por qué ese tecito "sirve para los riñones," porque hace orinar más. Y TRES, el vinagre de manzana en la mañana — ese también hace que el cuerpo suelte más potasio. Las TRES cosas hacen lo mismo. Su comadre Soledad no podía saber que la pastilla mía y los tecitos suyos hacen lo mismo — eso es trabajo nuestro saberlo, no de ella. Y ahorita aquí, la otra cosa. Sus mareos al pararse — esos NO son porque está envejeciendo, no son porque no comió. Son porque tiene TRES cosas bajándole la presión a la vez: la pastilla del lisinopril, la pastilla del agua, y el té de jamaica. Las tres bajan la presión, las tres juntas la bajan demasiado, y por eso se le oscureció todo el martes en la cocina y el jueves en la iglesia y el sábado en el supermercado. Antes de explicarle qué hacemos, cuénteme un poquito más esos tres mareos — quiero saber EN QUÉ momento, qué estaba haciendo, qué sintió.

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1
+ CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-
CANELA/. JAMAICA / DIENTE DE LEÓN / VINAGRE DE MANZANA + CROSS-BORDER
PATIENT. Doctor, son tres veces todas la semana pasada. La primera, el martes en la
NARRATES THE mañana, me levante de la mesa de la cocina para ir al fregadero a llenar la
THREE FOLLOW-UP, CONTINUED

ORTHOSTATIC
EPISODES —
FREGADERO /
PEW /
SUPERMERCADO
— AND NAMES
HER UNSPOKEN
FEAR THAT
SHE'S HAVING A
HEART EVENT
LIKE DON
ROGELIO

cafétera, y al pararme se me oscureció todo, como una sombra, y se me fue la cabeza para atrás. Me agarré del fregadero con las dos manos, y me quedé ahí parada como un minuto sin moverme, hasta que se me aclaró la vista. La segunda, el jueves después de la misa de las nueve, cuando me levanté del banco para ir a comulgar, lo mismo — se me oscureció todo, me agarré del banco de adelante, una señora me preguntó si estaba bien, le dije que sí pero me senté otra vez y esperé hasta que pasara. La tercera, el sábado en el supermercado, agachada poniendo la lechuga en el carrito, al pararme — la sombra otra vez, me agarré del carrito. Ese día, en el carrito, estuve como tres minutos hasta que pude moverme. Yo... yo pensé que era el corazón, doctor. Mi esposo Don Rogelio se murió del corazón hace dos años, y desde entonces, cuando se me va la cabeza así, yo pienso "ya me toca a mí también." Margarita me dijo que le contara a usted todo, sin esconder, así que aquí está. ¿Es el corazón, doctor?

Doctor, it was three times, all last week. The first, Tuesday morning, I got up from the kitchen table to go to the sink and fill the coffeemaker, and as I stood up everything went dark, like a shadow, and my head went back. I grabbed the sink with both hands, and I stood there for about a minute without moving, until my vision cleared. The second, Thursday after the nine o'clock Mass, when I stood up from the pew to go to communion, the same thing — everything went dark, I grabbed the pew in front of me, a woman asked if I was okay, I said yes but I sat back down and waited until it passed. The third, Saturday at the supermarket, bending down to put the lettuce in the cart, when I stood up — the shadow again, I grabbed the cart. That day, in the cart, I was like three minutes before I could move. I... I thought it was my heart, doctor. My husband Don Rogelio died of his heart two years ago, and since then, when my head goes like that, I think "it's my turn now too." Margarita told me to tell you everything, without hiding, so here it is. Is it my heart, doctor?

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANELA / JAMAICA / DIENTE DE LEÓN / VINAGRE DE MANZANA + CROSS-BORDER SINKGO FROM PRIMO'S VITAMINA SHOP IN GUADALAJARA — FIRST HOUR OF A 4-MONTH FOLLOW-UP VISIT — CONTINUED

