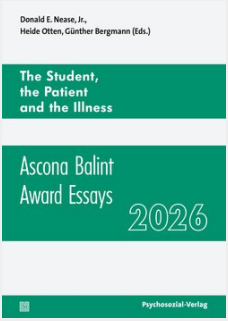
Sepanta Sadafi

Opening the Wounds You Cannot Stay to Tend



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It had only been a few hours since I'd nervously walked down the steps of the small plane they'd sent us to Mildura on, a rural Australian town about an eight hour drive from my home city, Melbourne. I had been thrown into the hospital for the first time as a medical student. I was in second-year and this was shaping up to be an arduous three-day rural placement.

Barely a minute into the morning group meeting before my first ever ward round, I felt more obsolete than I ever had before. I stood silently in the corner, after introducing myself politely. I understood that their lack of warmth was likely a consequence of the pressure the doctors were under, so I tried not to take it to heart.

I stood there observing the room, wondering whether I was allowed to sit in the empty chair, take notes from the confidential patient list, or ask what all these new acronyms were. I didn't sit on the chair, or take notes. After deliberating with myself, I found a moment of silence and finally struck up the courage to ask what "NDKA", "CVA" and "PRN" meant against my better judgement. One of the doctors begrudgingly responded.

This was my first ever beat-down in the hospital system. Afterwards, the fifth year student on the team who was "responsible" for me consoled me and justified the doctor's tone as "just part of the journey!" stating it was "part of the med student experience".

Nevertheless, I compartmentalised, and followed behind the team, which comprised five doctors and four students. We struggled to even fit half of us within the thin walls which were no more than dirt stained curtains. Every word we said felt completely intelligible to the patient in the next bed and their family, despite the illusion of privacy the curtains were meant to provide.

I stood outside the room of a thirty-eight year old woman being informed about stage four pancreatic cancer, her children beside her. Amid the sound of sobbing, I wondered if I'd have the opportunity to speak to her, or any patient at all.

I yearned to be of use, if not emotionally, at least logistically.

Would I be this useless for the whole day? All three days of this rural placement? Even worse, would I be this useless for the next three years of medical school?

We maneuvered around the curtains to the next bed. By chance, I was standing far enough away from the first patient that I became the first point of contact with the next one.

I did not notice his gangrene at first, but I did hear his voice. Low, fractured, carrying the exhaustion of trauma, long endured. It rasped through the room like static from an old cassette, each word fraying at its edges. The tone was unmistakable, the eyes of a man who had seen atrocities but had been heard too little.

He lay in a small room at the far end of a rural ward, half in shadow even when the blinds were open. The light seemed to stop at the doorway, as if uncertain about entering. His chart was clipped neatly at the end of the bed, the summary line brisk in its finality, "Diabetic foot ulcer, advancing to gangrene."

I've always felt the language of medicine was too clean for the realities it describes. Beneath those words was something else entirely, a story scribed in scar tissue, a man awaiting witness, not cure.

I had never felt such purpose at the prospect of listening to his story, caught in a wave of curiosity and empathy.

A small flock of students in stiff lanyards, learning to fit questions inside the gaps between obs rounds and discharge summaries. We were taught which boxes to tick, how to phrase "any concerns?" so that it did not invite more than we could afford to hear.

Compassion was encouraged rhetorically, but the day was scheduled in five-minute increments. I absorbed the lesson quickly. Move fast, smile often, do not get stuck.

He was meant to be a quick follow-up. The nurse had already peeled away the outer layers of gauze when we walked in. I remember the way the air thickened, it was instant and heavy, with the metallic sweetness of decay. It was the type of smell that bypasses language and goes straight to the body, lodging somewhere deep in the throat.

I focused on not flinching, acutely aware of my own performance of professionalism. We leaned in as the registrar inspected the wound, narrating the findings in terms of perfusion, tissue viability, surgical options.

Then, almost casually, the man turned his head towards me and said, in that rasping voice, "It smells like war again."

