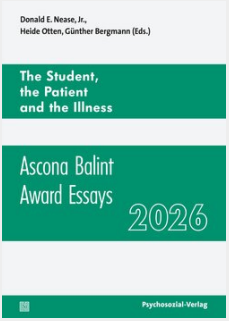
Fabiana Benedini Galli Zambardino

The Fabulous Right-Sided Heart



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The examination room was sterile in the way teaching clinics often are – white walls, fluorescent lighting, two bright red chairs for the patient and his accompanying family member. In the center, a table. Behind it, I sat on an office chair whose gas lift had long given up its original purpose. Every few minutes I felt myself sinking slowly toward the floor, until I had to grip the sides, lift myself, and let the faulty mechanism clatter loudly back into place. To my right, a fellow student perched on a metal two-step ladder, another leaned against a flimsy metal stretcher.

It was an ordinary afternoon in an otherwise unremarkable two weeks of pediatrics rotation. Nearly all our patients had come with learning concerns or controlled asthma – cases that were too neat, too stable, too clean to offer the kind of learning every student secretly hopes for. We yearned for more: a strange rash, an unusual murmur, something we'd only seen in textbooks. That day we were patiently awaiting the attending pediatrician to assign us our first patient. At 08:15 hours, the doctor walked in, handed us the patient chart and informed us that it was another asthma follow-up. The teen wasn't his patient, but the doctor who usually treated him was on vacation, so he took over the case momentarily. He emphasized we should investigate his asthma symptoms carefully but otherwise gave no further instructions.

I read the patient's chart aloud, as I was the one tasked with the anamnesis and my two colleagues would both conduct the physical examination. I read aloud: "Patient M, 17 years old, from the neighboring town of Carapicuíba, located in the state of São Paulo, Brazil, accompanied by his father, Mr. J. Previous medical history includes controlled asthma with bronchodilator applied twice daily, previously treated for tuberculosis in 2022, and Kartagener's Syndrome."

My mind was racing. *Wait, Kartagener's Syndrome? I have heard of this before. Isn't this that rare condition we saw in pneumology class? What was it again? Something that was mentioned in the same class as Cystic Fibrosis. Cystic Fibrosis is screened for in neonatal triage tests, but this isn't. This is rare, but there's also mucous. Why do we insist on learning eponyms? Oh, it has to do with the cilia! That's why mucous accumulates, there's less clearance. What other symptoms were there? The cilia are defective in all cells; they move slowly and ineffectively. Ah, it is Primary Ciliary Dyskinesia! Anyways, the symptoms ... mucous accumulates, so there are recurrent respiratory infections, higher risk of pneumonia. Ah, there's infertility too – but there was more. Patients can also have situs inversus, so the heart can be on the right side! And there was also something about situs inversus totalis, where the abdominal organs are also mirrored. Woah, this is definitely not just another asthma follow-up. This is unbelievable!*

The rarity itself intrigued all of us. A genetic disorder we'd only read about, the kind whose diagrams we memorized for exams, the kind whose clinical findings – like dextrocardia – make students' eyes widen. Even now, I remember the electric shift in the room when this detail surfaced. It was as though the air thickened with anticipation. My colleagues and I exchanged glances, subtle but unmistakable, the kind that says "finally."

We eagerly called the patient into the room. He was a teenager, lanky, his shoulders slightly drawn forward like he was trying to take up less space. Naturally, he was a bit shy upon seeing three female student doctors gazing at him with wonder. When he walked in, he was followed closely by his father, a five-foot two-inch man whose posture, paradoxically, had a kind of dignified erectness. Later, I realized this posture that could be easily mistaken for pride, was in fact vigilance.

I began the anamnesis in my usual pattern: confirming his identification information, establishing rapport with lightheartedness, scanning his demeanor, guiding him gently toward the standardized questions.

There were absolutely no symptoms at presentation. He answered casually, almost dismissively:

No daytime asthma symptoms more than twice a week. No nighttime awakenings. No need for a rescue inhaler. No limitations to daily activities.

