Julia Carvalho Lima

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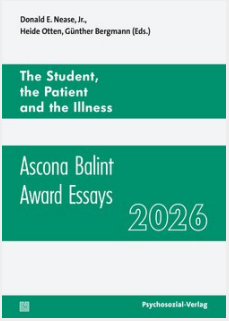

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My first contact with this patient was silent. She was sleeping or, more precisely, she was anesthetized. Her condition was a rare congenital heart disease known as Ebstein's anomaly. This pathology caused her tricuspid valve to be fixed lower than its normal physiological position, a displacement that led to the atrialization of the right ventricle. In practical terms, a portion of what should function as the right ventricle gradually came to behave as an atrium, altering the very architecture of her heart.

Up to that moment, at seventeen years of age, she had lived her entire life with a condition that resulted in right ventricular failure. This dysfunction gave rise to recurrent episodes of cyanosis and arrhythmias, a clinical reality that, over the years, deeply compromised her growth, her development, and her quality of life. With each examination, with each consultation, the medical team carefully monitored her vital signs and continuously adapted their therapeutic decisions. Yet on that particular day, all previous efforts converged toward a single, decisive moment: a surgical procedure capable of transforming her reality in a direct and tangible way, as she would undergo a valvular repair surgery.

That surgery was not merely a technical intervention, it represented the beginning of a new life for her.

For me, it marked the beginning of yet another period of learning. I was in my third year, sixth term, and in the very first week of the general surgery rotation. I began the rotation already aware that it would be one of the most exhausting and challenging experiences of medical school. In conversations with senior students, I learned that we would face an intense workload, something close to nine hours a day in the hospital. "Surgery is always extremely tiring; if it is like this during medical school, imagine residency," were thoughts that lingered in my mind, shaped by the awareness

that residents frequently exceed a sixty-hour workweek. Even so, I entered the rotation with genuine enthusiasm, curiosity, and a willingness to fully absorb the experience unfolding before me, conscious that beyond learning technical skills, I would be learning how to relate to people in their most vulnerable moments.

One of the tasks we were assigned during this rotation was the writing of a report, containing the greatest possible amount of information about each surgery. The report was designed as a way to keep us more actively engaged in the operating room and, of course, as a means of improving our final grade at the end of the semester. We were required to narrate every surgery we observed, describing it step by step and adding every detail deemed relevant. Details about the surgical technique, the time intervals between each operative act, the names of the instruments, the medications used, and anything else we considered important. Yet, in order to write this text, I returned to what I had written in Iara's report, and what truly changed my way of living medicine was not there. In that report, I did not write about the physician–patient relationship, I wrote about theories and surgical techniques. And you may now be wondering: what kind of physician–patient relationship can be formed with someone who is anesthetized? The answer to that question is what I learned that day, and what I now wish to convey here, as faithfully as possible.

I think of the surgical act as an act of trust, both on the part of the patient and on the part of the physician. It is an act of trust from the patient in allowing themselves to be handed over completely, in placing themselves in a state of total surrender, often at the greatest moment of vulnerability, courage, and hope of their life. It is the belief that when their eyes are closed and their ability for self-care is no longer present, there will be other eyes and other hands willing to assume that responsibility for them, and that upon awakening, there will be the possibility of living in a different way, always with the expectation that this new life awaiting them will be better than the one left behind. The physician's trust, in turn, lies in believing that the application of their knowledge, their care, and the techniques they have learned will be transformed, in that very moment, into a gateway for change in the life of another human being, a change that can often signify healing and a profound shift in the paradigms that structure someone else's existence. This was the understanding I held before the surgery rotation and the one I continue to hold now, but as I write this, it carries a different depth, the depth that my own senses have since been able to per-

ceive. I did not leave that operating room the same person I had been upon entering it that day, instead, a series of discomforts began to surface, some of which I was able to name immediately, while others required more time and reflection before they could be fully understood.