At first I thought I had misheard him. To my teenager brain, war did not belong in the neat clinical column of "diabetic foot ulcer." It belonged in documentaries, history essays, and dusty memorial plaques, not in the humid air of a rural ward. I hesitated, my mind already reaching for differentials.

"Vietnam. Sixty-nine," he continued, eyes fixed on some point above my shoulder. "They sprayed us with Agent Orange. Said it was harmless. Just something to clear the jungle."

He spoke without bitterness. His gaze did not seek pity. He was offering something else, a chance to remain, to see what most prefer to avert. There was an invitation in the way he said it, as if testing whether I would retreat back into the safety of the chart. I didn't say a word. Words, I sensed instinctively, would only diminish the gravity of what he carried.

"They never said we'd cough blood. Or bury our mates every few years. Cancer, lungs, skin, marrow. This leg, of many reminders, seems to be the last reminder."

The registrar shifted his weight, checked the dressing plan, and spoke about vascular reviews and probable amputation. The man nodded, as though discussing weather. I stood at the bedside, stethoscope idle, feeling as if two conversations were unfolding on top of each other. There was the clinical one about muscle and bone, and another, older one, about a war that lived on within him spiritually.

He paused, and the silence that followed was by no means absence, it was arguably more present than any silence 19 year old me had ever heard before. Thick, living, almost unbearable. The nurse reached for fresh gauze. The registrar gave a small, practiced smile and said we would "keep an eye on things."

The patient began to talk to me as we locked eyes one last time, talking me through the death of his wife and the unfortunate suicide of his son. About how he bought the car he always dreamed of but could not enjoy it one bit with the absence of his family. About how he was the injured, chronically ill soldier, and still the last man standing.

It felt to me like a final cry for help.

As he was speaking with profound candour, the registrar insensitively shut the conversation down, and pulled me out of the room.

As we stepped back into the corridor's fluorescent light, an older student beside me murmured, half to himself, "Be careful opening wounds you will not stay to tend."

The phrase lodged deep. It was akin to a splinter.

We moved on. The ward reclaimed me, as if I'd rejoined the pack of sardines. There were other patients, other wounds, other learning objectives. Yet all afternoon, my mind kept circling back to that room and the smell "like war again." I tried to redirect my attention to the tutorial on insulin titration, to the consultant's explanation of HbA1c targets, but his voice kept intruding, low and cracked, dragging the past into the present.

The official rhythm of the day demanded obedience. We had notes to write, checklists to complete. When our group was dismissed for an hour of independent study, most of my classmates vanished into the students' room with textbooks and laptops. I stood in the corridor, halfway between where I was meant to be and where I felt pulled.

The older student's warning replayed itself. "Be careful opening wounds you cannot stay to tend". I told myself that I was not opening anything, merely walking back to someone who had already begun to speak. I told myself it would be brief. I told myself it mattered.

I could not resist.

I returned to his room.

The light had shifted slightly, falling across the bed in a thin rectangle. He was awake, staring at the ceiling. For a moment I hovered by the door, self-conscious. I had no lab result to discuss, no update to deliver, nothing that could be categorised as "educational activity" on my logbook.

"Hi," I said, feeling the inadequacy of the word. "I'm sorry we couldn't finish our conversation this morning, the doctors were quite busy, but if it's okay with you and if it's something you'd like, I could sit here and listen."

He turned his head and regarded me quietly, as if weighing this intrusion, this second arrival of a stranger in scrubs. A tear fell, he smiled subtly and gestured to the chair.

We did not start with Vietnam. He asked my name, how far along in my training I was, whether I was "going to stick with it or run for the hills." I laughed, slightly too loudly, and said I planned to stay. Only later did I realise it was the same question he was asking about himself.

Slowly, without any prompting I could identify, his words shifted. He

spoke of the day they flew home from Saigon, young and sunburnt, expecting parades and finding protest. He spoke of nightmares that never stopped, of waking with the sound of helicopters in his teeth.

Then he spoke about home.