His asthma was evidently controlled. I moved onwards to question him about any other symptoms he might be experiencing from head to toe. He promptly denied headaches, difficulties in hearing, sore throat, heartburn, stomach pain, diarrhea or any local pain. Up until this point, this was as

uneventful as any other. Meanwhile, as I continued the anamnesis, my two colleagues away on their phones, absent from the moment. I was relieved they weren't interrupting my flow of questions, since it made it easier for me to organize my thoughts and document everything on his chart.

I then proceeded to inquire about his previous medical history, shifting the anamnesis towards the common ailments associated with Kartagener Syndrome. The atmosphere in the room changed, because we all knew this was where the learning would be. Now everyone was listening attentively, all eyes on him.

He said he sometimes had a cough, but that was mostly it. He didn't seem to be much bothered by his disease, having learned to live with it and normalize any symptoms.

I asked what he knew about his disease; his nonchalant expression turned into mild confusion. He couldn't describe a condition he had lived with his whole life nor what to expect of it. As I explained the dysfunction of his ciliary cells, the tendency toward mucous accumulation, susceptibility to respiratory infections, and possible infertility, he listened with genuine curiosity. That jerked his memory and he mentioned he had multiple ear infections as a kid but denied lingering auditory deficits. He treated tuberculosis in 2022. I questioned if anyone else in the family had had tuberculosis, since people who live in close quarters are susceptible to getting infected.

His father, who had thus far remained silent, interrupted gently to share that his younger daughter had had it as well, but no one else. Suddenly, M and his father's postures stiffened, as if bracing for the sorrowful news that would be shared next.

His father drew a deep breath and my attention shifted to him. He crossed his arms tightly across his chest, holding himself together, a subconscious self-embrace, and uttered: "My daughter, his younger sister, died of pneumonia. Do you think it was because of this syndrome she had, doctor?"

The younger sister had the rare syndrome as well and she died due to pneumonia. These two people in front of me have seen the worst possible outcome of this disease.

I immediately felt a tightening in my chest. *This is heartbreaking.* I simplified the technical terms as much as I could as I elucidated what could've happened to his beloved daughter. "You see, Mr. J, the accumulation of mucous creates a breeding ground for bacteria, which can lead to an infec-

tion, namely pneumonia. The course of pneumonia can be fatal in people with a chronic condition compromising the lungs." I asked if they had any questions about the disease in general. I relied heavily on medical information to comfort his grief.

Mr. J's full head of gray hair had been gelled back with meticulous care, giving him a neatly groomed appearance that contrasted with his large, calloused hands – hands shaped by years of manual labor. He referred to me as "doctor" with a level of respect I felt I hadn't earned, at least not yet. The horizontal lines on his forehead, the deep wrinkles around his eyes, and the sun-tanned skin all hinted at a life lived outdoors, working, enduring, providing. He held his hands together, palms facing each other, the way one might hold them in prayer.

His concern was the thick, heavy kind that fills the room like a second presence. His voice trembled as he asked what he could have done to prevent his daughter's death. He wanted to know whether the fact that his daughter also had tuberculosis could have also worsened her pneumonia. He didn't know how both his kids had tuberculosis. He thought it was a disease long gone. He sought information to justify the unjustifiable. His urgency for information was also prompted by his paternal duty to protect the son sitting beside him.

I felt myself leaning toward him, instinctively trying to meet the vulnerability he had offered. I validated his feelings. I explained the symptoms to be mindful of. I listened and expressed my deepest sympathies for their loss.

After all, the feeling of confusion and desperation about a diagnosis of a loved one were all too familiar to me. Years before considering a career in medicine, my mother, the closest person I have, was rushed to the emergency room with a stabbing pain at the pit of her stomach that she assumed was gastritis. As we were informed days later by a team of stern doctors we had never seen before, she had multiple arterial dissections. They said it was rare, that they themselves had never seen any cases before ...

My reminiscence of old memories was interrupted when the door burst open.

