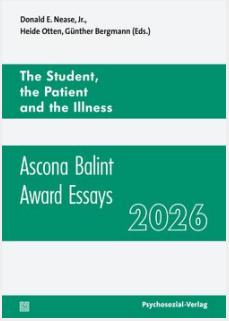
Jood Ghunaim

Boldog Születésnapot



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The Hungarian Phrase For "Happy Birthday"

Jood Ghunaim

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It hasn't been easy acclimating to my environment. I'm sitting in the cardiology Intensive Care Unit of my university's hospital. In small landlocked country in central Europe, Hungary, and South of Budapest, a tiny city called Pécs is where I call home for the next six years. There are not many people here who look like me, and even fewer that speak any of my languages. I like to call myself a linguophile, usually, capable of picking up languages quite easily and holding my trilingual status as a badge of honor. However, the Hungarian language is not one that comes easy to me, in fact, more than a few words and I feel my cheeks get flushed at the visible giggles I get from the native speakers listening to me attempt to speak their language. My accent is not quite right, and no matter how I twist my mouth and how hard I press my throat, the person across from me usually tilts their head to the side and gives me a confused look. After several classes, and several attempts, I decide, there's no need for me to speak, I'll do what I'm meant to do. I mean, that's what matters most, isn't it? Medicine is all about the practical aspects. Fill the syringe, prescribe the medication, and know the steps to perform procedures. So, I simply nod, and smile, and hope this can be the way I am able to communicate. I find comfort in knowing my practical skills will likely be sufficient enough to be my main form of treating patients. I hope that my smile is enough to help the patient across from me feel any type of comfort.

This is my first exposure to the clinical setting as a future physician. I have just finished my first year of medical school; and I'm doing my summer practice. It's a mandatory practice that my university requires students to complete, from year one all the way to year six. This first year's

practice is referred to as "Nursing Skills". As a student, I must practice the basic procedures in the hospital setting. Administration of medication, taking blood pressure, drawings of blood, and of course; care for the patients. This involves making sure they are fed; their gauze is changed should they have any wounds. My course director places me in the ICU of the cardiology unit; quite an intimidating unit for a student with no previous practical experience on real patients.

The ICU is a world of its own. There's a hurried rhythm, beeping monitors, alarms and footsteps I'm trying to keep up with. My first days are spent observing everything. I stay silent but diligently watch the way catheters, syringes and gauze are handled. I watch the small nods and gestures used to communicate without speaking, both nurses and doctors. Each room has its own rhythm. I am an outsider trying to learn. I carry a small notepad with me, writing down steps while watching the nurses perform tasks.

By the end of the first week, I have become flawless at blood withdrawal. I know which medication is for each patient, and I prepare syringes for the nurses in a timely manner. I neatly arrange them on the bedside table for the nurses. I earn a nod of approval and take it as a sign of a job well done. It's hard to communicate well, but I assure myself that if I do things in a procedural manner and if I follow every rule exactly, I will accomplish what I am meant to do. I feel an unspoken pressure to stay out of the way and not make anybody's job harder. So I do just that. I keep myself small and follow instructions without deviation; step by step, and meticulous in my performance.

It is during this first week where I feel my first real sense of accomplishment. I hear my name being called by one of the doctors and quickly make my way into the room. Inside, I find it crowded with nurses and doctors alike. A defibrillator is being set up next to a patient who is on a ventilator. The doctor explains to me that the patient has an abnormal heart rhythm, ventricular fibrillation. A life-threatening abnormal rhythm, he tells me. He dives into the theoretical material I've covered throughout this year. I smile as I recall the pathology unit on ECG's as he explains. As he continues speaking, I notice that that there is a lull in the room as nurses pause and wait for the doctor to finish his explanation and that's when a sudden realization dawns on me: I will be the one performing the defibrillation today.

I feel the blood drain from my face.