He told me that two weeks earlier, his wife had died. They had spent years talking about a shared dream, saving slowly for a second-hand Mustang and planning to drive it around Australia once "the doctors' appointments settled down." He smiled when he described the car, but that was only a reflex of remembering his soulmate. A small, crooked smile that held both pride and disbelief. "We finally got it," he said. "But now I don't have her, or my son." She saw it, sat in it twice, and then her heart gave out."

In the days after her funeral, he said, their son ended his own life. He told me this without drama, almost as if stating another side effect, another item on a long list of losses. There was no language big enough for the shape of that grief. A wife gone, a son gone, the car they had bought to outrun the years now sitting idle in a shed, keys glinting uselessly on a hook.

He spoke of mates who overdosed and of those who "just faded away." He spoke of the slow erosion of his body and the faster erosion of meaning. The war had followed him home in various uniforms. Cancer, nightmares, funerals, an empty passenger seat where his wife was meant to be.

This conversation was not intended to be history taking practice for me. It felt like being trusted with something that was precious and dangerous. His voice moved between memory and confession, circling what language could not contain. He did not ask to be fixed. Only to be met.

I listened, acutely aware of how little I knew, of how far outside my training this all fell. Every instinct I had been cultivating told me to summarise, to clarify, to reflect back using phrases we practiced in communication skills workshops. None of that felt right here. To package his sentences and pain into neat formulations would have been erasure. This was not a conversation to take notes about.

So I stayed mostly silent. Occasionally I asked a small question, more to show I was still there than to direct him. I felt the weight of his story settling around us, heavy as the smell of antiseptic and decay.

Until then, I had mistaken compassion for its performances: kind phrases, careful tones, a well timed nod. Sitting with him, I realised that compassion is not spoken. It is endured. It demands that we resist the reflex to retreat from what wounds us.

By the time I stood to leave, the light had thinned further. I thanked

him, awkwardly, knowing the word was too slight for what he had laid out between us. He shrugged, as if to say that talking had changed nothing and yet, perhaps, a little.

That evening, guilt and a kind of fierce tenderness twisted together in my chest. I replayed his sentences in my mind, trying to decide whether I had done something good or something foolish. Part of me felt that staying had honoured him. Another part braced for the possibility that I had transgressed some unwritten rule.

The next morning, as the ward round was about to begin, the registrar asked if he could speak with me. His tone was neutral.

"I heard you went back to Mr H's room yesterday afternoon," he said. "On your own."

I nodded, heart quickening. "Yes. We talked for a bit. He wanted to tell me about – "

He held up a hand gently, stopping the sentence before "Vietnam" could land between us.

"I appreciate that you care," he said. "But you cannot just go and have unsupervised in-depth conversations like that. You are a student. There are boundaries. We are already stretched. If every student sat talking for an hour, nothing would get done. You also risk bringing up things you are not trained to manage. Trauma, depression, all of that. You open doors we cannot guarantee we can help them close."

He did not raise his voice. There was no dramatic anger. That almost made it worse. The reprimand was delivered in the same tone as instructions about heparin doses, as if this were just another protocol I had failed to follow.

I felt my face burn. I apologised automatically. I heard myself say that I had not meant to overstep, that it would not happen again. In that moment, the previous afternoon, with all its fragile honesty, shrank into something labelled "inappropriate over-involvement" in my mind.

The sting of being disciplined wasn't just about the embarrassment. It was the sudden suggestion that my attempt to be present had been not only inefficient but potentially harmful. I had walked out of his room feeling that I had honoured a story. Now I was being told that I had mishandled it, that in opening space I could not fill, I may have re-injured a man already flayed by institutions and recent grief.

I thought of the red Mustang in his shed, of the wife who had sat in it twice, of the son who could not imagine a future without her. I thought

of how easily my own departure, abrupt and unexplained, could become another small confirmation that everything and everyone destined to care eventually departed whether by choice or not.

After the round, I sat in the empty tutorial room and stared at the whiteboard. Part of me bristled. Had I really done something so wrong by sitting with a man who had lost his wife, his son, and his leg within weeks of each other, and who wanted to speak? Was the system so fragile that one hour of listening could destabilise it? Unsettlingly, I recognised a kernel of truth in what I had been told.