Four giggly students barged in, breathless with excitement. Now I understood what the students in the room with me were doing on their phones: they were texting their friends to come see the teen with dextrocardia. I can still hear the shift in tone, the transformation of the room's atmosphere.

My emotional reaction was immediate, visceral. Disbelief. Incredulity.

A hot outrage that rose from somewhere deep. *What in the world is happening right now?* was the sentence that thundered through me – but only internally. I swallowed it whole. My professionalism suppressed my impulse to reprimand them with vehemence.

Because I looked at the teen, and he was smiling proudly.

These were pretty girls, giddy to auscultate the only right-sided heart they might ever encounter. To him, it felt flattering. At his age, with his vessels pumping with testosterone, attention from four enthusiastic female medical students was likely a welcome distraction. For a second, the condition he's lived with his whole life and that contributed to the death of his sister wasn't a source of suffering. Instead, it made him special, it garnered attention, awe, and admiration. It seemed like a refreshing shift in perspective, even if just for a fleeting moment.

So, I watched, silent, as they crowded around him. The first one to come in asked if they could all auscultate his heart, and he willingly lay back down on the stretcher. She placed her stethoscope tentatively on the right side of his chest. She was delighted to locate his *ictus cordis* on the right side. She exclaimed, "I found it! It's here!", as she pointed to the pulsating area. His body fat percentage was low in that distinct way of adolescents who have been through a growth spurt, so you could easily see his heart in the right fifth intercostal space in the mid-clavicular line. The second student proceeded to auscultate, sharing in the excitement. The third student auscultated the heart, but that wasn't as novel a finding, as the other's had already heard it. She moved on to the abdomen and percussed the left upper right quadrant, hearing an unusual dullness. Then, she percussed the right upper quadrant and heard an unusual tympany. Her furrowed brow accused her confusion. After all, she hadn't read the case, and she didn't really know what Kartagener's Syndrome meant. She barged in to hear a right-sided heart, plain and simple.

Her friend, the one who messaged her to witness this once in a lifetime opportunity, proudly announced, "He has total *situs inversus*." That wasn't enough to soothe her furrowed brow, so her friend explained in full, "All of his organs are switched, so his liver is on the left side, and his gastric bubble is on the right side." This statement cleared up any confusion. The fourth student then auscultated his heart and percussed his abdomen, this time around there was no exclamation of wonder. As abruptly as they barged in, they hurriedly left the room again, thanking the teen for letting them examine him.

The teen appeared relieved to seat back down in his chair. Four consec-

utive auscultations and people drumming on his belly for the purpose of learning probably wasn't what he had expected from the initial flattering attention. There was no meaningful exchange with him, just academic curiosity.

This was a unique learning opportunity, and they took advantage of it. They were learning. They were utterly oblivious to the sorrow in the room before they came in, I'm consciously aware. But inwardly, I was unsettled. It had felt like an invasion of something sacred. I was building a connection with the son and the father, absorbing and processing the tragedy they had recently experienced. Suddenly, my peer's curiosity and excitement assumed the protagonism in the room, while the grieving son before me became an object of wonder and the father became a silent extra.

Somehow, their lack of real interaction with the patient also felt like they were taking advantage of him. They came in to marvel at the anomalies in his physical examination but did not care to stay for the remainder of the anamnesis. They laser-focused on the disease and neglected to see the patient living with the disease. Through my eyes, it was a betrayal of the humanizing principles we are taught. Obviously, the anomalies in his physical examination were interesting, but a doctor must build trust and rapport with the patient to be granted the privilege of examining him. It must be a mutually beneficial interaction: the patient is cared for, while the doctor learns from his case.

I handwrote the remainder of my anamnesis in silence until they left. My thoughts were racing. *I get that this is a cool case, that it's super rare, but I've never seen anyone barging into an exam room like that. This is not a rare dog breed that you find on the street, ask the tutor to pet, and then go about your day as if you had crossed that off your wish list. He is a patient in an exam room, a space that's supposed to be safe, where he shouldn't be made into a spectacle. The door to the exam room didn't say: "Come one, come all! The Fabulous Right-Sided Heart! A show you can't miss!"* That stuffy examination room suddenly felt suffocating. All I could do to divert my attention from my anger was to focus on completing his chart, on moving forward with questions that seemed irrelevant given the severity of the prior conversation in the room.