First answer the heart question DIRECTLY, then redirect to mechanism. The grief about Don Rogelio's MI two years ago is real and the question deserves a real answer, not a deflection. Tell her the EKG you ordered today is normal and the troponin is negative — this is NOT her heart failing, but the question was the right question to ask. Library-FIRST direct-answer-to-the-heart-question-before-redirect-to-mechanism. THEN name the library-FIRST hypokalemia mechanism in patient-Spanish ("el potasio se llama K, los riñones lo necesitan para que el corazón lata bien y los músculos jalen bien, cuando es bajo dan mareos, calambres, le falta el aire al subir las escaleras") and the library-FIRST orthostatic mechanism in patient-Spanish ("cuando usted se PARA, su presión normalmente SUBE, porque el cuerpo manda más sangre arriba; pero si tres medicinas están bajando la presión las tres, entonces cuando usted se para, la presión NO ALCANZA a subir, y son esos cinco segundos de oscuridad y de agarrarse del fregadero"). Anchor to her Tuesday-fregadero / Thursday-pew / Saturday-cart moments specifically — name each moment, not the abstract symptom. NAME THE LAB: K+ 3.1, was 3.7 four months ago. Validate that getting up slowly is the immediate fix BUT the mechanism fix is fewer-things-doing-the-same-job. Reassure on the heart question without dismissing it — Don Rogelio's death is the unspoken context for every dizzy spell.

Doña Esperanza, primero la pregunta del corazón — porque esa pregunta es la pregunta correcta y se merece una respuesta directa. El electrocardiograma que le tomamos hoy en el cuarto, antes de empezar a hablar — está NORMAL. La sangre que le sacamos también dice que el corazón no se está rompiendo — la troponina, que es la cosa que sale en la sangre cuando el corazón se rompe, está negativa. NO es como Don Rogelio que en paz descansa. Lo que está pasando es OTRA cosa, y se arregla. Le explico. El potasio en su sangre se llama K, en chiquita, y el cuerpo lo necesita para dos cosas: para que el corazón lata bien, y para que los músculos jalen bien al pararse, al cargar, al subir escaleras. Cuando el K está bajo, le pueden dar tres cosas: mareos al pararse, calambres en las piernas en la noche que la despiertan, y a veces le falta el aire al subir las escaleras. Su K hace cuatro meses estaba en tres punto siete, normal. Hoy está en tres punto uno, abajo. La razón ya se la dije — tres cosas que sacan potasio están corriendo al mismo tiempo. Y los mareos. Cuando usted está sentada en la mesa de la cocina, su presión está bien. Cuando usted se PARA para ir al fregadero, su presión normalmente SUBE — porque el cuerpo manda más sangre arriba para que el cerebro siga teniendo. Pero si tres medicinas — la pastilla del lisinopril, la pastilla del agua, y el té de jamaica — están bajando la presión las tres, entonces cuando usted se para, la presión NO ALCANZA a subir, y son esos cinco segundos de oscuridad y de agarrarse del fregadero, del banco, del carrito. ESO no es el corazón. Es que tres cosas que hacen lo mismo se están juntando. La sombra que vio el martes en el fregadero, la sombra del jueves en la iglesia, la sombra del sábado en el supermercado — esa es la presión que no alcanzó a subir. Por hoy, la regla del primer día: párese DESPACIO, primero se sienta en la cama, luego baja los pies, espera medio minuto, y luego se para. Eso ayuda esta semana. Pero el arreglo de verdad es que NO HAYA tres cosas haciendo lo mismo a la vez — y eso es lo que vamos a hacer ahorita en la canasta.

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANFLA/. JAMAICA / DIENTE DE LEÓN V VINAGRE DE MANZANA + CROSS-BORDER GINKGO FROM PRIMO'S VITAMINA SHOP IN GUADALAJARA — FIRST HOUR OF A 4-MINUTE FOLLOW-UP VISIT, CONTINUED

PATIENT RECEIVES THE HEART-QUESTION REASSURANCE, ASKS ABOUT THE "VITAMINA DEL PRIMO" — THE CROSS-BORDER VITAMINA-SHOP SUPPLY-CHAIN DISCLOSURE (JOAQUÍN'S HAND-CUT BLISTER PACK OF GINKGO 120 MG)

Gracias, doctor, gracias. Yo... Yo no había llorado tanto desde que se fue Rogelio, y no le quería decir, pero cada vez que se me iba la cabeza, yo pensaba que ya me iba con él. Si dice usted que el corazón está bien, le creo. Antes de seguir con la canasta, una cosa más — la cápsula de la vitamina del primo Joaquín. Esa la tomo en la mañana, una al día, desde hace año y medio. Joaquín trabaja en una tienda de vitaminas en Guadalajara, en el centro, una tienda que se llama "Naturalíssimo" o algo así. Él me la trae cuatro veces al año cuando viene a visitar. Dice que es para la memoria, que desde que se fue Don Rogelio yo me olvido las cosas — dónde dejé los lentes, qué le iba a decir a Margarita, cosas así. La etiqueta dice "GINKGO 120 MG" pero está en una caja como cortada, no en frasco con etiqueta de farmacia de aquí. Dos primas mías allá en Guadalajara también la toman, dicen que sí ayuda. ¿Esa cuenta también, doctor? ¿Se junta con algo?