I listen intently to the doctor's instructions, while simultaneously trying to recall the safety steps from the first-aid class I took months earlier. No need to panic, I tell myself. Just follow the instructions; it's always just in the instruc-

tions. After a quick debriefing, it's time for me to perform. There is a heavy tension in the room as I walk over to the patient and ready myself. I hold the two paddles in my hand, feeling their weight; both physically and metaphorically. There are two silicone pads on the patient's chest to protect him. I position the paddles over the silicone and take a deep breath.

"Clear."

Everyone takes one step back.

I deliver the shock.

The patient's chest rises, then settles back down. My heart is pounding, yet I do not dare show any emotion. I earn a small round of applause from the attending physician and the nurses in the room. I place the pads back into the machine as another nurse wheels it away. The interaction is precise, and procedural. Everything was done correctly, exactly as I was taught.

Before leaving the room, I glance at the patient's roommate. He is an older man, watching me quietly after what I have just done. He has a tracheostomy tube inserted, and I think he may be my patient next week. In that moment, I still believe the lesson lies in what I have just performed, in the flawless execution of a life-saving procedure. I don't yet know that the deeper lesson will come not from the patient I shocked, but from the one in the bed beside him.

Meeting Laszlo

It's my second week in the ICU. My head nurse, Tunde, walks me into the same room I defibrillated a patient in, last week. She points me in the direction of his roommate. It is here I meet the patient I am responsible for this week. His name is Laszlo. I walk over, and grab his chart and I take an index of him. His file says he is only 65 years old, however he has a tracheostomy tube inserted, and he's unable to stand, walk, or even feed himself. Laszlo has suffered a severe stroke, and has concurrent cardiac events. This has left him unable to feed himself, clothe himself, walk, or communicate. And so, I take my time to familiarize myself with his background. Laszlo was a coal miner on the outskirts of Pécs. Through his job, he was chronically exposed to silica dust, unknowingly, Laszlo had now developed silicosis.

As I finish reading the file, my head nurse walks in. She hands me a orange colored jar with a spoon inside of it. I glance at the label, there's a picture of the baby on the front; pumpkin and carrot flavor. I understand, she wants me to feed him. I nod, knowingly. She smiles at me, and says "Birthday", while

pointing at Laszlo. I glance at the date and compare it to his chart. Laszlo is turning 66 today. Laszlo glances over at me, then at the jar. I watch his eyes peer behind me at the slice of birthday cake the nurses had prepared for him. "Can he have some cake?" I ask. "Little. Small bite," she says to me in broken English. I smile back at her as she turns and leaves the room.

I open the jar, start mixing the baby food, I ready the spoon, and start to feed Laszlo. He doesn't look very happy with me, or maybe it's just the flavor. I hesitate with the spoon in mid-air. I'm suddenly realizing how intimate this task is. Feeding another adult feels entirely different than any other task I've been assigned to do. Drawing blood, changing gauze, all tasks which are procedural, mechanical. Even defibrillation, despite its "violence" felt strangely impersonal. Everything has been rules, commands, adrenaline, noise. But not this. This is quiet. Very quiet. The only sound in the room is the hum of the monitors and the slight hiss or air moving through his tracheostomy tube.

I try to smile at him, unsure if my eyes are reaching him; if he's able to read my emotion. I exaggerate my movements as I move the spoon towards his mouth, hoping each time he understands what I'm doing. He watches me carefully, his gaze alert. There is nothing absent or vacant about him. This is not a man who has disappeared. This is a man trapped.

When he opens his mouth, I miss, just slightly. The puree of pumpkin and carrot lands on his chin. Bright orange. My stomach drops slightly, I feel my cheeks flush.

I rush to wipe it away, apologizing under my breath, embarrassed.

"I'm sorry," I say, reflexively.

He makes a sound, half breath, half frustration, and turns his head ever so slightly away from my direction. I freeze, unsure of whether to persist or retreat. No one has taught me how to read this. Is this refusal? Fatigue? Discomfort? There was no lecture slide explaining this moment.

I wait.

After a few seconds, he turns back towards me. I try again, slower. I take my time. Smaller bites. He swallows with visible effort and I watch his throat move counting seconds, terrified at the chance of aspiration. Only when I watch his breathing steady do I relax.