He ate three meals a day and we went through each one carefully to analyze his nourishment status. For breakfast, he had white bread and butter in the morning, a cup of coffee without milk. He didn't have a morning snack. His next meal was lunch at school, which was a balanced meal con-

sisting of a wide variety of leafy greens and vegetables, some carbohydrates, such as brown rice or pasta, and protein, which the menu alternated between grilled chicken and slow-cooked meat. For dessert, they offered fruit. He skipped the afternoon snack. He arrived very hungry at home every day and ate industrialized snacks. I interjected here and alerted him to the harms of consuming industrialized foods and suggested he eat a snack with yoghurt, fruit and some rolled oats to curb the evening hunger. In the evening, he had basically the same meal he had for lunch.

We asked about his performance at school, and he said his grades were good, his favorite subject was math. His father confirmed that his teachers liked him and he had good relationships with his friends. He played volleyball at school. At this moment, I asked his father to momentarily wait outside the exam room, so we could ask his son more personal questions which could be embarrassing to answer in front his father.

I asked M about his habits and partying. He didn't smoke or drink alcohol or use drugs. He didn't have a girlfriend. He also shared, in an embarrassed tone, that he hadn't had his first sexual experience yet. I asked him if he had any questions he'd like to ask us, assuring him that this was a safe space. He was curious to know why he could be infertile, returning to the beginning of the anamnesis. I explained, "the tubes that carry your reproductive cells from your testicles to your urethra have cells lining them. These lining cells have eye lashes, which are supposed to help guide your reproductive cells onto their path, but since the eye lashes move slower in your case, that might compromise your reproductive cells from getting to their intended destination. Does that help understand it?" He said it was clearer now. Then I emphasized, "you still need to use condoms whenever you engage in sexual activity, alright? There are a lot of sexually transmitted diseases from which wearing a condom protects you." He smirked coyly and shook his head up and down in agreement. With the more private part of the anamnesis over, we called his father back into the room.

Finally, we reached the end of the anamnesis, and the two girls examined him, for the fifth and sixth time. The excitement had worn off from the first physical examination, but this one was more thorough than the initial four auscultations. They examined him from head to toe. His head was free of lice. His ear canal was skin colored with small hairs, a light coating of yellowish-brown earwax, and a light gray eardrum that reflects light. He had pinkish-red mucosa, and a smooth, midline septum, with no discharge in his nose. His oral mucosa was hydrated; there was no evidence of dental

caries. There were no palpable lymph nodes in his neck. The remainder of his physical exam was normal.

He did, however, bring a chest X-ray, where we could visibly see the heart-shaped opacity in his right chest. Faced with the vivid image of his interior organs, the two girls insisted on taking a picture of his x-ray. M asked what for, and they simply answered that they would cut his name out, but that they had never seen anything like it, so you wanted to register it for yourself.

As I wrote down the physical exam findings, I looked down and the student next to me was looking at her phone under the table. I immediately recognized the layout she had open on her screen. She was looking through the list of people who had viewed and reacted to her Instagram stories featuring *The Fabulous Right-Sided Heart. YOU HAVE GOT TO BE KIDDING ME! You said you wanted to take a picture of his x-ray for posterity, as a memento of his rare case. Instead, you blatantly lied to him for your self-promotion online. Is it fulfilling to get a "like" using someone else's pain without their consent? Does it bring you joy to expose a patient like that? Why are you here if you are worried about posting content on social media? You could have become a travel influencer or a food blogger. You know, professions that depend on being relevant online? Hell, if you want to divulge people's tragedies, you could be a wartime journalist!*

In my head, I was screaming. Outwardly, I bit my lower lip to keep my mouth shut. *This is not the moment to say anything. I have patients in the room.* Once again, I felt my blood boiling with anger. Not because of rules or ethics committees or confidentiality guidelines – though those matter. But because posting it felt like the final confirmation that the boy had ceased to be a person in their eyes. He had become a curiosity, an anatomical anomaly, an objectification, a spectacle.