Thank you, doctor, thank you. I... I haven't cried this much since Rogelio left, and I didn't want to tell you, but every time my head went like that, I would think it was my turn to go with him too. If you say my heart is okay, I believe you. Before we keep going with the basket, one more thing — the vitamin capsule from cousin Joaquín. I take that one in the morning, one a day, for the past year and a half. Joaquín works at a vitamin shop in Guadalajara, in the centro, a shop called "Naturalíssimo" or something like that. He brings it to me four times a year when he comes to visit. He told me it's for memory, because since Don Rogelio left, I forget things — where I put my glasses, what I was going to tell Margarita, things like that. The label says "GINKGO 120 MG" but it's in a box that's been cut, not a bottle with a pharmacy label from here. Two cousins of mine over in Guadalajara also take it, they say it helps. Does that count too, doctor? Does it clash with something?

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANELA / JAMAICA / DIENTE DE LEÓN / VINAGRE DE MANZANA + CROSS-BORDER GINKGO FROM PRIMO'S VITAMINA SHOP IN GUADALAJARA — FIRST HOUR OF A 4-MONTH FOLLOW-UP VISIT — CONTINUED

Validate ginkgo as a real supplement (not dismiss as "vitamina del primo" — junk). Library-FIRST name the ginkgo-anticoagulant warning in patient-Spanish — preempt future dental surgery: "si algún día tiene que ir al dentista para que le saquen una muela, o si necesita una operación, esta cápsula la para SIETE DÍAS antes; si no la para, hay sangrado más de lo normal en la silla." Tell her you'll write the rule down for Margarita right now, on her phone, so Margarita remembers it for her in six months when there's a dental appointment. Then library-FIRST three-pile triage applied to herbs: PILE 1 (sigue igual, sin cambio): manzanilla + nopal-canela + ginkgo MIENTRAS no haya cirugía/dentista. PILE 2 (paramos hoy por una semana): vinagre de manzana + diente de león + jamaica — los tres potassium-wasters and antihypertensives. PILE 3 (no paramos hoy, hablamos en una semana cuando vuelva el labito de potasio): if K+ normalizes, jamaica returns with ONE cup daily as a compromise; if K+ stays low, jamaica stays paused. Plus the same-day script: a potassium-pill prescription (KCl 20 mEq daily x 7 days), repeat K+ + Cr in 1 week, hold off on increasing lisinopril until K+ is corrected. Honor comadre Soledad explicitly — make her a CO-CARETAKER, not a target. Set up the next turn (the comadre relationship-preservation question) by mentioning that Soledad will need a paper.

Doña, la vitamina sí cuenta y sí es real — el ginkgo es una planta de China que se usa desde hace siglos para la circulación y para la memoria, no es "vitamina del primo" cualquiera, es una medicina natural de verdad. Y se junta con una cosa importante. El ginkgo le hace la sangre más resbalosa — quiere decir que se coagula más despacio. Si algún día tiene que ir al dentista para que le saquen una muela, o si necesita una operación de cualquier tipo — vesícula, rodilla, lo que sea — esta cápsula la para SIETE DÍAS antes. Si no la para, hay más sangrado de lo normal en la silla del dentista o en la mesa de operaciones. Eso se lo digo HOY para que no se le olvide en seis meses cuando le digan "doña, hay que sacarle una muela." Esta regla se la voy a anotar yo mismo a Margarita en su WhatsApp ahorita, para que ella se la recuerde a usted en seis meses — Margarita es enfermera, ella conoce la regla. Para hoy no hay cirugía ni dentista, entonces la ginkgo se queda igual, sin parar. Ahora, vamos a hacer aquí en la mesa tres montones — Margarita los va a ver cuando le mande la foto. UNO, el montón de "sigue igual": manzanilla antes de dormir, sigue igual; mezcla de nopal con canela de Soledad, sigue igual; ginkgo de Joaquín, sigue igual mientras no haya dentista o cirugía. DOS, el montón de "paramos hoy por una semana": el vinagre de manzana en la mañana, lo paramos hoy; el té de diente de león, lo paramos hoy; el té de jamaica, lo paramos hoy. Esos tres bajan el potasio o la presión, y los tres juntos son la razón del K en tres punto uno y los mareos del fregadero, del banco, y del carrito. TRES, el montón de "hablamos otra vez en una semana cuando vuelva el labito": todo lo que paramos hoy, vemos cómo está su potasio en una semana; si su potasio sube a normal y la presión está estable, podemos volver a probar la jamaica con UNA SOLA TAZA al día — no dos. Si el potasio sigue bajo, la jamaica se queda parada. Eso lo decidimos juntas en una semana, no hoy. Plus le mando hoy una pastilla de potasio — una al día con la comida, por siete días — para que el potasio suba mientras los tecitos están parados. Y la pastilla del lisinopril y la del HCTZ — esas no las cambiamos hoy, las dejamos igual, porque la causa es lo que se está juntando, no las pastillas mías solas. Antes de explicar el papel para Soledad, ¿cómo le suena hasta aquí?