I remembered the older student's warning in the corridor: "be careful opening wounds you will not stay to tend". Until then, I had heard it as a call to be efficient, a cynical acceptance that we should not "get too involved." After the reprimand, I began to hear a second meaning. To invite a story is to enter into a kind of contract, however implicit. You become, in that moment, part of the architecture holding it. If you vanish abruptly, the structure can collapse, leaving the other person buried under what they have unearthed.

I would only be on that ward for two more days. I could not promise him continuity, only a brief flare of attention in a long corridor of neglect. Did my presence give him something, or did it remind him that people can still leave without warning? Was I a salve or another small laceration in a life already cross-hatched with them?

This question haunted me as his clinical course unfolded.

Within hours, the decision was made to amputate. The leg that "smelled like war" became a surgical specimen. The notes in his file described the procedure with precision. "Below-knee amputation performed. Uneventful peri-operative course." The phrase "uneventful" felt obscene. The nurses managing his post-operative pain did not have capacity to also manage the old pain resurfacing under the morphine. The physiotherapists focused on mobilisation. The endless business of saving bodies continued.

I visited him twice more, each time more aware of my own inconsistency. He was alternately drowsy and sharp, drifting between ward remarks and fragments of memory. Once, in a lucid interval, he looked at me and said, "You're the one who keeps coming back." It was said without accusation, but it landed like one. Keeps coming back, as if my intermittent returns were a pattern he recognised from elsewhere. Things that appear and disappear, promising solidity and dissolving, like the promises made before Agent Orange soaked into his skin and before the Mustang key turned useless in the ignition.

The next morning, it was my final ward round on this placement.

His bed was empty.

The nurse at the desk told me he had gone to high dependency overnight with sepsis. The operation site looked clean, but his blood pressure had collapsed. "These old blokes," she said, half sighing, "one thing knocks them off course and the rest just follows." I nodded, feeling both included and excluded from some adult knowledge about mortality.

I read the note. It was short: "Expired overnight. Sepsis following surgery. Family informed." I wondered who there was left to inform, maybe a brother or sister.

That was all. Clinical, complete, conclusive. Whatever war had been continuing in his dreams ended without ceremony in a three-line entry.

I still think of him, in the smell of iodine mingled with darkness, in the split second of hush before I ask a patient about their past, in the awareness that our pains predate our arrival in any room. Medicine teaches us to take histories, not to bear them. But every story offered in trust becomes a small inheritance of suffering. To witness it without turning away is not ancillary to care. It is care.

After his death, I tried to talk about him with my classmates. I mentioned how he had compared the smell of his wound to the jungle, how he had spoken of Agent Orange and buried friends, and of how in the space of a fortnight he had lost his wife, his son, and now, finally, his leg. They nodded politely, said "that's intense," and then resumed their exam revision. The moment compressed into anecdote, something one might one day use to get a good mark in an OSCE station on "breaking bad news."

Something in me shifted. I felt an odd dislocation, as if I were straddling two realities. In one, he was a case study in complications of diabetes. In the other, he was a man whose life had been shaped by decisions far beyond his control, whose final days were spent in a room that smelled of both rot and disinfectant, whose last significant conversations may have been with a student who had later been reprimanded.

I began to pay more attention to the texture of everyday apathy on the ward.

It was rarely dramatic. No one announced, "I do not care." Instead, it seeped in around the edges. A registrar who once sat at the bedside would now stand at the door. A nurse who used to ask about grandchildren now focused solely on blood pressure. Jokes became sharper, flung into the air as a way to blunt the emotional sting of the work. Phrases like "You cannot

save everyone" and "You get used to it" floated through handovers like protective spells.

Initially, I judged this as moral failure. How could they not care? How could they talk about a man's amputation in the same tone as they discussed the lunch menu? As the days passed, my judgment softened into something closer to understanding.

The ward was understaffed. Nurses were carrying six patients instead of four. The registrar's pager seemed to scream constantly. Rosters were stretched so thin that most people had not had a proper break in weeks. In such an environment, emotional presence becomes a privilege and a luxury rather than a standard. Apathy, I realised, was not always a defect of character. Often, it was an adaptive reflex to scarcity.