Like my mother once had been. My mind drifted back to my mother in that hospital room years ago. To that sterile room in the most renowned hospital in the country. We had walked in thinking she had gastritis. A simple gastritis. Nothing more. And then, days later, we received her real diagnosis.

I remember sitting beside her in that hospital bed, both of us squeezed together for emotional support. We were surrounded by an impressive medical team composed of a vascular surgeon, a cardiologist, a general surgeon and multiple residents. They didn't know her, they didn't understand her, it was the first time we saw them.

The vascular surgeon, who introduced himself as Dr. K., lead the group.

He stood at the end of the bed in his neatly pressed medical vest and delivered the words I will never forget: "Miss Juliana, you have one large dissection at the celiac trunk and multiple dissections in both renal arteries." We both looked at him with confusion. His words carried no meaning whatsoever, since we didn't know what a dissection was. We had heard of aneurysms and clots, but never dissections. *What even is the celiac trunk? Celiac as in the disease that makes you gassy and bloated and have diarrhea?* He continued, "you had a two percent chance of survival. This is the type of condition I've only seen in autopsies, so we aren't sure what the treatment or prognosis is. Generally, we treat dissections with a stent, but yours is located at the celiac trunk, so we are unable to take the usual surgical approach."

The casualness with which he delivered the news was baffling. With the accumulated knowledge of a vascular surgeon, a cardiologist, a general surgeon and multiple residents who visited her daily, it was surprising that no one bothered to explain the details of her condition to us. But then again, they themselves didn't know much about it. Would a clot form and prevent the blood flow to her internal organs? Would these dissections rupture and she would have internal bleeding? No one dared to infer.

We didn't know how long she would survive. We didn't know if it could happen again in some other artery. We had no clue what could cause such a rare condition. This was a woman with no prior medical history, and in excellent physical health thus far. She didn't smoke, she was fit, she ate an apple a day, or in her case, papaya was more accurate. She owned her own company and that was stressful. Was it stress-induced? Could it be genetic? What was she supposed to do now to prevent any other dissections? How can we prevent it if we can't identify what caused it? We had so many questions and no answers.

Up until her being released from the hospital, doctors and interns visited the "woman who survived multiple dissections." They would come in large groups, look at her in surprise, as if to check that she had lived through another night, and leave. No one asked how she was feeling or if she had questions. No one talked to me at all. It was as if suddenly her humanity, her loud laughter, her adventurous nature, her unwavering work ethic had been reduced to a health condition that inspired awe, but no concrete answers nor treatments. She had defied medical odds and was a wonder to behold, a must-stop on the daily rounds.

And now here I was, witnessing the dehumanization of another patient

with a rare disease. The two patients collapsed into each other: my mother on her hospital bed, and M sitting across from me. Both vulnerable. Both exposed. Both needing humanity more than academic enthusiasm. And internally, something clicked. I recognized that the same thing that unsettled me then – that sense that medicine had turned my mother into "a case" – was what unsettled me now. She had been treated like the *Rare Arterial Dissection*, not like my mother. And M had been treated like *The Fabulous Right-Sided Heart*, not like a teenage boy. It was the same story – just different characters.

Similarly, I identified with the worried family member. I have been in the same position as Mr. J. Granted, I didn't have the paternal responsibilities he had, but I recognized his vulnerability; the feeling of helpless, the incessant worrying, the nagging wondering of what you could've done to prevent this. He needed to protect his son from the tragic fate of his daughter, while I had faced the potential loss of the person who meant the most to me in the world.

