Yunis Alexandre El Jaroush Palhavan

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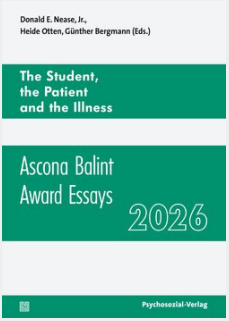

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Part I: Before the Encounter

Before that man, I believed medicine was, above all, an exercise in control. Control of time, of symptoms, of risks. Control of biological variables which, once organized into protocols, seemed to obey a predictable logic. I did not yet know or perhaps did not want to know that the hospital is the place where control most often fails, and that it is precisely there that medicine reveals its most human face.

The General Hospital of Carapicuíba was the setting for this learning. A public hospital, pulsating, marked by long corridors, harsh lighting, and a constant flow of interrupted stories. There, illness did not arrive as abstraction, but as concrete urgency: injured bodies, disoriented families, decisions made under pressure. The ward was a space where life always seemed provisional.

I was an intern. I carried with me the technical enthusiasm of someone who learns quickly and the silent insecurity of someone who still does not know what to do with what cannot be resolved by knowledge alone. I wore the white coat as if it could protect me not from mistakes, but from the emotional impact of standing daily before human fragility. There were days when I left the hospital convinced that learning medicine meant accumulating answers. Other days, more difficult ones, showed me that learning medicine also meant learning to live with questions that do not cease.

The ward, in particular, unsettled me. Unlike the emergency department, where immediate action creates an illusion of effectiveness, the ward demands permanence. One must return to the same bed, listen to the same complaint, follow the same body that improves slowly or does not improve at all. There, time does not run; it weighs. I walked among the beds observ-

ing patients who no longer expected cure, only care. Some spoke too much, others hardly at all. Many had learned the language of the hospital better than I had: they knew the schedules, the names of exams, the expressions that signaled severity. Illness, there, was also a form of literacy.

I still believed my main task was to understand the body. Subjective suffering seemed important, yes, but secondary. Something to be heard with respect, but not something that substantially altered medical conduct. Clinical practice, I thought, was made of objective data; the rest was context. It was in this state of mind technically attentive, emotionally contained that I arrived at his bedside.

There was also, in my understanding of medicine at that time, a quiet faith in neutrality. I believed it was possible and desirable to remain untouched. To enter rooms, gather information, perform examinations, and leave without carrying anything back with me. I confused professionalism with emotional impermeability, as if to feel less were synonymous with being more competent.

This posture was reinforced daily. We were taught to "stay objective," to avoid "getting involved," to protect ourselves from emotional overload. And indeed, the hospital demands defenses. Without them, one risks being overwhelmed. But I did not yet understand that there is a difference between protection and withdrawal. Between caring for oneself and erasing oneself.

I watched older physicians move through the wards with an efficiency I admired. They spoke little, decided quickly, rarely hesitated. Their authority seemed unquestionable. I assumed that this was the endpoint of formation: certainty replacing doubt, mastery replacing vulnerability. I wanted to arrive there as soon as possible.

And yet, I could not ignore a recurring sensation that accompanied me during long shifts a sense that something essential was being bypassed. I noticed it especially in moments of apparent routine: a patient who asked a question after I had already turned toward the door; a family member who lingered in silence, waiting not for information, but for acknowledgment. I learned to interpret these moments as delays, interruptions, inefficiencies.

Time, in the hospital, is never neutral. It is measured in beds to be freed, exams to be ordered, discharges to be planned. Lingering felt almost transgressive. Still, part of me resisted the constant acceleration. I sensed that haste, while often necessary, also functioned as a defense against what emerges when one stays. I remember standing at the end of the ward on

certain afternoons, watching the light change through the windows, feeling an exhaustion that was not merely physical. It was as if the accumulation of encounters unfinished, unresolved created a residue that no rest could entirely dissipate. I did not yet have the language to describe this sensation. I only knew it existed.

As an intern, my position was paradoxical. I was close enough to patients to hear their stories, but rarely empowered to act decisively. I absorbed narratives, fears, expectations and then passed them along, condensed, translated into medical language. In that translation, something was always lost. I did not yet know what it was, but I sensed its absence. I also began to realize that my own identity was being reshaped by this environment. The white coat did not merely signify learning; it reorganized how others saw me and how I saw myself. Patients trusted me before I felt deserving of that trust. Families listened to my words with an intensity that unsettled me. I became aware that medicine grants authority even to those who are still learning and that this authority carries ethical weight.