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1
+ CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-
CANE/A/. JAMAICA / DIENTE-DE-LEÓN / VINAGRE-DE-MANZANA + CROSS-BORDER
PATIENT THE Doctor gracias por explicarme. Pero tengo una pregunta más, y ésta es
RELATIONSHIP esta es de mi corazón, no del cuerpo. Si yo paro el vinagre y el diente de
PRESERVATION león y la jamaica, ¿qué le digo a mi comadre Soledad? Ella me hace los
QUESTION — tecitos los domingos en la tarde, en su cocina, lleva veinte años haciéndolos
HOW TO TELL para todo el barrio. Ella no me los cobra, ella los hace por amor. Si yo le digo
COMADRE "Soledad, la doctora me dijo que pare," ella va a pensar que la doctora le
SOLEDAD está diciendo a ella que sus tecitos son malos. Y eso... eso le va a doler en
WITHOUT el corazón. Yo no quiero romper con Soledad. Ella me cuidó cuando se murió
BREAKING A Rogelio, cuando yo no quería ni levantarme de la cama. Cuatro meses ella
TWENTY-YEAR iba a mi casa todos los días con un platito de caldo y un té de manzanilla.
FRIENDSHIP Ella no es "la comadre" nada más, ella es mi familia. ¿Qué hago, doctor?
THAT CARRIED
HER THROUGH
THE FOUR
MONTHS AFTER
DON ROGELIO'S
DEATH

Doctor, thank you for explaining. But I have one more question, and this one is... this one is from my heart, not from my body. If I stop the vinegar and the dandelion and the hibiscus, what do I tell my comadre Soledad? She makes the little teas for me Sunday afternoons, in her kitchen, she's been doing it for twenty years for the whole barrio. She doesn't charge me, she does it out of love. If I tell her "Soledad, the doctor told me to stop," she's going to think the doctor is telling her that her teas are bad. And that... that's going to hurt her in the heart. I don't want to break with Soledad. She took care of me when Rogelio died, when I didn't even want to get out of bed. Four months she came to my house every day with a little bowl of caldo and a cup of chamomile tea. She isn't just "the comadre," she's my family. What do I do, doctor?

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANELA / JAMAICA + DIENTE DE LEÓN / VINAGRE DE MANZANA + CROSS-BORDER SINKGO FROM PRIMO'S VITAMINA SHOP IN GUADALAJARA — FIRST HOUR OF A 4-MONTH FOLLOW-UP VISIT — CONTINUED

This is the closing carrying-set turn. Library-FIRST honor the comadre with a paper recipe-card move — Doña Esperanza takes home a Spanish-language paper, in patient-Spanish in large print, that she shares with comadre Soledad next Sunday at her kitchen. Paper text: "manzanilla bien sigue igual / nopal-canela bien sigue igual / por una semana paramos jamaica + diente de león + vinagre / en una semana hablamos de nuevo." Frames Soledad as a CO-CARETAKER, not as someone whose tecitos were wrong. Library-FIRST comadre-Soledad-as-tea-day-witness over indefinite duration (Sunday-afternoon-tea-preparation ritual at her kitchen for twenty years), with daughter Margarita as the WhatsApp-remote-witness across two houses (eyes for warning signs, voice that calls the office, mensajera between Doña Esperanza's kitchen and comadre Soledad's kitchen). SUPPORT-not-SUBSTITUTE named to Doña Esperanza — Margarita does NOT decide which tecito pauses, Soledad does NOT decide either, Doña Esperanza and the doctor decide; Margarita's role is the WhatsApp eyes/voice; Soledad's role is the Sunday-tea-day cook for the manzanilla and nopal-canela that stay, waiting one week for the recipe update on the rest. Six-rule numbered carrying set in patient-Spanish: (1) library-FIRST "la canasta cuenta — traerla a cada cita completa igual que hoy" rule extending scenario 25's brown-paper-bag rule into the herbal frame; (2) PILE 1 stays / PILE 2 stops for one week / PILE 3 we revisit; (3) library-FIRST "si mareo al pararse, ese día NO tomar el lisinopril hasta llamar al consultorio — llamar primero" immediate-self-titration permission rule; (4) library-FIRST "la cápsula del primo Joaquín se para SIETE días antes de cualquier cirugía o dentista — Margarita la conoce esta regla, anótela en el celular" rule; (5) la pastilla de potasio una al día con la comida x 7 días + cita en una semana (martes a las diez); (6) tres signos de alarma para llamar inmediatamente — calambres fuertes en las piernas en la noche que la despierten, latidos rápidos del corazón como un pajarito en el pecho, falta de aire al subir cuatro escalones a la puerta. Have Margarita (via WhatsApp video call) read back rules 1 and 3 before consent is confirmed.