Slowly, but surely, we find our rhythm. Spoon. Pause. Swallow. Wait.

I watch his eyes glance behind me. I turn and look. White frosting, chocolate shavings, and a single candle. I smile at him.

"Boldog születésnapot" I say quietly. Loud enough for him to hear, but hoping the other nurses can't hear my attempt.

I watch as his eyes widen, for just a fraction. He looks at me- not through me, not past me – at me. He holds my gaze longer this time. Longer than what feels comfortable. Then, knowingly, he blinks twice and gives me a small smile.

Suddenly, it feels like we both understand each other.

For the next week, Laszlo becomes an anchor for me. In a unit where everything feels urgent and overwhelming, his room is the one place where time seems to move differently. I begin to recognize his routines, his preferences, and his dislikes. He prefers a cushion under his knees, his head slightly turned to the left and he relaxes when his blinds are open. I learn these things, not because it is written somewhere in my textbook, but rather because I pay attention. His chart tells one story: age, condition, diagnoses, former occupation.

But the man in front of me tells another story, wordlessly. Through the ways his eyes follow movement, through tension in his jaw when he's uncomfortable, and the rare softness I see in his expression when the nurse adjusts his sheets. Administrating medication became more than following instructions, but rather a chance to connect. It was a chance to speak softly and to reassure him despite the lack of verbal communication. Even when performing blood draws, I realized that explaining the steps, despite his lack of response, was a part of creating trust. Every action, no matter how technical, required attention to his experience.

I start greeting him every morning. At first a nod, accompanied with a smile. Then, I become bolder, speaking some simple words. "Jo reggelt." Good Morning. I practice the pronunciation beforehand, repeating it to myself in the hallway before I come in. Sometimes he gives me a smile, sometimes he doesn't. Sometimes I wonder if I'm doing it more for myself than for him.

Reflection: Experiencing the Relationship

Silence became one of the most unexpected teachers during my time in the ICU. This was a setting dominated by alarms and rapid commands. Silence felt out of place and was deeply uncomfortable. Yet it was within these quiet moments, particularly in Laszlo's room that I learned to listen in a different way. Strangely, I found that this silence was not an absence of communication, rather a form of it. There was a need for patience and attentiveness, and there were no words to guide me. I was being forced to observe closely, to watch carefully; to look for cues. These cues became his

language, and learning to read them felt as important as learning any medical terminology.

With Laszlo, silence carried a different weight. He was unable to speak, and this was not a choice, nor a temporary discomfort. It was imposed on him by his injury. Observing this forced me to confront my own privilege. I could choose when to speak and when to remain quiet; he could not. The asymmetry in our relationship had extended far beyond language. I had mobility, autonomy, and an anticipated future. He existed within constraints, in many aspects. Physical, communicative, temporal, all which shaped every interaction he had. And yet, despite these imbalances, he continued to persevere and take charge of his autonomy. A blink, a turned head, a held gaze. Recognizing and respecting this became one of my most important responsibilities

I am acutely aware of my position in this relationship. I am young, inexperienced and transient. I will only be here for a week. He has been here for months. I have the privilege of leaving at the end of my shift. He does not. As I reflect on this relationship, I recognize how asymmetrical it was. I had access to language, time, choice and mobility, while my patient does not. And yet, despite this, I often felt that he was the one guiding me. The stillness in my patient demanded I be attentive. The silence and knowing looks required interpretation. There was no autopilot in his presence.

It took time for me to realize how patients like Laszlo become absorbed into routine. Tasks are performed correctly, yet often without acknowledgement of the person receiving them. I understand why this happens. The ICU is a place of constant urgency. Efficiency is not a preference but rather a survival mechanism. Still, watching this made me uneasy. I wondered how easily I could slip into a rhythm. How quickly could my attentiveness be replaced by habit? How do I maintain empathy in a setting where speed and precision are prioritized? It is in this moment I recognized that true medical competence is not only procedural; it is just as much relational. It lies in noticing small cues and adjusting care according to individual needs.

