Jeppesen Iben Armann

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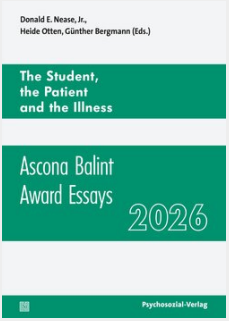

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It's 6:15 a. m. as I pack my lunchbox and get ready for another shift. This is my fifth day in the emergency room in Norway. It's busy – not unusually so. In fact, it is the most visited emergency department in the country. Having previously worked only in a small cardiology ward in my hometown, this feels like a refreshing change of pace.

As a second-year medical student, my role is modest. I assist wherever I can and keep storage rooms and equipment in order – hoping to be at least somewhat useful to the nurses and doctors flying past me. Not really knowing what to do often leaves me feeling in the way, a feeling more bitter than I had expected.

Lost in my own thoughts, it's easy to overlook the fifth-year students around me, working as interns for the first time – just as nervous, unsure, and scared as I am. This story takes place during the summer break, the brief period when we students are finally allowed to participate in real-life medicine. But real-life medicine is something entirely different from medicine at the school bench. Little did I know how soon I would come to understand that.

As I make my way through the ward, collecting urine samples and delivering blood gas analyses, my pager goes off. The head nurse is trying to reach me. One lesson that stayed with me from the orientation shifts was simple: whenever the head nurse asks you to do something, you drop everything else and do it.

I pick up the pager and call back. She tells me she needs me – hesitating slightly before explaining that I am required for a "long-term cleaning project" in one of the isolation rooms.

Without fully understanding what that entails, I hand my current tasks back to the nurses and hurry toward isolation room 208, dressed for drop-

let precautions. I cover myself with layers of plastic, sealing myself off from the outside world. The process changes my perspective – much like going through a microbiology course. Suddenly, potential sources of infection seem to be everywhere.

While suiting up from head to toe, I am joined by a young intern doctor. She briefs me quickly on the patient we are about to meet. He is a sixty-year-old man who has had no contact with the healthcare system throughout his adult life. He lives alone in the woods, isolated from the modern world. He complains of pain in both legs and a high fever. We rush through the final steps of donning our protective gear. The ritual of dressing has already created distance before I meet him. Just before the air pressure equalizes, the young doctor looks at me with a tired, almost apologetic expression and says, "This is going to smell."

Thoughts of disgust flash through my mind as we enter the room. I feel shame at feeling disgust – but the thought shatters instantly under the gaze of the patient's restless eyes.

Sitting in front of me is a burly man with a nervous smile. He is shaggy, with long brown hair reaching his shoulders. His clothes are old and no longer fit him, hanging loosely on his body. He makes brief eye contact before turning his gaze toward the window. The smile fades, replaced by embarrassment. The young doctor introduces herself, and then me, as her assistant. The patient acknowledges us with a slight nod, but his eyes remain fixed on the outside world. The first minutes of the encounter fail to establish any sense of trust or comfort. Gradually, however, he begins to answer the doctor's questions, meeting her gaze more often as she works to identify his chief complaint. He explains how he treated his swollen, red legs with what he describes as "a bit of duct tape." Six months later, the tape is still wrapped tightly around his legs. The pain has grown steadily worse, now keeping him awake at night.

As the young doctor carefully begins removing the layers of tape, the room fills with the heavy, unmistakable odor of neglected wounds. The tape resists, clinging stubbornly to swollen skin. Beneath it, the tissue is raw, inflamed – alive with movement. The doctor exhales sharply and regains her composure. She labels samples, photographs the wounds, and documents meticulously. Her movements are focused – until the isolation room door opens abruptly.

The chief physician steps in, already mid-sentence, eyes scanning the scene without slowing. It is striking how quickly authority shifts. He glances at the wounds, then at the samples, then at the chart.

"You'll need to redo all of this," he says flatly.

At that exact moment, I hear a soft, tension-filled exhale from the young intern. Her shoulders drop slightly.

"Use the correct protocol. These samples are useless." He pauses briefly. "Any questions? No? I have to go."

Before the young doctor has time to respond, her pager vibrates. Once. Twice. Again. She nods, biting back frustration, and starts over. Samples are retaken. Notes rewritten. Her pen scratches faster now. Her questions shorten. Time is leaking. Finally, she looks at me briefly – an apologetic glance – before stepping out of the room, promising she will be back soon. The door seals shut behind her. The noise of the emergency department fades. For the first time since entering, it is quiet.

I stand awkwardly by the bedside, aware of my own breathing inside the protective mask. The patient shifts slightly, then turns his head toward me. For the first time, he holds my gaze.

There is no embarrassment now. No nervous smile.

"I could never live in your world," he says calmly.

The words stop me. He is not asking for an answer. I don't know how to respond. Outside the window, ambulances come and go. Somewhere beyond the walls, pagers buzz, monitors beep, footsteps rush past. Inside the room, the patient waits. And for a brief moment, so does time.

After the shift, I return home to my partner. We spend the evening exchanging stories about our day. When I try to explain what my day was like, I struggle. It is hard to describe a hospital to someone who has never been inside one. Instead, I reduce the day to a story. I laugh and say, "We had this strange guy on the ward today – thought it was a good idea to duct tape his infected legs." Saying it out loud, I pretend it means nothing more to me than that. But I know I am not being honest. Not with her – and not with myself. Why this felt so natural is still unclear to me. Perhaps it was a way of placing a lid on emotions I had not yet explored. Perhaps it was a form of protection, a way of creating distance before I even noticed I needed it.