There was a growing tension between what I knew and what I felt. Between what I could explain and what I could not resolve. I often returned home mentally reviewing interactions, wondering whether I had said too much or too little, whether silence had been appropriate or cowardly. These reflections rarely found space in formal teaching. They remained private, unshared. I noticed, too, how often suffering was framed as a problem to be solved. Pain, uncertainty, fear everything demanded intervention. And yet, some forms of suffering persisted despite all efforts. They did not diminish with medication or explanation. They lingered, asking for something else. I did not know what that something was.

Before meeting him, I still believed that the limits of medicine were primarily technical. That with more knowledge, better tools, and more experience, uncertainty would recede. I imagined that maturity meant accumulating answers until questions became rare. I did not yet understand that some questions are not provisional that they accompany the practice itself. I also did not yet understand that encounters, not cases, shape physicians.

That certain moments, seemingly ordinary, can quietly dismantle years of assumptions. At that point, however, I still believed formation followed a linear path: study, practice, mastery. The hospital, I thought, was a place where knowledge was applied. I did not yet know it was also a place where identities are undone.

It was from within this framework structured, defended, still intact

that I approached his bed. I did not suspect that what awaited me there would not be a lesson in pathology or prognosis, but an encounter that would fracture the very notion of control I had been relying on.

It was in this state of mind technically attentive, emotionally contained, and quietly resistant to my own uncertainty that I arrived at his bedside.

Part II: The Patient

He did not draw attention at first glance. He was not intubated, did not groan, did not require constant interventions. Sitting in bed, he maintained a calm posture, almost indifferent to the agitation around him. His body bore visible marks of past surgeries scars that seemed already incorporated into his identity. Beside the bed, an open Bible.

It was not uncommon to find religious objects in the ward. Rosaries, images of saints, small prayer books often shared space with charts and IV bottles. Still, in this case, the Bible seemed to occupy a different place. It was not there as an amulet. It was open, used, handled. It was an active presence. He looked at me as I approached. The smile came before speech a calm, sustained smile that asked for neither explanations nor extra care. There was a serenity there that contrasted sharply with the contents of the chart.

I read the clinical history with growing attention. Severe traumatic brain injury. A steel beam had pierced the skull during a workplace accident. The trajectory of the injury included the lateral ventricle, a region whose integrity I had studied with anatomical rigor and functional reverence. The initial predictions had been harsh. The prognosis, guarded. Aphasia. Hemiparesis. Ataxia. Words that, in theory, describe deficits. In practice, they redefine lives.

I closed the chart and looked back at him. He was speaking to me. Slowly, but with enough clarity to make himself understood. He moved with some limitation, but without the rigidity I had expected to find. He was conscious, oriented, present. There was a dissonance that was difficult to ignore. I sat beside him not out of obligation, but out of a curiosity that was beginning to surpass academic interest. I asked how he was feeling. He answered simply:

"I'm alive."

He did not say "well." He did not say "getting better." He said "alive." As if that alone were sufficient.

He spoke slowly, choosing his words carefully. One could perceive the cognitive effort involved in each sentence not as difficulty, but as attentiveness. As if language now demanded respect.

At a certain moment, he mentioned faith. Not as an explanation for the accident, nor as a critique of medicine. He spoke of faith as one speaks of something intimate, almost domestic, something that had accompanied him during the days when he did not know whether he would speak again, walk again, or recognize his own body.

There was an absence of resentment in his speech that unsettled me. No questions of "why." No attempt to assign blame. Only the acknowledgment that he had fallen ill and, somehow, was recovering. I asked perhaps too soon what faith meant to him in that process. He looked at me for a few seconds before answering. The silence was not awkward. It was necessary.

Then, without saying anything, he picked up the Bible.

He leafed through it slowly, with a gesture that seemed familiar, almost ritualistic. He stopped at a marked page and read aloud, softly but firmly:

"There is a time to be ill and a time to be healed."

His eyes filled with tears. He closed the book, holding it against his chest, as if needing to contain something that threatened to overflow. He said that faith had returned to him what medicine could not promise that in the hardest moments, when he could not understand his own body, faith gave him meaning enough to continue.