Moral Distress and the Pace of the ICU

I became increasingly aware of the unspoken tension between efficiency and attentiveness. This unit functioned on urgency. Lives depended on speed, accuracy, and coordination. In this environment, slowing down felt

as if it was not an option. Spending extra minutes in one room meant less time elsewhere. Presence was a luxury rather than a necessity.

It was an unsettling realization to recognize that I had moments of moral discomfort. I had tense instances where care was technically correct but emotionally incomplete. Patients were repositioned without explanation, procedures were performed without eye contact, and conversations were had over bodies rather than with them. Of course, I understood why this happened. The volume of work was relentless. Emotional distance often served as a protective mechanism, a way to endure repeated exposure to suffering.

As part of the medical team, there is an expectation of being useful, efficient, and sometimes invisible. No one explicitly tells me this, but it is implied in every hurried instruction and every sideways glance when I linger too long in a room. There is always something else to do. Another patient, another task. As a student, I occupied a strange standing amongst colleagues. The hierarchy weighed heavily on me. I was expected to observe, but not interfere, and to care, but just the right amount. It felt as if presence was a misuse of time. I feel guilty for it. As though caring too much is a kind of indulgence. As if emotional engagement is something to be earned later; after I am competent enough, after seniority. These doubts forced me to confront an important truth: emotional awareness is not a luxury or reward to be earned later. Emotional distance was not synonymous with professionalism.

Watching the nurses in the unit reinforced this lesson. I noticed how differently the nurses interact with Laszlo. They spoke to him freely and without hesitation, all while knowing he cannot answer. They adjusted his blankets, they remembered his birthday, it was almost instinctive. Their fluidity showed me a form of competence which combined both skill and presence. This is part of the medical practice that often is unseen, unmeasured and remains unacknowledged; however it shapes the patient experience in a profound manner.

Touch and Intimacy in Clinical Care

Another lesson emerged through touch. Clinical training often frames touch as functional: palpation, auscultation, positioning. It is something done to a body rather than with a person. Feeding Laszlo disrupted this

framework entirely. The act of feeding demanded patience, ease, and cooperation; mutual participation was required. Every movement had to be deliberate. There was no room for rush. The proximity required trust, and trust could not be rushed.

I became acutely aware of how rarely students are prepared for the emotional weight of these moments. No instructions exist for interpreting hesitation, frustration, or eventual consent. No textbook prepares you for the fear of causing harm, embarrassment, or a loss of dignity. Instead, I relied on observation, intuition, and responsiveness. This learning felt fundamentally different from memorization. It was immediate, intimate, and deeply human.

Through this experience, I began to understand how intimacy exists within healthcare, often unspoken and overlooked. Patients repeatedly entrust their bodies, and with them, their autonomy and vulnerability to strangers in the hope of care and healing. Every technical action carries emotional consequences, whether acknowledged or not. The rhythm of feeding, the careful adjustments of posture, the smallest gestures of reassurance all became as essential as any procedure. In these moments, I realized that medicine is not complete without attending to both the body and the person inhabiting it. Touch is never neutral; it communicates attention, respect, and dignity.

Moreover, I began to see touch as a form of communication in its purest sense. When words fail, when a patient cannot speak or express themselves, touch becomes a language of presence. A gentle adjustment of a blanket, the careful support of a limb, even the steadiness of a hand during a procedure, all convey empathy, recognition, and acknowledgment. These moments demand a heightened awareness of timing, intention, and consequence. One misstep can cause pain or discomfort; one careful gesture can convey reassurance that transcends any verbal explanation.

Through feeding Laszlo, I realized that intimacy in medicine is inseparable from responsibility. It is not merely about performing a task correctly; it is about holding the patient's vulnerability with care. This intimacy is a practice of ethics.

Cultural Displacement and Identity Formation

Being an outsider shaped my experience in profound ways. By the age of 19, I had lived in 3 different countries across three different continents. I came into my medical school journey believing I was immune to culture

shock; I had moved, adapted, and thrived before. I never thought that anything could shake me. However, it was not the country itself which challenged me, but rather the hospital setting. Within these walls my sense of displacement intensified. I was navigating not only a new healthcare system but also a new professional identity. As a first-year medical student, I existed on the margins, present but peripheral, eager yet cautious, capable but insecure.