Later that evening, I find time to reflect. The discomfort is difficult to name, but it settles into a quiet fear – not of the patient, but of myself. Although I was raised in a busy town, surrounded by technology and constant noise, I have often struggled to feel fully at ease in that environment. That day had felt different. Unsettling. And perhaps the strangest realization came hours later: that in the patient, I had recognized something of myself. Something I had not expected.

In the days that followed, his words stayed with me.

When the patient said those words, I first thought he was talking about modern medicine and technology – machines, monitors, protective equipment, and the strange way we must have looked to him, covered in plastic and masks. Standing there with him, however, I began to understand that he was not talking about objects or appearances. He was talking about pace. In the emergency department, speed shapes every interaction. Questions are short. Answers are filtered. Conversations are interrupted. People are reduced to symptoms, timelines, and test results. The faster we move, the safer we believe we are. Standing in that isolation room, I became aware of how little space there was for a man like him.

He had lived for years outside this system. Outside schedules, appointments, and expectations. His body had adapted to slowness. His wounds had developed quietly, over months, without alarms or urgency. When he finally entered our world, it happened suddenly and on our terms. There was no time to adjust.

I noticed how quickly his story was interrupted – not out of cruelty, but out of necessity. The pager demanded attention. The protocol demanded repetition. The system demanded speed. Slowly, and without anyone intending it, the patient became a task that needed to be completed.

I began to wonder what it must feel like to enter a place where your pain is real, but your pace is wrong. Where silence feels out of place, and hesitation feels like a mistake.

At the same time, I became more aware of the pressure placed on healthcare workers. Watching the young doctor, I saw how easily good intentions collide with limited time. She wanted to be thorough. She wanted to be present. Yet she was pulled in several directions at once and expected to adapt instantly.

Observing her, I recognized something uncomfortable in myself. I shared her desire to be efficient. I wanted to fit in. I wanted to be useful. Slowing down felt irresponsible, even when no immediate task required my attention.

This made me think about how early this mindset develops in medical training. Long before becoming doctors, we learn to value activity over presence, answers over listening, and movement over stillness.

For the first time, I questioned whether becoming efficient also meant becoming distant. I began to understand that this distance is not only a loss; it is also a form of protection. In a workplace where suffering is con-

stant and time is limited, distance can help doctors cope. It allows them to move on, to make decisions without being overwhelmed, and to return the next day without carrying every encounter with them.

Standing there, I realized why the system demands emotional distance. It quietly rewards it. Those who move faster and contain their emotions are often the ones who endure.

At the same time, I wondered what is lost when distance becomes the default. When protection turns into habit. When efficiency replaces curiosity. This left me with an uneasy awareness. Curiosity and a desire for human connection were what drew me to medicine in the first place.

Looking back, the only thing I truly did in that room was stay.

Left alone with the patient, I realized there was nothing I needed to fix. No samples to take. No forms to fill out. The thought of standing there, doing nothing, crept in. I felt a fear of "doing nothing" in a system that values activity.

But I also realized something else. I had something the doctors on the ward did not.

Time.

So I stayed.

I pulled a chair closer to the bed and sat down. I asked him where he lived, and he told me about the forest – about the light, the seasons, and how time feels different when days are shaped by weather rather than schedules. I did not interrupt him. When he paused, I waited.

For a moment, the emergency department felt distant. Staying felt like a small social risk. I was not doing anything that could be measured or explained.

When the young doctor returned, the room filled with movement again. Gloves were changed. Questions resumed. The rhythm returned. But something had shifted. The patient met her eyes more easily now. He answered more fully. His shoulders seemed less tense. I did not change the course of his treatment. I did not make his wounds heal faster. I did not save time.

But I had stayed.

And in that moment, I understood that action does not always mean intervention. Sometimes it means resisting the urge to leave.

The following day, the system reminded me how quickly moments pass.

The next day, I return to the emergency department. The entrance looks the same. Whiteboards are already filled. Beds are occupied. The isolation room is in use again. I catch myself wondering whether the patient is still

there. I do not ask. There is no natural place to do so. The ward has already moved on.

During handover, his case is mentioned briefly. A diagnosis. A plan. Nothing unusual. The discussion moves on. The bed he occupied is now filled by someone else. The sheets have been changed. The smell is gone. I return to my tasks. The rhythm is steady and efficient. There is comfort in the familiarity of it.

At first, I feel more alert than usual. I notice small pauses, small delays. But as the hours pass, the pace takes over. Efficiency feels necessary again. The awareness I carried with me thins out. No one asks me about the previous day. I do not mention it either. There is no space for reflection built into the shift.

At one point, I pass the isolation room again. I slow down briefly. Then my pager goes off, and I keep walking.

The experience does not disappear, but it dulls. I begin to understand that moments like this fade unless something holds them in place.

By the end of the shift, I am tired. As I leave, I am struck by how easily the system absorbs everything – suffering, care, and even moments of presence.

Months later, I can see what this encounter quietly began to change.

After spending most of my summer break in the emergency department, I carry these experiences with me in a way I did not expect. I do not believe that healthcare can or should abandon efficiency. Resources are limited. Staff shortages are real. Technology will continue to shape medicine. But presence is rarely acknowledged because it is invisible. It leaves no note in the chart. It shortens no queue. A student who sits quietly with a patient may appear inactive, despite being fully present.

Medical training does not discourage presence – but it does little to protect it. What cannot be seen risks being erased. I do not hope to carry forward a solution, only an awareness. I know I will be tired. I will be interrupted. I will move fast. But I hope to notice the patients who struggle to keep up. Awareness alone does not solve their problems, but it may prevent them from feeling invisible.

If I can retain even a small space for stillness within a system built for movement, then the time spent in that isolation room will continue to shape the doctor I am becoming.

The Author

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