The encounter with M and Mr. J. ended with the pediatrician coming in and my going through the full anamnesis, emphasizing that his asthma was controlled. We renewed the prescription for his bronchodilator inhaler. The father looked me in the eyes and thanked me profusely for explaining the disease to him, took my hand into his two rough hands, while the son nodded in agreement next to him, and they left. To them it's possible this was just another examination. To me, this prompted a reflection as to the type of doctor I will strive to become.

The moment the girls barged in prompted a reflection for me. They were bright-eyed, breathless, practically vibrating with the kind of excitement that makes one forget to lower their voice in an exam room. Their giddiness filled the space before they even finished introducing themselves. In another context, maybe their enthusiasm would have been contagious. But here, next to a father and his adolescent son navigating a lifelong, rare disease, it felt jarringly tone-deaf.

And I could recognize myself in them.

I too had been intellectually unstimulated from seeing patients with controlled asthma symptoms for the previous two weeks. I too was excited to finally see a patient living with a rare disease that most doctors only read about in books. I was eager to question his symptoms and to learn about his experience living with disease and to cross-reference it with my notes from class. I was thrilled by the novelty of it, even if I didn't express it in

a giddily tone-deaf manner. I recognized that my own motivations, even when well-intentioned, were not untouched by the thrill of rarity.

When a rare finding appears in front of us, something in our training lights up. It's almost reflexive. A rare disease sharpens our curiosity and crystallizes concepts that otherwise blur together in textbooks. I only remember that epithelial cells hold themselves together through desmosomes – and that desmosomes rely on desmogleins 1 and 3 – because of vulgar pemphigus. In that condition, the immune system attacks those desmogleins, and the patient's skin blisters and peels. Moments like these anchor physiology and pathology to real faces and real stories. They reinforce what is normal, clarify what is abnormal, and keep feeding the endless loop between studying and seeing, memorizing and understanding.

Rare cases also tease something deeper: legacy. Every once in a while, you hear the story of some observant clinician who identified a peculiar triad, or a strange radiological pattern, or an unexpected complication. And suddenly that finding bears their name forever. An eponym is a form of immortality in medicine. It transforms a moment of curiosity into a place in history. Even if we never consciously form the thought as students, the idea hovers underneath our enthusiasm: what if I am the one who notices something new? What if my name survives longer than my own body will?

What's more, a rare disease offers the opportunity to write a case study. You could present at congresses and achieve prestige in the academic community. This could be added to your *curriculum vitae* and it could mean the difference between getting accepted into the residency of your dreams or getting rejected.

This subconscious hunger intertwines with the structure of our education. We are rewarded for spotting abnormalities, for racing toward diagnoses, for catching the one detail that everyone else missed. The more obscure the disease, the more satisfying the chase. And in that chase, the patient can quietly dissolve into the background, overshadowed by the magnificence of their pathology.

It becomes startlingly easy to see a patient as a case rather than a person. This happens out of habit. Out of the way we are trained to survive the avalanche of information we must memorize. Out of the need to organize suffering into categories, patterns, syndromes. We learn to think in terms of findings – crackles, murmurs, hyperresonance, cyanosis – because that is how we are tested, graded, ranked. We become fluent in the language of disease, even as we risk forgetting the language of people.

This is why rare findings feel so electrifying. They give us a break from the monotony of controlled asthma and well-managed hypertension. They validate the years of sacrifice, reminding us that the body is full of mysteries waiting to be decoded. They give meaning to the pages we've underlined and highlighted and annotated until our notebooks look like a rainbow. They feed the loop between theory and practice, between the hundreds of hours spent studying and the fleeting moments in which reality reflects exactly what the textbook promised.

But the danger is that, in these moments of intellectual pleasure, we can drift away from the human being sitting in front of us. The person who has lived with this disease long before we opened the door to the exam room. The person who will continue living with it long after we move on to our next patient, our next rotation, our next thrill.

As much as the theoretical learning is crucial to being a good doctor, understanding the individual patient in front of you – their aspirations, their worries, their beliefs, their doubts – is crucial to being a great doctor. That tailored investment in a patient is what differentiates average medical practitioners from exceptional ones. As Sir William Osler wisely professed, "the good physician treats the disease; the great physician treats the patient who has the disease."