That first morning, in the surgical unit, I arrived earlier than necessary so I could prepare myself and have the chance to choose the surgery that most intrigued me. I reached the hospital around 7:30 a. m., and I remember feeling genuinely excited. I put on my surgical scrubs and felt, for the first time, as though I truly belonged to the team, filled with a quiet pride for having reached that stage of my training. I walked into the corridor and examined the board listing all the surgeries scheduled for the day. Standing there, I read through the names one by one, until a single line caught my attention: "Operating Room 14/Ebstein's Anomaly/valvular repair." I was unfamiliar with the condition. I quickly searched for it on my phone and then asked the supervising monitor if I could follow that procedure. I approached her and asked whether I might observe the surgery in Operating Room 14, and because I had been the first to ask, I was granted the opportunity.

I walked to the end of the corridor, entered the room, and the patient was not there yet. Still, a team was already in motion, orchestrating every detail that would be needed for the surgery. I introduced myself as a third-year student and allowed myself to simply observe the flow of activity, absorbing the rhythm of the space. It felt as if I were standing before a symphony, each movement deliberate, each gesture in perfect harmony, dynamic and alive.

I sought to connect with the team, to learn more about how the day would unfold, and I approached Andressa, the operating room nurse. She patiently explained the sequence of the surgical procedure and offered me the patient's file, her anamnesis, and her previous exams. In that moment, I learned her name, Iara, and caught a glimpse of her state of health.

About twenty minutes later, I saw a stretcher being wheeled into the room by a man. On it lay a young girl, and by her side, a woman, her presence steady, protective, and quietly anxious.

The woman had an indigenous face feature, a warm brown complexion with a subtle reddish undertone, wavy black hair, roughly 1.60 meters tall, and approaching her seventies. She was slender, holding a rosary gently between her hands, and wore a colorful dress that seemed to reflect fragments of her personality. I greeted her with a "Good morning" and introduced

myself. She returned my greeting, telling me she was Iara's grandmother. On her face was a tentative, cautious smile, yet her eyes held a quiet relief, she spoke of her happiness at having secured the surgery for her granddaughter and of the reassurance she felt with the care being provided to them.

Our conversation was brief, soon the man who had brought her and her granddaughter called for them to leave. We shared a hug, and she whispered to me, "Take care of my granddaughter." I smiled and replied that I would, that I would be there for the entire surgery, observing. Yet, in that instant, a thought crossed my mind: Does she know that third-year students are considered "cones" in operating rooms? That this is exactly the category I belong to?

As if to answer the unspoken tension, someone from the team overheard her words and gently reassured her: "Don't worry, we will take care of her." And with that delicate affirmation of care and trust, she finally stepped away, leaving behind a presence that lingered in the room like a quiet promise.

As soon as the grandmother left, a flurry of activity began to prepare Iara for the surgery. I had already attended classes on various types of surgeries, surgical techniques, asepsis, and antisepsis, but this was the first time I was witnessing that knowledge come alive in reality.

I looked at Iara lying there as the team removed her sheet, established intravenous access for medications, and prepared for intubation. She shared the same warm brown tone as her grandmother, her hair straight, her stature average. As I gazed at her, I found myself trying to imagine her life, who this girl was, and what impact that tiny, precise defect just a few millimeters below her tricuspid valve had had on her existence.

Had Iara learned to rest more quickly during games with her friends? Had she missed many school days? Had her diagnosis in childhood led her family to be overprotective, shaping the way she experienced the world? What imprint had growing up this way left on her personality?

I stared at her, searching for some answer, as if I might find it etched in her body, in the subtle marks of her face, some unspoken sign. I longed to connect with her somehow, to reach across that quiet distance. My thoughts drifted back to my own experiences at her age, and then beyond that moment, into the complex months that lay ahead in her recovery, months that would challenge her resilience and shape her future in ways I could only begin to imagine.

My thoughts were abruptly interrupted as the asepsis of Iara began. The sharp scent of antiseptic filled the room and invaded my nostrils. An intense, almost physical discomfort rose within me as I watched the process unfold on her small body. My stomach tightened with the acute awareness of how completely she was surrendered.