When the system is stretched to breaking point, what frays first is not technical skill. It is softness. To feel everything fully, day after day, in a context that offers little space for recovery, would be to risk collapse. So people learn to narrow their emotional aperture, to see wounds primarily as problems to be solved, not as stories to be heard. They cut their empathy to fit the available time. It is therefore unsurprising that my parents, emotionally depleted by the cumulative traumas of immigration, have long been unsupportive of my passion for psychiatry, seeking to shield me from what they perceive as the psychological unravelling inherent in sustained emotional exposure.

In that light, my reprimand took on a different hue. It wasn't simply about me, or about this particular veteran. It was about the system's fear of any interaction it could not sustain. If every student spent an hour with each patient who wanted to talk, the already overburdened staff might be left with a ward full of opened wounds and no capacity to tend to them.

My act of staying was, in one sense, a small rebellion against this pragmatic logic. It was also, potentially, an additional burden placed on a team already at their limit.

This did not absolve the pain of being disciplined for trying my best with a patient.

It did, however, complicate it.

So I find myself caught between two imperatives.

The first is internal and moral, to be the kind of clinician, who does not turn away from suffering, who stays seated when the wounded speak candidly.

The second is external and structural, to become the kind of clinician

the system could accommodate, applauded for efficiency and bounded. After all, most of the metrics we seem to strive for are based on how fast we can successfully discharge patients.

Each time I choose one, I feel as though I'm betraying the other.

I returned back to Melbourne and eventually started metropolitan placements. Some days, exhausted and anxious about assessments, I tried on the detachment I saw around me. I hurried through questions, avoided asking anything that might lead to tears, laughed at jokes that flattened patients into "frequent flyers" and "heartsinks." On those days, I went home with a tightness in my chest, sensing I had rehearsed a version of myself I did not want to grow into.

On other days, I allowed myself to slow down, to linger at the bedside of someone whose eyes followed me as I moved past. Those days carried a different cost. I risked falling behind, risking criticism for inefficiency. I risked, as with the veteran, disciplinary conversations that framed my empathy and presence as a problem.

Somewhere between these extremes lies the practice I hope to cultivate.

Attentive yet boundaried, open yet honest about my limits. To reach it, I will need more than personal resolve. I will need training that acknowledges these tensions instead of punishing their emergence.

Looking back, I can see that my return to that room was less an isolated misjudgment and more a collision between two pedagogies. The formal curriculum taught me to take a history, examine a limb, write a succinct note. The hidden curriculum taught me that spending too long with someone was suspect, that tears were time-consuming, that the safest question was the one that did not invite a complicated answer.

The veteran taught me something else again; that bearing witness is itself a form of treatment.

My grandparents had always called the doctor itself "a drug", teaching me quite young that the clinician's presence, personality, and way of relating can be therapeutic, for better or worse. In that rural ward, I glimpsed this truth. I could not prescribe anything. I could not adjust his insulin. Yet something in our sitting together shifted the distribution of weight in the room. I was, briefly, part of the medicine. The reprimand that followed was, among other things, a reminder that I was not yet authorised to administer this particular drug.

I understand the caution now more clearly. There is risk in inviting someone to unseal old grief if you are unable to offer a reliable container.

To open wounds you cannot stay to tend may re-enact earlier abandonments. If I had stayed away, perhaps his final days would have been more uniformly dull, less fissured by reminders of a war the ward could not acknowledge and a family he had just lost.

And yet, when I imagine the alternative, I feel otherworldly unease. I picture him lying in that dim room, his leg turning black, the smell thickening, his memories pressing against his ribs with nowhere to go. I picture the red Mustang sitting cold in a shed, a monument to a future that never happened. I picture everyone walking past, seeing only an "advancing diabetic foot ulcer." I do not know whether my listening did more good than harm. I do know that to have left his words unspoken would also have been a form of neglect.