This dual outsider status, both in a cultural and professional aspect, made me acutely sensitive to hierarchy, routine, and expectations. I learned quickly when to speak and when to remain silent, when to step forward and when to recede. Approval came in subtle forms: a nod, a brief acknowledgment, permission to stay. I internalized these cues, measuring my worth through usefulness, my efficacy, and my invisibility. Everyday felt like a balancing act, weighing the desire to contribute against the need to stay small. I became hyperaware of my presence and how it might be perceived by others in this complex environment.

Furthermore, language, or rather the lack of a shared one, had shaped my early days in the hospital. I had prided myself in my English and French skills, sometimes even showing off my Arabic. They were tools I carried with confidence. However, in this environment, there was a strange vulnerability I hadn't experienced before. I struggled with the vulnerability of not being understood. Hungarian had truly resisted me. Its sounds felt unfamiliar in my mouth, its grammar incredibly difficult. Each attempt left me flushed with embarrassment, hyperaware of my accent and the sly but amused smiles of native speakers. Over time, I began to associate my attempts at speaking with exposure, and silence with safety. I convinced myself that competence could substitute communication. My precision and compliance in the practical aspects may compensate for my inability to speak fluently.

Yet, with patients like Laszlo, this assumption was challenged. His silence was not a choice, it was imposed on him. Observing him forced me to confront my own privilege. I could choose when to speak, when to move and when to rest. He could not. His constraints, physical and communicative, shaped his every interaction. This demanded patients. It demanded empathy and presence on my part. This invisible power imbalance between the clinical and patient was becoming more apparent to me. I was becoming more aware of the autonomy I carried versus the limitations my patients endured.

Being an outsider made me aware of these imbalances and the responsibilities they impose. It forced me to realize that communication ultimately transcended language. There is a dialogue in silence and a conversation in touch. My own vulnerability and occasional uncertainty heightened the sensitivity I had to his cues. It helped me recognize that beyond the diagnoses and charts, there was a human being who was constrained.

Navigating this dual identity in being both culturally displaces and professionally marginal also taught me to be resilient. I learned to tolerate uncertainty and to adapt in real time. I had to be effective without imposing. I realized that being an outsider is not a limitation but rather a perspective. It was a lens that allowed me to notice what others might overlook. This dual identity had not hindered my learning, but rather enhanced it. They had made me aware in the inherent privilege in mobility, language and in choice.

Progression: Looking Forward

This experience reshaped my understanding of what it truly means to be be a medical student and a future physician. I entered the hospital believing that my value lay primarily in my ability to perform tasks without error, and to follow protocols perfectly as well as remaing unnoticed. I believed that procedural competence was the primary measure of doing well. As a medical student, I find comfort in organization. There is a sense of reassurance and calm that comes from following steps, from knowing there is a correct order to things. Our textbooks reinforce this way of thinking: everything is systematic, everything is ordered. This is science, and by extension, this is medicine. Steps of hematopoiesis. Steps of bile formation. Steps of an appendectomy. Read, understand, memorize, follow the sequence, and do not stray. I believed that if I performed all tasks correctly, I would fulfill my purpose as a student and eventually, as a physician.

It was through reflecting on my experience with Laszlo that a more uncomfortable truth came into focus. There exists another kind of responsibility; One that does not come with protocols, checklists, or assessments. It cannot be memorized nor can it be numbered. This responsibility lies in holding space for emotional care alongside practical care, recognizing that the two must work in tandem. Medicine cannot be separated from its core purpose. At its foundation, the practice of medicine is guided by

the principle of "primum non nocere": first, do no harm. This principle extends beyond the avoidance of physical injury or procedural error. True adherence to this oath requires attending to the emotional, psychological and human needs of the patient alongside the physical interventions we perform. Emotional support is not secondary to the physical care but rather it is a part of the same ethical and professional obligations. To fail to recognize a patient's fear, discomfort or vulnerability is, in its own way a form of harm. Likewise, providing emotional comfort without attending to physical needs is incomplete. These two aspects of care are inseparable.