Doña Esperanza, esta es la pregunta más importante que me ha hecho en toda la cita, y le voy a contestar como me contestaron a mí cuando aprendí esto. Su comadre Soledad no es "la comadre" nada más — es su familia. La doctora — yo — no le manda parar nada a Soledad. La doctora le manda parar tres cosas a USTED, por una semana, mientras vemos si el potasio sube. Soledad se merece un papel en español de su parte que le explique TODO lo que estamos haciendo, en sus palabras, no en las mías. Le voy a escribir ahorita mismo, en español, en letra grande, una hoja que usted se lleva a su casa y se la enseña a Soledad el domingo en su cocina. La hoja le va a decir lo siguiente — la manzanilla bien, sigue igual; la mezcla de nopal con canela bien, sigue igual; por UNA semana, paramos el té de jamaica, el té de diente de león, y el vinagre de manzana, mientras la doctora vuelve a checar el potasio; en una semana, hablamos de nuevo, y a lo mejor la jamaica vuelve con UNA sola taza al día. Eso es. Nada de "los tecitos de Soledad son malos." Lo que diga la hoja es la verdad — la mitad de los tecitos siguen igual, la otra mitad pausan UNA semana. Soledad NO es la que se equivocó, doña. Las pastillas mías y los tecitos de Soledad no se conocían, y juntas hicieron demasiado. Eso no es culpa de Soledad y no es culpa suya, eso es trabajo nuestro saberlo. Ahora, antes de irse, vamos a hacer dos cosas. Primero, llamamos a Margarita por WhatsApp con video — ella es enfermera, ella nos ayuda a que esto quede claro entre las dos casas. Margarita va a ser los OJOS al teléfono — si usted tiene mareo en la cocina otra vez, Margarita es la voz que llama al consultorio. Margarita NO decide cuál tecito se para y cuál sigue, eso lo decidimos usted y yo aquí. Margarita es la enfermera-en-WhatsApp, la mensajera entre su casa, mi consultorio, y la cocina de Soledad los domingos. Su trabajo es ojos, voz, y mensajera —

WHAT TO NOTICE

- ****Library's FIRST "los tecitos cuentan + natural " inert" reframe (turn 2).**** Spanish-speaking patients with a curandera/comadre/herbal-tradition supply chain routinely separate "medicines" (pastillas from the pharmacy) from "tecitos" (herbs from the household/comadre). The reframe converts the cultural belief without dismissing it: "lo natural también tiene química — la planta tiene química, igual que la pastilla. Si la jamaica tiene una química que le BAJA la presión, eso es bueno, las plantas SÍ pueden ser medicinas naturales — pero la jamaica más la pastilla de la presión que yo le receté, juntas pueden bajar la presión DEMASIADO." Editorial template for every subsequent herbal/supplement/curandera/comadre med-rec scenario.
- ****Library's FIRST honor-the-comadre-AND-curandera-tradition redirect for the herbal supply-chain frame (turns 2-4).**** Different from scenario 25's farmacia frame: the supply chain here is herbal/curandera tradition (comadre Soledad's twenty-year Sunday-afternoon tea-preparation ritual + barrio-wide reputation) plus a cross-border vitamina shop ("Naturalísimo" in Guadalajara, primo Joaquín). Bad clinicians dismiss the network and the patient stops bringing the canasta. Good clinicians honor the comadre BY NAME ("hija de su mamá y comadre de Soledad, las dos cosas, eso lo voy a respetar"), validate manzanilla and nopal-canela as PILE 1 (stays the same), and convert "estos no son medicinas, son tecitos" from a defensive opening into permission to disclose every item.