He cried.

And I, standing beside him, realized that I did not know exactly what to do with that. I knew the mechanisms of neurological recovery. I could speak about brain plasticity, functional reorganization, collateral circulation. I could explain, in technical terms, how an injured brain can find alternative pathways. Still, there was something in that encounter that completely escaped the field of explanation.

His crying was not despair. It was gratitude a gratitude that did not fit into any clinical scale.

At that moment, I sensed something shifting within me still imprecise, still unnamed. I was not merely before a recovering patient. I was before an experience that challenged the way I understood my own role there. And that unsettled me more than any difficult diagnosis.

After that first dialogue, I began to visit him more often than strictly necessary. Not because there were new medical decisions to be made, but because something in that initial encounter remained unresolved. There was a calmness in him that could not be explained by clinical evolution alone, and that incongruity drew me in.

I began to observe him more closely. His movements were economical, almost cautious, as if he were still relearning the limits of his own body. Before lifting a cup to his mouth, there was always a brief moment of calculation imperceptible to a hurried observer, evident to one who had learned to look slowly. Small adjustments revealed the silent effort of an organism forced to rebuild paths that had once been automatic.

I asked, during one of these visits, whether he remembered the first days after the accident. He said he did not. His memory of that period was fragmented, composed more of sensations than images. He spoke of voices without faces, of intense lights, of a persistent feeling of displacement as if he were awake in a place he did not fully recognize.

"It was as if I was here ... but not whole," he said, after a pause.

That sentence followed me for the rest of the day. In medical training, we tend to treat consciousness as a binary datum: present or absent. We rarely speak of these intermediate states, of the experience of existing without being able to fully recognize oneself. He had inhabited that place. And he had returned.

In another conversation, I asked about his family. He spoke of his wife with sobriety, without dramatization. He said she had been present every day, even when he could not recognize her. He told me that in the hardest moments she would sit by the bed in silence, holding his hand, as if believing that the bond could precede understanding.

In that account, I perceived something that had previously escaped me: what sustained him was not only a system of beliefs, but the persistence of someone. The continuity of presence. The refusal to give up when the other was not yet able to respond.

The religious object beside the bed, which I had initially interpreted as an expression of faith, began to seem to me also a marker of time and waiting something that occupied the space while his identity reorganized. What mattered was not so much the content of the book, but the fact that it was there, open, available, accompanying a process that could not be rushed.

I asked whether there had been fear. He thought before answering.

"There was a moment when I thought I wouldn't return to who I was," he said. "Then I realized that maybe I was returning in another way."

There was no bitterness in that statement. Nor euphoria. Only acknowledgment as one who accepts that crossing a rupture necessarily implies change.

One particularly quiet morning in the ward, I sat beside him without opening the chart. We spoke little. At a certain point, he closed his eyes for a few seconds, as if resting from his own presence. Then he opened them again and remarked, almost casually:

"I notice things more now."

I asked what he meant. He pointed toward the window. Light entered irregularly, drawing shadows on the floor of the room.

"Before, I used to rush past this."

In that moment, I understood that his recovery was not limited to the restitution of neurological functions. A deeper reorganization was underway a reconfiguration of his way of being in the world. The injury had interrupted his trajectory, but it had also imposed a pause that made another form of presence possible.

As a physician in training, I found myself before something that did not appear in therapeutic goals, but that might be one of their most significant effects. He had not only survived. He had returned with a different rhythm. I realized then that my own listening was also beginning to change. I was no longer asking questions merely to complete the chart. I was asking in order to accompany to sustain to remain.

There were days when I left that room with the uncomfortable feeling of having received more than I had given. Medical training prepares us to act, decide, intervene. It teaches us little about recognizing when we are affected and transformed by another's experience. He demanded nothing of me. He asked for no explanations, requested no answers. He simply existed before me with an integrity that did not fit into clinical records. And by doing so, he confronted me with the limits of my own way of practicing medicine.

It was in this context made of silent visits, brief conversations, and long pauses that the encounter began to exceed the category of an "interesting clinical case" and become something harder to name. Something that no longer concerned only him, but me.

And perhaps it was precisely there that everything began to change.