Especially in the case of rare diseases, we often won't be able to treat the condition successfully. Rare diseases impose a heavier burden on patients than more common illnesses. The diagnosis itself brings uncertainty and isolation. At best, we are able to manage symptoms so that patients can pursue their individual goals – their one-of-a-kind dreams. We can work to ease their pain and bring them comfort. We can soothe the worry of their family members. What we are unfortunately unable to do is address the root of the problem altogether. Research funding is scarce, pharmaceutical interest is limited, and our resources are minimal.

To be able to help patients in a truly meaningful way, we need to get to know them – to listen to their concerns and to understand their priorities. In his poignant book *Being Mortal: Medicine and What Matters in the End*, Dr. Atul Gawande sheds light on this issue we face as medical professionals: "We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive." In other words, as important as treating symptoms and searching for a cure may be, our role as doctors is also to ask the ques-

tions that allow patients to voice their wishes and struggles – to name their pain and to share what they hold dear.

We must remind ourselves to listen attentively to their suffering, which naturally also incites pain in us. Perhaps this is precisely what we try to avoid when we focus exclusively on the disease: sharing in the patient's pain. This detachment can be interpreted as a coping mechanism that allows us to keep working despite the many tragedies we witness every day. It can become the crutch we use to remain professional. It hurts to see pain, especially when our treatment options are limited. Yet emotional detachment does not help our patients, and so we must remain vigilant of ourselves.

In this precise case, my tactfulness and empathy in the exam room came from experience – a painful experience that though I do not wish upon my fellow colleagues in that examination room, has certainly set me apart from them. For that, I am relieved.

This is by no means a pat on my back or a scolding of my peers; that would be a wild oversimplification. On the contrary, this reflection serves as a daily mantra. Connecting with M and his father does not mean that I will immediately succeed in demonstrating empathy with every other patient I encounter. This is a continuous, lifelong exercise in recognizing individual suffering. This is me urging myself to remember that any mysterious exam finding, any rare mutation, any complex procedure may impact a patient's life forever. It is a note to self: patients are not a means to learning – they are the end in themselves. A patient is not a dummy in a simulation lab, and he is certainly not material to post on social media.

Until that day, the soft skills necessary to build a good doctor-patient relationship were mostly something I saw in PowerPoint slides: bullet points about attire, punctuality, confidentiality, maintaining eye-contact, building rapport, and speaking in culturally appropriate terms. It felt straightforward, like a checklist we were expected to memorize for OSCEs.

But watching those students rush in – seeing the boy become a spectacle, seeing the father shrink back into a corner after having shared the most devastating part of his life – taught me that building a relationship with a patient goes far beyond an outline. It requires restraint and self-awareness. It means reading the emotional temperature of a room before crossing its threshold. It is knowing when my eagerness to learn must yield to someone else's pain. It is remembering that a body lying on

a stretcher is someone's mother, someone's daughter, someone's brother – someone's whole world. It is ensuring that I don't overvalue my curiosity to the detriment of the patient's privacy.

I want to be a doctor who never treats suffering as an anecdote. Who never lets curiosity eclipse compassion. Who never forgets that a novel right-sided heart is still a heart. I want to be the doctor who closes the door gently behind me – not because of protocol or caution, but because I understand that the space I'm entering is sacred.

A space where someone is scared, or confused, or mourning, or trying their best to make sense of the body that keeps betraying them. A space where every word matters. Where the phrases I utter will echo in my patients' memories. Where my advice will shape life decisions. Where my presence – my demeanor, my restraint, my empathy – can either heal or harm.

I want to be a doctor who remembers that behind every rare anomaly is a real life. Behind every chart is a story. Behind every exam finding is a person. And that the world-famous right-sided heart belonged to M, a boy who lost his sister and was deeply loved by his father. And who deserved better than to be anyone's spectacle.

The Author

Fabiana Benedini Galli Zambardino, Brazil
Centro Universitário São Camilo, São Paulo