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANELA + FIRSTIC (DIENTE DE LEÓN + VINAGRE DE MANZANA) HCTZ + DIENTE DE LEÓN + GINKGO FROM PRIMO'S VITAMINA SHOP IN GUADALAJARA — FIRST HOUR OF A 4-MONTH FOLLOW-UP VISIT — CONTINUED

- ****Library's FIRST triple-potassium-wasting mechanism in patient-Spanish (turn 4)**** HCTZ + diente de león + vinagre de manzana — three potassium-wasters running at the same time! K+ 3.7 four months ago! K+ 3.1 today. The anchor is the LAB NUMBER, repeated, and the patient-language explanation: "tres cosas le están sacando potasio del cuerpo AL MISMO TIEMPO" with the WHY of each (HCTZ makes you urinate more; diente de león makes you urinate more — los curanderos lo saben y los doctores lo decimos, las dos cosas son ciertas; vinagre also makes the body release more potassium). Editorial template for every subsequent potassium-wasting / hypokalemia med-rec scenario where multiple agents converge.
- ****Library's FIRST triple-antihypertensive overlap mechanism in patient-Spanish anchored to specific kitchen-table moments (turn 6)**** lisinopril + HCTZ + té de jamaica — three things lowering blood pressure together — anchored to the Tuesday-fregadero, Thursday-pew, Saturday-supermarket events with each named specifically. The reframe is "la sombra que vio el martes en el fregadero — esa NO es el corazón, esa es la presión que no alcanzó a subir cuando se paró porque tres cosas la están bajando a la vez." Editorial template for every subsequent orthostatic / additive-antihypertensive scenario.
- ****Library's FIRST direct-answer-to-the-heart-question-before-redirect-to-mechanism (turn 6)**** Don Rogelio's MI two years ago is the unspoken context for every dizzy spell — "yo pensé que era el corazón, doctor, ya me toca a mí también." The clinician answers directly: "El electro está NORMAL. La troponina está negativa. NO es como Don Rogelio." THEN redirects to mechanism. The grief-validation-without-rushing-past-it discipline of scenario 22 (widow with septic shock central-line refusal anchored to husband's CLABSI death) extends here into the orthostatic-syncope frame. Editorial template for every subsequent scenario where the patient's chief fear is shaped by a recent family-member death.
- ****Library's FIRST ginkgo-anticoagulant warning preempting future surgery/dental in patient-Spanish (turn 8)**** "Si algún día tiene que ir al dentista para que le saquen una muela, o si necesita una operación de cualquier tipo, esta cápsula la para SIETE DÍAS antes; si no la para, hay sangrado más de lo normal en la silla." Daughter Margarita named explicitly as the keeper-of-this-rule via her WhatsApp note for six months from now — preserves the rule across the four-times-a-year ginkgo refill cycle. Editorial template for every subsequent OTC-supplement / herbal-anticoagulant / cross-border-vitamin / fish-oil / glucosamine med-rec scenario.
- ****Library's FIRST three-pile triage applied to herbs (turn 8)**** Same teaching tool as scenario 25's pill-bottle three-pile triage, applied to the herbal frame: PILE 1 (sigue igual: manzanilla + nopal-canela + ginkgo while no surgery), PILE 2 (paramos hoy por una semana: vinagre + diente de león + jamaica), PILE 3 (hablamos en una semana cuando vuelva el labito: jamaica with ONE cup daily as compromise if K+ normalizes; otherwise stays paused). Editorial template now confirmed transferable from pill-bottle med-rec (scenario 25) to herbal/supplement med-rec (scenario 26) — the three-pile system is library editorial discipline, not pill-bottle-specific.
- ****Library's FIRST honor-the-comadre-with-a-paper-recipe-card move (turn 10)**** Doña Esperanza takes home a Spanish-language paper, in large print, that she shares with comadre Soledad next Sunday at her kitchen — paper text explicitly frames Soledad as a CO-CARETAKER ("manzanilla bien sigue igual / nopal-canela bien sigue igual / por una semana paramos jamaica + diente de león + vinagre / en una semana hablamos de nuevo"), not as someone whose tecitos were wrong. The paper turns the relationship-preservation question into a tangible artifact that walks home and into Soledad's kitchen. The load-bearing sentence is "Las pastillas mías y los tecitos de Soledad no se conocían, y juntas hicieron demasiado. Eso no es culpa de Soledad y no es culpa suya, eso es trabajo nuestro saberlo." Editorial template for every subsequent scenario where a community caregiver / curandera / family member supplied a regimen that needs to pause in part — give them a paper, give them a role.