I believe part of this profound feeling stemmed from my own attempt to understand who she was, and from a sense of identification with her, not in her position, but as a fellow human being, aware of the fragile thread upon which our existence hangs. We are delicate creatures, constantly seeking shelter in one another to receive love, care, tenderness, and affection. And the absence of these very affects in our lives can fracture us internally, leaving us fearful, putting us on a kind of autopilot, for sometimes it is easier not to feel than to feel at all.

The same seemed true for Iara. For her own protection, she existed physically in the room, yet was absent from herself, absent from her senses. The asepsis began on her thoracic region, then moved to her abdomen, extending down to the distal third of her thighs. It was the first time I had ever witnessed someone being prepared for surgery. It was the first time I had ever seen a person suspended in that profound space between being fully present in the environment and, at the same time, not being present at all.

The blessing of the science of anesthesia was unmistakably clear to me in that moment. No lecture on anesthesia had ever given me the visceral understanding of the profound benefit this science provides to the practice of medicine. Amid all the bustling activity around her, Iara remained still, her features calm and unmoving. She existed in a state of sleep, entirely shielded from any discomfort, untouched by sensation, without awareness or capacity to resist, neither the glances of those around her nor the thoracotomy that awaited.

The surgery itself was a procedure of extraordinary complexity, defined by the precision of sophisticated cardiac engineering techniques. First, extracorporeal circulation (ECC) was established through the cannulation of the great vessels, the aorta was cannulated to maintain systemic flow, while the superior and inferior vena cavae each received separate cannulas, isolating the right atrium to create a bloodless operative field.

With the heart rendered completely bloodless, the tricuspid valve was repaired through the delicate technique of annuloplasty, a procedure in which the dilated valvular ring was meticulously reshaped to restore the perfect coaptation of the leaflets. As an additional measure of structural

support, a bovine pericardial graft was employed, carefully placed to reinforce zones of tension, stabilize the valve's geometry, and ensure both the durability of the reconstruction and the integrity of the cardiac walls throughout the procedure. Every detail, every movement, every decision demanded absolute precision.

It was evident, in all gesture and in every glance exchanged in that room, just how much this operation demanded from every professional present. It demanded rational, cognitive intelligence, the kind that maps every step, anticipates every reaction, foresees every risk. It demanded relational intelligence, the ability to coordinate, to communicate, to connect and synchronize with every other member of the team, seamlessly, without hesitation. It demanded physical endurance, standing for hours, often in the same position, with bodies taut and alert, eyes never leaving the operative field. And it demanded emotional resilience, the weight of knowing that every decision carried the potential for life or death, the responsibility of holding another human being's existence, fragile and irreplaceable, in your hands.

Even when unspoken, even when treated as routine, there is a profound emotional impact in opening another human being, in witnessing a still, motionless heart, in confronting the possibility of death while simultaneously holding the fragile hope of giving new life. There is a gravity that cannot be softened, a tension that cannot be ignored.

The room itself seemed to breathe, a living entity guided by its own rhythm, shaped by the constant, steady sounds of monitors and by the precise choreography of hands, minds, and intentions. Every professional present carried a lifetime of experiences, their own way of being in the world, their own history, and each of them had their own first day in an operating room, some as patients, some already as students. Just as I had mine, that first day, when there is no room to perform normalcy, when there is no space to pretend everything is ordinary in the midst of such extraordinary complexity, in a space where life and death, fear and hope, fragility and strength, walk side by side, inseparable, intertwined, shaping the very air you breathe.

During Iara's connection to the extracorporeal circulation, the tension in the air was almost tangible. A dense silence hung over the room, broken only by gestures executed with surgical precision, each movement deliberate, each pause weighted with responsibility. The team organized itself meticulously, ensuring that everything proceeded in the best possible manner. It was profoundly moving to witness the unity, the cooperation, and the

subtle reactions of each member when this critical phase of the procedure was successfully completed. One of the phrases I heard, uttered quietly by one of the doctors operating the extracorporeal machine, was: "The most critical part is over, now everything will be easier."