Part III: The Central Encounter

The silence that formed after his tears was not empty. It was dense. A silence that did not ask for words, but for presence. I remained beside him, unsure of what gesture was expected of me. There was no intervention to prescribe, no test to order. For the first time since entering medicine, I felt that any attempt to explain would be a form of escape.

The ward continued to move around us. Monitors beeped, professionals spoke in low voices, carts passed through the corridors. And yet, at that bedside, time seemed suspended. The crying subsided slowly. He took a deep breath, wiped his eyes, and looked back at me with the same serene smile as before now more fragile, but also more truthful.

He said only:

"I thought I wasn't going to come back."

He did not ask whether I agreed. He did not seek confirmation. He simply shared an existential fact a boundary crossed. In that instant, I understood something I still lacked the language to fully articulate: I was before a man who had survived not only a brain injury, but the experience of nearly disappearing from himself. What he mourned was not the pain of the accident, but the astonishment of continuing to exist.

I wanted to respond. I wanted to say something that might rise to the height of that moment. I thought of phrases we are trained to use technical words softened by rehearsed empathy. But all of them felt inadequate. I remained silent. And for the first time, silence did not feel like omission.

There, I realized that listening is not merely a clinical skill; it is an ethical position. To listen is to accept that the other exists beyond our explanatory frameworks.

When I stood to leave, he held my hand for a few seconds longer than usual. Not as a gesture of dependence, but of recognition as if to say: you were here. I left the room with a strange sensation not of a task completed, but of having been summoned to something I did not yet fully understand.

The rest of the day passed uneasily. I attended other patients, reviewed charts, answered objective questions. But something had shifted. Complaints that once seemed routine now carried another

density. I could no longer hear only the symptom. There was always something underneath, something that did not present itself directly.

I realized that the encounter had produced a fissure a small but definitive fracture between the physician I believed I was becoming and the physician who was beginning to emerge.

Part IV: Science, Faith, and the Inner Fracture

At the end of the shift, I sought out a neurologist from the service. I needed to reinscribe that encounter within the territory I knew best: scientific explanation. I described the case carefully the extent of the lesion, the initial deficits, the surprising functional recovery. I asked how such an outcome was possible.

He listened attentively and answered without hesitation:

"There was collateral circulation. The brain found alternative pathways."

The answer was correct. Elegant. Reassuring. It placed the event back into a familiar map. Faced with injury, the brain reorganizes itself. It recruits neighboring areas. It creates detours. It adapts. Neuroscience offers solid models for understanding phenomena that, at first glance, seem extraordinary.

I thanked him and walked away holding the explanation. And yet, something remained out of place.

Collateral circulation explained motor recovery. Brain plasticity explained the return of language. But none of these explanations touched the essential core of the experience I had witnessed. None of them reached the tears, the gratitude, the meaning he attributed to his own survival.

I realized then that my discomfort did not arise from the patient's faith it arose from my own limit. I had been trained to believe that to understand is to explain. And now I found myself before something that could be explained, but not exhausted by explanation.

His faith did not compete with science. It occupied a different register. It did not answer the how, but the what for. It did not deny biology, but traversed it with meaning.

It was there that I understood that the risk of medical training lies not in an excess of science, but in the illusion that it suffices. When technical knowledge becomes a total answer, the human experience we intend

to care for is impoverished. I began mentally revisiting other patients the ones I had labeled "difficult," those who insisted on narratives I considered irrelevant to medical conduct, those who spoke of fear, guilt, hope, belief. I realized that I often listened only until the information was useful for diagnosis. The man with the open book showed me there was something beyond that.

He was not a miracle, nor a statistical anomaly. He was a subject attempting to reinscribe his existence after a radical rupture. For him, faith was not an escape from reality it was a way of reorganizing it. I, on the other hand, was beginning to realize that my own medical identity also required reorganization. To be a physician is not only to intervene in another's body. It is to sustain one's own ignorance in the face of what cannot be fully mastered. It is to accept that there are experiences that do not ask for solutions, but for witnessing.

Since that encounter, I have grown suspicious of explanations that close the conversation. I have learned that, many times, explaining too much is a sophisticated way of not listening.

Science remains my ground. But it is no longer my ceiling.

Part V: After the Encounter

In the days that followed, I realized that the man had not remained merely as a memory. He had infiltrated my way of being in the hospital not in a spectacular way, but subtly, almost imperceptibly, like certain transformations that reveal themselves only once they have become irreversible.