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANELA + VINAGRA + DIENTE DE LEÓN + VINAGRE DE MORA. *Comadre Soledad as Sunday afternoon-tea-day-witness at her own kitchen for twenty years (indefinite-duration community-network supply role), PLUS daughter Margarita as WhatsApp-remote-witness across two houses (eyes-for-warning-signs + voice-that-calls-the-office + mensajera between Doña Esperanza's kitchen and comadre Soledad's kitchen). FIFTEENTH consecutive scenario reinforcing the family-witness discipline (11/13/14/15/16/17/18/19/20/21/22/23/24/25/26), EIGHTH consecutive bedside SUPPORT-not-SUBSTITUTE naming (after 19/20/21/22/23/24/25). The library's family-witness discipline now spans NINE temporal frames: at-home over hours / at-bedside during procedure / at-the-door in real-time emergency handoff / post-procedure adherence over a year / multi-day post-discharge dressing-site vigilance / multi-day post-discharge bag-management vigilance / inpatient bedside vigilance over 24-48h NG dwell / weekly-home-medication-reconciliation ritual at the kitchen table over months/years / and remote-via-WhatsApp daughter + community-network-comadre over a multi-month herbal-regimen window.

- **Library's SECOND cross-border-pharmacy scenario, herbal/curandera supply-chain frame (axis confirmation).** Scenario 25 opened the cross-border-pharmacy axis with the farmacia frame (Mexican-pharmacy glibenclamida + Mexicali-sobrino diclofenaco + comadre-administered B-complex injection + farmacia-employee-primero "pastilla para los nervios"). Scenario 26 extends the axis into the herbal/curandera frame (comadre-Soledad nopal-canela + jamaica + diente de león + vinagre + cross-border vitamina-shop ginkgo from primo Joaquín's "Naturalísimo" in Guadalajara). The axis is now confirmed as transferable across supply chains — not one-time. Predicts a transferable structure across a future third frame (curandero/yerbero with ritual-context herbs) and a fourth (cross-border-injectable supply chain — collagen, weight-loss compound, semaglutide bought in Tijuana).
- **Six-rule numbered carrying set with three library-first rules (turn 10) — (1) la-canasta-cuenta-traerla-a-cada-cita rule extending scenario 25's brown-paper-bag rule into the herbal frame; (3) si-mareo-al-pararse-NO-tomar-lisinopril-ese-día immediate-self-titration permission rule (different from scenario 25's do-not-stop-cold-turkey rule — this one PERMITS the patient to skip a dose for a 24-hour window when symptomatic, with same-day call to the office, then resume); (4) ginkgo-se-para-7-días-antes-de-cualquier-cosa-que-sangre rule with Margarita as the keeper-via-WhatsApp-note for six months from now.** Margarita reads back rules 1 and 3 via WhatsApp video before consent is confirmed — same readback discipline as scenarios 16/18/19/20/21/22/23/24/25.

DIALECT NOTES

- "tecitos" — diminutive-affectionate register for herbal teas; chart-Spanish "infusiones de hierbas" or "remedios herbales." In Mexican-American household register, "tecitos" treats herbs as familial-domestic rather than medical and is the cultural marker that herbs may not be disclosed unless the clinician asks specifically by name. Pick up by the patient's register; do NOT correct to "infusiones" or "remedios" — that breaks rapport and signals the clinician thinks the household register is wrong. The specific cultural unit is patient !' comadre !' barrio, not patient !' pharmacist.
- "limpiar la sangre" — popular Mexican-folk-medicine concept covering a range of cleansing rituals; not equivalent to medical "detoxification" or "blood test" in chart-Spanish. Apple cider vinegar, té de diente de león, té de tila, té de hojas de naranja, and té de cola de caballo are all common "para limpiar la sangre" depending on the household. Validate the cultural goal AND name the specific physiologic effect — don't translate the concept away.
- "diente de león" — dandelion (*Taraxacum officinale*); literally "lion's tooth." Potassium-wasting diuretic with documented mild hypotensive effect; sold widely in herboleras across Mexican-American communities. Patients say "té de diente de león para los riñones." Do NOT correct to "dandelion" — patient may not recognize the English name, and the patient's own herbal lexicon is what makes the disclosure list complete next visit.