It is fascinating to observe what becomes easier and what becomes more difficult when every task in a given procedure is inherently complex, demanding extreme care, unwavering attention, and absolute dedication. Observing the professionalism, the focus, and the carefulness of each individual was in itself an immense lesson, a teaching beyond what any textbook could convey.

The procedure began at eight in the morning and concluded around four in the afternoon. In total, twelve people were directly involved in the surgery, each contributing in their own way to a collective effort aimed at granting Iara the chance at a new possibility of existence, a renewed life shaped by the meticulous care and commitment of those in the room.

After the most tense moments passed, approaching the midpoint of the surgery, the atmosphere in the operating room subtly shifted. It moved toward a sense of greater coordination and rapport, the surgeons grew slightly more relaxed, allowing space for small conversations about salaries, their children's schools, upcoming vacations, and jokes drawn from the mundanity of everyday life. And yet, even in this lighter air, the gravity of the task at hand never disappeared, it was a delicate balance between human levity and unwavering focus, a coexistence of humor and responsibility, of relief and the ever-present weight of life and death.

As this moment of greater ease and lightness settled over the room, I noticed that Andressa's behavior, in particular, had not changed. She remained as attentive and serious as she had been from the very beginning. Her gaze seemed to organize everything within that space, and her posture maintained the level of care that the moment demanded.

I had noticed her careful demeanor from the first time I interacted with her, when she had taken the time to offer knowledge, guidance, and information that made a significant difference in my understanding and learning throughout the surgery. Watching her now, I realized that she remained fully active, fully alert to every minute detail. She cared for the environment with a rare precision and agility, a kind of meticulous stewardship that ensured nothing was overlooked, nothing left to chance. It was in her presence that the invisible architecture of the operating room, the order, the flow, the harmony, became tangible, visible through her eyes and expressed in every movement she made.

With the atmosphere in the room now more amicable and the procedure having reached a more stable stage, one of the surgeons began resting his arm on Iara's leg. I noticed it, and an immediate discomfort stirred within me, yet I could not express it, could not find the words to articulate what I was feeling. I remembered Iara's grandmother telling me to take care of her, and my response affirming that I would, while at the same time thinking about the hospital hierarchy in which I found myself, a hierarchy that, in my thoughts at the time, did not allow me to communicate my concerns to a superior. Especially in a surgical context, where hierarchy is meticulously delineated, not always spoken aloud, but enforced through symbolism, through words, and through the behaviors that dominate collective dynamics. I kept my unease to myself, holding in the discomfort I felt at the weight and fatigue resting on Iara's leg.

After a few minutes of this, the nurse whose eyes had been observing the entire room from her position noticed exactly what I had seen. Standing three meters away from the surgeons, she spoke in a tone that carried across the room: "Take your arm off her leg. Her leg is not a table." Immediately, the surgeon withdrew his arm, and in that instant, the previously relaxed atmosphere shifted back to the seriousness the moment demanded.

In that room of twelve people, she was the only one to voice what should have been obvious – that the patient's body was not to be treated as just another object of the operating room. That life, even in a state so vulnerable that she could not feel the opening of her sternum, was far from being merely another object in that space.

It is striking to reflect on the subtlety inherent in the act of resting one's weight on a patient's leg, and on the extraordinary capacity for sensitivity required to recognize, articulate, and transform the space around oneself. Especially in an environment where the norm is to operate under extreme conditions most of the time, the ability to intervene, to assert care, and to uphold the dignity of another human being is a rare and profound form of courage.

This episode revealed to me how fragile the boundary is between care and objectification, and how easily the patient's body can be reduced to a functional surface when exhaustion, routine, and hierarchy take precedence over awareness. In that moment, I understood that the greatest threat to dignity in medicine is not cruelty, but normalization. It is not the deliberate intention to harm, but the silent acceptance that certain gestures no longer require reflection. The arm resting on Iara's leg was not an act of

violence, yet it symbolized how subtly the patient can disappear from view, becoming part of the environment rather than the center of it.

