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Narrative Medicine Essay

The Lab Value Ah-Ha Moment That Changed My View

Kenechukwu "Kene" Ojukwu[1]

[1] Pathology and Laboratory Medicine, UCLA

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I want to tell you a story about a patient who changed the course of my research career. It happened when I was a surgical resident at a safety-net hospital – the kind of place where people often come in already carrying the weight of structural barriers and systemic gaps. One morning, I met a man who was scheduled for a below-the-knee amputation. Diabetes had damaged the vessels in his leg so severely that we had exhausted our options. He was terrified. Given our training, I was excited for the opportunity to take lead in this surgery. I felt the weight of that moment too because losing a limb is not just a medical event. It changes how a person moves, works, earns income, and sees themselves moving through the world. Before the surgery, I sat with him to talk through what to expect. At one point, I asked a routine question: "Do you know what your HgbA1c is?" He looked at me and said, "What is that?" I remember feeling stunned because HgbA1c is the main test we use to monitor diabetes control. It's the number we use to decide whether someone is improving or worsening. It is the marker that tells us when complications are coming. And this patient, who was about to lose his leg to diabetes, responded as if he had never heard of it. At first, I wondered, *how is that possible?* Surely someone must have mentioned it to him. Maybe more than once. Then it hit me: mentioning something is not the same as communicating it. And communicating something is not the same as ensuring someone understands it. In that moment, I realized the real failure wasn't his disease. It was the system around him. He didn't lack motivation. He lacked access – access to clear information that made sense to him, in a way he could act on. If a person doesn't understand the very tool we are using to measure their health, how can they possibly participate in protecting it? That encounter stayed with me. It changed me. It forced me to see that medical expertise alone is not enough, especially when the system is designed in ways that routinely leave people behind. Particularly those with the fewest resources, the least stability, or the greatest historical barriers to care.

Over time, I began to see that same communication failure everywhere. When I transitioned from surgery to pathology, I realized I had walked directly into one of the biggest blind spots in the entire system. Pathology reports (the documents that define a person's cancer diagnosis) are written for doctors. Dense terminology, Latin roots, long compound words, paragraphs of microscopic descriptions. It's a language we *literally* spend years learning. Patients now receive these reports immediately through portals and at times before they even speak with their oncologist. And here's the reality, research shows that many patients cannot correctly state their diagnosis after reading their pathology report. The gap is even wider in safety-net settings, where many patients are navigating multiple systems, multiple stressors, and sometimes limited English proficiency. When a patient doesn't understand their diagnosis, it affects everything, including their anxiety, their trust, and their ability to make decisions that align with their values. Some delay care. Some withdraw. Some say "yes" to treatments they don't fully understand. Some say "no" to treatments they desperately need. This isn't just a communication problem. This is a health equity problem. Patients with fewer social resources face an even steeper climb when navigating dense, jargon-heavy documents. And when understanding fails, the burden doesn't fall evenly. It falls hardest on people who already experience the greatest inequities in care. That's when I knew pathology wasn't just another specialty; it is a leverage point. A place where improving communication can transform the entire patient journey – from diagnosis to surgery to oncology to survivorship. So, I made a deliberate choice. I entered pathology not just to study disease, but to help redesign how diagnostic information is communicated. I wanted to build a system where patients are not passive recipients of medical decisions but informed partners in their care. This path builds on my early foundation in the CDU/UCLA PRIME program, where I was trained to think about health disparities at both the clinical and policy levels. PRIME taught me that addressing inequity requires intentional design and a willingness to challenge the structures that were never designed with all patients in mind. This is what drives my work now. Creating tools, curricula, and systems that ensure patients, especially those historically marginalized or under-resourced, can understand their diagnosis, ask questions, and make decisions that align with who they are and what matters to them.

I think back to that patient often. I don't just remember the saw I got to use, the perfect stump I created, or the surgery I got to do. I remember his confusion, his fear, and his willingness to trust us despite receiving so little clarity from the system. He deserved more. All our patients do. That moment, that one question, "What is that?", became the beginning of my mission to build a healthcare system that communicates clearly, designs intentionally, and values patient understanding as a fundamental part of health equity.

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