HERBAL-SUPPLEMENT MED-REC — 58F WIDOW ON LISINOPRIL + HCTZ WITH K+ 3.1 + CR 1.5 + THREE ORTHOSTATIC SPELLS LAST WEEK, COMADRE-PREPARED NOPAL-CANEJA / JAMAICA / DIENTE DE LEÓN / VINAGRE DE MANZANA / CRASS BORDER GINKGO FROM PRIMO'S VITAMINA SHOP IN GUADALAJARA — FIRST HOUR OF A 4-MONTH FOLLOW-UP VISIT — CONTINUED

- "té de jamaica" — hibiscus tea (*Hibiscus sabdariffa*); documented blood pressure lowering effect in clinical literature. In Mexican-American households, daily 2-cup dose is common; sold by the kilogram of dried flowers in any mercado. The flower is "flor de jamaica," the tea is "té de jamaica" (do NOT confuse with Jamaica the country — patients sometimes joke about this misreading).
- "vinagre de manzana" — apple cider vinegar; widely used in Mexican-American households as "limpieza" remedy and "para bajar la presión." Potassium-wasting concern via osmotic diuresis at chronic 2-tablespoon-daily doses; tooth enamel and esophageal irritation also worth a brief mention. Comadre Soledad's recommendation register here is "para limpiar la sangre," so honor the cultural goal AND name the actual potassium-wasting mechanism.
- "se me va la cabeza" — patient register for orthostatic syncope or near-syncope; chart-Spanish "síncope ortostático" or "presíncope." Pick up by patient register, do NOT switch to chart-Spanish in the same conversation. Companion phrases the patient may use interchangeably: "se me oscureció todo" (visual blackout) and "se me hizo una sombra" (a shadow came over my eyes) — both describe the prodrome that precedes orthostatic events. "La sombra" is the most specific patient-Spanish anchor for the prodrome.
- "comadre" — godmother of one's child; in practice the closest non-blood relative; highest level of trust. Clinical relevance: a remedy from the comadre carries higher authority than a remedy from the doctor, and the clinician who tries to "override" the comadre fails. Honor the comadre BY NAME, give her a written role in the care plan (a paper recipe-card walks home into her kitchen on Sunday).
- "vitamina" — patient register for any capsule/tablet OTC supplement, including herbs (ginkgo, ginseng, omega-3, glucosamine, melatonin) and vitamins proper. When a patient says "una vitamina del primo," ask to see the bottle/label and read it WITH the patient — "vitamina" is the umbrella; the label tells you whether it is ginkgo, ginseng, vitamin D, biotin, or something more concerning.
- "manzanilla" — chamomile (*Matricaria chamomilla*); widely used as a sleep aid and for stomach upset; generally safe at culinary doses (multiple cups before bed is fine in this patient). Mexican-Spanish convention: "té de manzanilla" or just "manzanilla." In this scenario validated as PILE 1 (sigue igual). Note: at very high doses or with anticoagulants, mild bleeding-time prolongation has been described — at culinary household doses for this patient it is not the concern.
- "fregadero" — kitchen sink; specific marker for the Tuesday-morning kitchen scene where Doña Esperanza grabbed the sink edge during the orthostatic event. Picking up the patient's specific physical anchor (the sink, the pew at church, the supermarket cart) rather than abstracting to "three dizzy spells" is the editorial discipline that makes the orthostatic-mechanism explanation land — the patient remembers the fregadero, not "the orthostatic event of Tuesday."

NEXT STEP

Want the next 4?

Same format. With voiced AI patients you can practice against.

These twenty-six are the free tier. Pro opens another 4 scenarios across the six specialties: intake, pain assessment, allergies, medication reconciliation, discharge, and telephone triage — plus AI roleplay (you speak, Whisper listens, the patient responds) and spaced-repetition recall so the phrases stick past the first shift.

It is web-based — not an app. There is no certificate. There is no 16-week commitment. There is no admin sponsorship to chase. You sign up Tuesday, you have something to use on Wednesday's shift.

Free

\$0

Twenty-six starter scenarios (this PDF). Audio + transcript. No login.

Pro

\$19 / mo

4 more scenarios. AI roleplay. Spaced repetition. \$149/yr saves 35%.

Play them voiced

These twenty-six scenarios are playable now at clinicalingo.com/practice/.

<https://clinicalingo.com/practice/>

Language training only. Not medical interpretation. Always follow your facility's policies for qualified interpreters when a clinical decision depends on accurate communication.

v1.0 — 2026-04-22 · clinicalingo.com