What struck me most was not only the nurse's intervention, but the solitude of her voice. Among twelve professionals, she was the only one who perceived and named what was happening. This made me wonder how many similar moments pass unnoticed each day in hospitals, diluted by the pressure of time, by physical fatigue, and by the emotional armor that health professionals learn to wear. Sensitivity, I realized, is not something that survives automatically in such environments, it must be actively cultivated and consciously protected.

Her words transformed the space. They reintroduced Iara as a person into a room that had momentarily begun to treat her as infrastructure. With a single sentence, she restored the patient's humanity and reminded everyone present that beneath the sterile drapes and surgical instruments there was a young girl whose body carried not only organs and vessels, but history, relationships, and a life still unfolding. That intervention did not interrupt the surgery, it deepened it. It anchored the technical act back into its ethical meaning.

I began to understand that courage in medicine does not exist only in dramatic gestures or life-saving decisions. It also resides in the quiet insistence on respect, in the refusal to allow fatigue to justify indifference. There is bravery in seeing what others no longer see and in naming what others have learned to ignore. The nurse's action demonstrated that authority does not come solely from hierarchy or titles, but from ethical clarity and presence of mind.

This moment also confronted me with my own silence. I had noticed the discomfort, yet I had not spoken. I attributed this to my position as a student, to the rigid structure of the operating room, and to the fear of overstepping invisible boundaries. But beneath these justifications lay a deeper question: at what point does obedience to hierarchy become complicity in dehumanization? And how can one learn to speak without becoming disruptive, to intervene without arrogance, to protect without confronting violently?

These questions began to echo through the rest of my experience in that rotation and beyond it. I saw more clearly that the formation of a physician is not only a technical apprenticeship, but a moral and emotional construction. Every day, students are shaped not only by what they are taught, but by what they witness and by what is left unquestioned. If moments like this

are not reflected upon, they risk becoming part of an unconscious routine, reproduced endlessly without awareness.

Thus, that single sentence spoken by the nurse became for me a point of rupture and of learning. It revealed that medicine is built not only through procedures and protocols, but through small acts of vigilance over the humanity of those who entrust their bodies to us. It taught me that the doctor–patient relationship is preserved not only at the bedside, but also in the operating room, in gestures that seem insignificant yet carry profound symbolic weight. And it showed me that to care is also to interrupt, to remind, and sometimes, to gently but firmly say: this body is not an object, it is a life.

That day became a portal for reflection and questioning. First, alongside the feeling of discomfort that arose from witnessing that scene and contemplating the vulnerability in which patients are placed, especially during surgical moments, I also reflected on the grueling, often exhausting routines that surgeons endure before completing their training. It brought to mind a widely known case in my country, Brazil, which occurred in 2022, when a group of Orthopedics and Traumatology residents at UNICAMP collectively submitted letters of resignation due to excessively demanding schedules and the disregard for the legally established 60-hour workweek limit.

On social media, many health professionals dismissed their action as a trivial complaint, asserting that in their own time, the workload had been far worse than what trainees face today, and therefore there was no reason for protest. They went further, suggesting that this new generation of doctors is doomed to be inadequate, simply because they are unwilling to endure the kind of sacrifice that previous generations accepted without question.

Reflecting on this, I thought about the extent of dehumanization that occurs during medical training. Beyond the long hours and the physical exhaustion, this is a formation that does not primarily deal with machines, numbers, or abstract ideas. It deals, above all, with lives, countless lives, each carrying its own pain, joy, hope, loss, and ultimate departure from the material world. If students are not given the opportunity and time to process these experiences, to digest the emotions that arise from daily encounters with human suffering, it is to be expected that, over the years, they will develop a professional persona marked by permanent dissociation.

It is to be expected that they will become colder, less sensitive to the

suffering and vulnerability of the human beings around them, because in the same way, they are functioning within a modus operandi that gradually erodes their own sensitivity and humanity. There is a tremendous cost in treating doctors as machines, in glamorizing exhaustion, in placing above all else an ideal of medical formation that sacrifices the well-being of those learning to care for others in the most crucial and vulnerable moments of their lives.