I continued my routine. Shifts followed one another. The wards remained full. New patients occupied the beds. At first glance, nothing had changed. But I had changed, and that altered everything.

I began to enter rooms with less haste not because I had more time, but because I no longer believed speed was always a virtue. I noticed that the way I introduced myself, the tone of my voice, my willingness to listen all of this produced effects that did not appear in exams, but profoundly shaped the experience of illness.

I began to notice something that had previously escaped me: patients do not speak only to inform they speak to exist. Each narrative, no matter how repetitive or disorganized it may seem, carries an attempt to reorganize the

world after the rupture imposed by disease. And often, the physician is the only available interlocutor for that attempt.

I remembered an elderly woman hospitalized for decompensated heart failure. From a clinical standpoint, her course was predictable adjustment of diuretics, monitoring, planned discharge. Still, every day she insisted on telling the same story about her husband's death. Before, I would have listened with polite efficiency. After that encounter, I stayed. I listened. I did not interrupt or redirect. At the end, she said:

"Now I can rest."

There was no change in medical management. But there was a change in experience.

I began to understand that much of the anguish that circulates in hospitals does not ask for technical answers, but for recognition. Suffering intensifies when it finds no language. And the physician, when willing to listen, can offer something no prescription can replace: legitimacy to the other's experience.

The man with the open book taught me this without pedagogical intent. He did not try to convince me of anything. He gave no speeches. He simply existed before me with his history, his beliefs, his gratitude. And that was enough to destabilize my certainties.

I also began to perceive my own emotional limits more clearly. I once believed distance was a condition for effectiveness. I now understood that the true risk lies not in being affected, but in becoming anesthetized. Excessive detachment does not protect it impoverishes.

There were days when I felt more vulnerable. To listen more is to feel more. Some stories stayed with me beyond the end of the shift. Some deaths began to reach me differently not as technical failures, but as real losses. And this demanded a new form of internal support.

It was through this process that I understood the importance of caring for the physician not only as a professional, but as a subject. Medical training teaches us to deal with the pain of others, but offers little preparation for dealing with what that pain awakens in us. The encounter with that patient opened space for questions I did not know I needed to ask.

"Who am I when I cannot cure?"

"What do I offer when science reaches its limit?"

"What is my place when the other finds meaning in something I do not share?"

These questions did not seek definitive answers. They began to accom-

pany me as part of medical practice itself. I learned that sustaining questions is often more honest than offering hurried answers.

His faith did not become my faith. But it transformed the way I respect what gives meaning to another's life. I came to understand that reducing the patient's experience to what I can explain is a form of epistemic violence subtle, but real. It denies the other the right to signify their own existence.

Medicine, I realized, is not merely an applied science. It is a relational practice. And every true relationship requires openness to the unexpected.

I returned to his bedside a few more times. In none of those visits did we repeat the conversation about belief. It was unnecessary. There was between us a silent recognition a tacit agreement that something important had been shared, something that did not need to be constantly named.

When he was discharged, there were no long farewells. Just a handshake. A lingering look. A smile that remained serene, despite everything he had crossed. We exchanged no promises. There were no memorable final phrases. And perhaps that is precisely why the encounter was so definitive.

I never saw him again.

But he continues to accompany me in unexpected ways in every patient who clings to an improbable hope, in every family searching for meaning amid chaos, in every silence that settles when words fail.

He taught me that medicine is not a battle between reason and belief. It is a crossing a continuous attempt to remain human in a territory where dehumanization is always a temptation.

Today, when I enter a hospital, I carry more than technical knowledge. I carry the awareness that every encounter holds the potential to transform us if we are available to it. I no longer seek only to diagnose, treat, and advise. I seek to be present.

I have learned that the most radical medical gesture is sometimes simply to remain

to remain before pain that cannot be resolved, before meaning that cannot be explained, before the other without reducing them to what I know. Because, in the end, perhaps true healing lies not only in the restoration of biological functions, but in the possibility of not crossing illness alone.

And if something of that encounter remains alive in me, it is the certainty that medicine, when practiced with humility, does not eliminate mystery it learns to live alongside it.

It is in this space between knowledge and not-knowing, between what I can do and what I can only witness that I now recognize the deepest meaning of my practice.

Not as mastery.

But as presence.

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