I imagine a system where, after such an encounter, I could go to a mentor and say, "He spoke of Vietnam and nightmares and his wife and son, gone within weeks of each other. I feel out of my depth. Can we think together about what I have opened and what can be offered now?" I imagine a ward where there is space to hand over not only blood results but stories, where the psychosocial wound is acknowledged as something the team shares responsibility for, not something smuggled into a spare moment by a student.

Instead, I learned to silence my own unease. I learned that certain kinds of care can attract punishment. I learned that resource-related struggles can harden into apathy that is almost indistinguishable from cruelty, except that it is born of depletion, not malice.

His story continues to shape the doctor I am becoming. When I sit with patients now, I am more deliberate about the questions I ask. Before I invite someone to talk about old losses, I consider what I can realistically offer in return. Continuity? Or maybe a referral and handover that honours what has been said. If my role is transient, I name that openly. I say, "I am here with you today. I may not be the one you see next week, but I want to understand what matters to you so we can pass it on properly." It is not perfect, but it feels more honest than pretending I can stay when I cannot.

He also changed how I think about medical education. We spend countless hours memorising receptor pathways and management algorithms. We are given far fewer structured opportunities to explore what it means to be the person who hears, and sometimes triggers, another human being's deepest pain. When those moments do occur, they are often handled privately, in the spaces between formal teaching sessions, or punished through quiet admonishments to be "more professional."

We need spaces, where students can bring these encounters not as embarrassing missteps to be corrected, but as complex events to be examined. In such groups, my story of the veteran could have been unpacked with nuance. We could have acknowledged the real risk of opening wounds without adequate support. We could also have honoured the value of a young clinician learning to tolerate the smell of war without fleeing. We might have asked what changes at the level of rosters, staffing, and supervision would be needed for such listening to be sustainable.

Most of all, we might have named openly the pain of being disciplined for trying one's best with a patient. That pain, early in one's career, can feel like personal humiliation. It is a micro-trauma to the developing professional identity. Each time a student is told, implicitly or explicitly, "Care less, you are in the way," a small piece of their initial idealism is amputated. Over time, those losses accumulate, producing the very apathy we then lament.

I do not romanticise my own role in his story. I was a brief visitor in a long campaign. His leg would have been amputated whether or not I sat down that day. His nightmares would have continued long after my rotation ended, had he lived. Yet within the narrow band of influence I had, he taught me something I could not have learned from a lecture.

He showed me that the body does not forget what the world refuses to name. He showed me that some wounds smell of jungle and jet fuel even when described as "infected tissue." He showed me that sometimes the most radical act a clinician can perform is to stay seated when silence speaks, while also being humble enough to recognise when you must call others to help bear what has been uncovered.

I still see his room when I close my eyes on certain nights. The dim light, the peeling poster on the wall, the metal frame of the bed. I still hear his voice when I stand at the threshold of difficult questions. When I am tempted to ask about a past that I suspect is littered with landmines, I pause and ask myself: What will I do with the answer? Who will help me carry it? How will I ensure that my curiosity does not become another unkept promise?

I have not resolved these tensions. I suspect I never fully will. Perhaps that is the point. The work of medicine, especially in its relational core, is not about achieving a stable equilibrium between care and distance. I am learning to live honestly in the pull between them, to recognise

when the system's constraints are shaping my choices, and to protect, whenever possible, the small, fragile practice of being present.

He died days after I first met him. In institutional time, he is long gone, his notes archived, his bed occupied by others. In my time as a student becoming a doctor, he is still there, in every decision I make about how long to stay and when to leave. His war continues to echo not only in his scarred lungs and damaged marrow, but in the reconfiguring of one student's understanding of what care demands.

I do not know if he would recognise himself in these pages. I hope, at least, that he would recognise the effort to listen without turning away.

If I have opened his story again here, I do so with immense responsibility, one I am also still learning to inhabit. The responsibility to let his life, and my brief mis-steps within it, shape how I stand in rooms that smell of antiseptic but emanate a life full of battles. I will teach those who come after me not merely to take histories, but to bear their stories.

The Author

Sepanta Sadafi, Australia
Monash University, Melbourne