Another point of reflection is this: there exists a certain degree of dissociation that health professionals must cultivate in order to perform in high-stress situations, especially in high-pressure environments like the operating room. To be, at every moment, acutely aware of the profound responsibility of the work being executed, as in Iara's surgery, places an immense cognitive and emotional load on the human mind. It is exhausting to continuously process all these stimuli without succumbing to fatigue.

And so, how does one find the balance between this necessary dissociation, which enables professional performance, and the maintenance of sensitivity, which is itself sustained precisely by a continuous awareness of the importance, significance, and impact of the work being carried out?

This leads me to several questions: What did that nurse do, over the years, to maintain a gaze that remained both attentive and sensitive? What did she do to acquire the authority of voice, the confidence to assert herself firmly in defense of what her eyes were witnessing? How did she manage to construct a communication that was direct and horizontal in an environment so defined by hierarchy? These are questions I want to explore, as I strive to build a powerful and healthy doctor–patient relationship, and I have begun formulating some hypotheses.

I believe we must preserve the capacity for indignation and refuse to become desensitized to the magnitude and complexity of what we commit ourselves to performing each day, in hospitals, care units, and home visits. We can normalize the routine, but we must not trivialize it. We must not trivialize the touch, the deliberate choice of words we use to communicate with others, or the knowledge, importance, and participation of every individual on the team. Only through a humble, collective vision can we reduce the likelihood of errors and deliver a more humane, attentive, and conscientious form of care to our patients.

The illustrious Swiss physician, Carl Jung, once famously said, "Know all the theories, master all the techniques, but when you touch a human soul, be just another human soul." From that day in the operating room,

observing Iara's procedure, I learned that even when we command the full complexity of medical knowledge, without the sensitivity to care for another human being aware that there is a soul there, just as ours is our actions, however technically brilliant, may lack the ethical and compassionate dimension that dealing with human vulnerability requires.

Furthermore, we must bear in mind that the doctor–patient relationship also reflects the relationships that health professionals cultivate within their own teams. A team in which everyone has the opportunity to contribute their perspective, and where relationships are established as horizontally and collaboratively as possible, increases the likelihood that patient care will be more comprehensive and less prone to error. It allows for multiple perspectives, the integration of different forms of knowledge and worldviews. This was evident in Iara's surgery, where the coordinated attention of twelve professionals was essential to achieving a successful outcome. Each perspective, each careful observation, each subtle adjustment contributed to a collective precision that could not have been achieved by a single individual alone.

On that first day in the operating room, I learned that trust, sensitivity, and professionalism are inseparable from the human dimension of medicine. I carry with me now not only a broader understanding of holistic patient care, but also a clearer vision of the professional I aspire to be one who recognizes that every patient is a soul, not an object, one who approaches others with the care, attention, and presence that she herself would hope to receive in moments of vulnerability.

This experience revealed to me that the quality of the doctor–patient relationship depends as much on the professional's technical skill as on her capacity to remain human, fully present, and ethically attuned amidst the pressures, hierarchies, and fatigue inherent in medical practice. A truly effective practitioner is one who can navigate the balance between necessary professional dissociation and sustained sensitivity, who can honor the dignity and fragility of each life entrusted to her care, and who fosters environments within teams and with patients where voices are heard, perspectives are valued, and empathy guides action.

In the end, medicine is not only about performing procedures or mastering knowledge, it is about maintaining the consciousness of the life before us, of the soul we touch, and of the profound responsibility that comes with that contact. Every decision, every gesture, every word carries weight, and the human connection, the careful attention to vulnerability, the re-

spect for dignity, the acknowledgment of shared humanity, is what transforms a technically successful procedure into an ethically and morally alive act of care. It is in this space, where competence meets compassion, that the true meaning of being a doctor, and the essence of the doctor–patient relationship, is realized.

Note: the names of the patient and the nurse have been changed to protect their identity

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