As I continue to move forward in my training, I hope to carry this awareness with me. I know that the pressures will intensify. Time will become increasingly scarce, expectations will rise, and emotional distance may feel not only tempting but necessary. There will be moments when slowing down feels irresponsible, when efficiency will seem to outweigh attentiveness, and when the demands of the hospital or clinic make it difficult to pause and fully see the patient in front of me. In those moments, I want to remember that medicine is practiced not only through intervention, diagnosis, and treatment but also through recognition. To truly see a patient, to acknowledge their presence, their fear, their dignity, and their humanity, is as vital as any technical skill. I will actively seek ways to connect, whether through language, gesture, patience, or silence. I will remind myself that even small acts, like an extra moment spent adjusting a pillow, a quiet word of reassurance, a nod acknowledging discomfort, can all profoundly affect a patient's experience and honor the oath I have committed to uphold.

I will also challenge the assumption that emotional engagement is a weakness or a liability. Too often, students are taught to maintain distance, to protect themselves from the suffering of others, or to focus solely on measurable, practical tasks. My experience with Laszlo has taught me that emotional engagement is not only a strength but a skill that requires practice, courage, and deep reflection. Being emotionally present does not reduce professionalism; it enhances it. Emotional awareness allows for nuanced care, better patient communication, and a more profound understanding of the complexities of illness and healing.

Furthermore, I believe medical education can and should do more to protect this awareness. Reflection should not be treated as an afterthought, a checkbox to be completed after the clinical day, but rather as an essential component of training. Students should be encouraged to write, to speak openly, to discuss their experiences, and to sit with discomfort. They

should be guided to notice the subtle lessons that emerge from small, often overlooked moments of care: the fleeting glance of recognition in a patient's eyes, the slight tension in a hand as a procedure begins, the way a patient relaxes when someone is truly present. These quiet interactions, which rarely appear in evaluations or assessments, profoundly shape professional identity and inform the kind of physician one becomes.

These small, subtle experiences cultivate empathy, ethical responsibility, and intercultural competence. They teach students how to navigate uncertainty, power imbalance, and vulnerability with humility and respect. They cultivate patience, self-awareness, and the ability to hold space for others' suffering without being overwhelmed by it. I want to advocate for a medical education that creates space for these reflections, one that encourages students to examine emotional encounters, and to learn from moments that are subtle, silent, and unmeasured. Such reflective practices do not diminish scientific rigor; rather, they strengthen it by anchoring clinical knowledge in lived human experience.

Laszlo never said my name. He never thanked me. Yet he taught me one of the most important lessons of my early medical training: care is meaningful even when it is not curative. Healing does not always come in the form of recovery or resolution. Sometimes, dignity is preserved through presence, through respect, and through continued attention. These moments which are quiet, unobserved, and intangible are ones which carry profound significance. They remind me that the essence of medicine lies not only in curing disease but in honoring the humanity of those we serve, a principle that is inseparable from the oath I have committed to uphold.

As I move forward, my approach to each patient will be shaped not only by technical skill and clinical knowledge but by deliberate presence and mindfulness. I will strive to notice the subtle cues of distress or comfort, to prioritize human connection even when efficiency is demanded, and to remember that the smallest acts of attention can resonate deeply.

Ultimately, this experience has taught me that being a physician is not simply about accumulating knowledge or mastering techniques; it is about cultivating the capacity to truly see and respond to the people entrusted to our care. It is about blending skill with presence, knowledge with compassion, and action with reflection. It is about holding space for the person behind the patient, recognizing the full humanity of each individual, and carrying these lessons forward into every interaction, every shift, and every decision in my career. This awareness, rooted in the principle of "do no

harm," will continue to guide my growth, shape my values, and define the kind of physician I aspire to become.

The lesson I learned from Laszlo will carry forward.

A simple phrase carries a heavy significance in my professional career.

Boldog Születésnapot.

The Author

Jood Ghunaim, Hungary
University of Pécs, Pécs