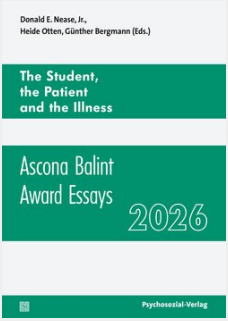
Amit Manor

Permission to Tremble



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All identifying details have been altered to protect patient privacy.

Medicine is built from small moments that look ordinary and feel enormous. It rests on relationships – quiet, brief, and simple, yet deeply intimate. Even the simplest routine blood draw – two tubes, a butterfly needle, a gauze square – is an intimate exchange. As doctors, we study a hand, choose a site, steady skin; in doing so we are invited into someone's private space. Many techniques lead to the same outcome, but the feelings on both sides can span a wide range. A pause, a word, a nod can change the moment entirely.

This paper begins with a bedside encounter from two and a half years ago. I remember it in granular detail – the winter light, the open door, the quiet contour of consent – because it has shaped how I practice every day since. It taught me that safety is a shared project voiced aloud; that a sentence can slow a room; and that skill means as much in our hands as in our language.

The argument that follows is about when practice becomes intrusion – about the moment a routine procedure stops being care and becomes ego-driven care. In a teaching hospital we learn on real bodies; that is unavoidable and, at its best, life-preserving. But learning does not give me unlimited access. After a reasonable number of attempts – when my hands begin to hurt the patient, when my judgment narrows, or when someone more practiced is available – the ethical move is not to push through. It is to stop, name what is happening, and hand over. My hands learned this lesson at a bedside; this essay traces how that learning widens from one patient to the practice of care.

Exposition

February makes a white, unforgiving light of the medical ward. The ceiling fixtures hum with the same quiet insistence as the nurses' station beyond the open door. Two beds share a room where the curtains are pulled back, exposing everything to that pale strip of winter sun.

On the bed nearest the doorway sits a man in his seventies, pale-skinned with long gray hair, upright but loose in his posture as if he has learned how to take up as little energy as possible. There is an apathy to his stillness, the look of someone who has been examined often. His breathing is slightly fast – more hurried than the calm of his face. We will call him Mr. Wolf.

He was admitted that morning with pneumonia, a heavy smoker's illness that sits in the chest like wet wool. He is alone. On the bedside table, beside the plastic cup and the folded paper gown, lies a book in Russian – closed, face down, as if it has been waiting longer than I have. He speaks in short, monotone answers with a faint accent. He does not try to charm the room. He looks practiced at being examined, as if the ward has asked him for his body many times before.

Eight students and our tutor compress themselves between his bed and the steel sink, trying to take up as little space as possible while still consuming all the air in the room. The tutor stands to the side – close enough to watch every movement, far enough to stay out of it. The air smells faintly of chlorhexidine and stale heat. Behind us, the corridor pulses – vitals carts rolling, phones ringing, the clipped efficiency of people who know what they are doing.

I do not know what I am doing. Not really. I am in my first clinical rotation, a fourth-year student armed with a head full of physiology and hands that have only ever practiced on plastic arms or the healthy, generous veins of classmates.

Mr. Wolf looks from face to face – a lineup of white coats and anxious eyes – and asks in short, monotone English with a faint accent, "Who wants to go first?"

My hand rises before I can second-guess it. It is a reflex born of four years of medical school conditioning: Be eager. Be visible. Be first. It is not courage; it is the desperate, performative hunger of a student who is tired of being a spectator. I am terrified of the needle, but I am more terrified of fading into the wallpaper, of being the student who watches while others do.

My tutor nods, validating the performance. I step forward, crossing the invisible line between the audience and the stage, driven by the naive belief that enthusiasm is a substitute for skill.

I wheel the mobile tray closer. I do not see the sterile packets or the Vacutainer holder; I see the bruises. His hands are mapped with them – yellow-green islands fading to a tea-stain brown at the edges. The backs of his hands carry the pale, scarred tracks of a dozen recent cannulas. These are not fresh territories; they are exhausted landscapes.

I lower myself to my knees so that my eyes are level with his hands. It is a posture of prayer, or perhaps begging. I introduce myself, my voice sounding too loud in the sudden quiet. I tell him I am a student. I ask for his permission.

He nods and offers his hand.

I snap on my blue gloves. The latex feels tight, a second skin that separates me from him. I scan his antecubital veins – the easy ones, the ones I want. They are crowded with old stories: corded vessels, beads of localized clot, scar tissue. I know better than to trespass there. I move to the back of his hand. It is technically trickier, the skin is thinner, the nerves are closer to the surface. But there is a small, springing thread at the base of his thumb that looks patient.

"A small one," I whisper. "Small, but good," my tutor replies.

The room shrinks. There is no corridor, no winter light, only the terrifying intimacy of his skin and the needle in my hand. I steady his hand in mine. His skin is cool; mine is damp inside the glove.

I enter. There is that distinct, sickening pop – the buoyant give of a vessel accepting a guest. A bloom of dark red traces its path down the tube. Relief floods my chest, hot and sweet. I am doing it. I am a doctor.

And then, as simple as a breath miscounted, I ruin it.

My hand shifts – a millimeter, a tremor of excitement – and the needle slips. The tubing goes limp. The flow stops. The second tube, barely half-filled, hangs between us like an accusation.

"I'm sorry," I say, pressing gauze to the site. My voice is professional; my stomach is hollow.

"It happens," he says. He is kind. His kindness makes it worse. I need two more tubes.

The ward custom is clear: two attempts, then you stop. You ask for help. It is a rule designed to protect the patient from the being hurt.

I try again, a little higher up. The vein rolls. I chase it – a clumsy, desperate movement – and I miss.

Now the silence in the room is heavy. I can feel the eight pairs of eyes behind me. They are not judging me with malice; they are judging me with pity, which is unbearable. I have hurt this man twice, and I have nothing to show for it but a bruise and a half-filled tube of blood that is already clotting.

My tutor steps forward. She does not take the needle, but her presence is a question. *Are you done?*

I look at Mr. Wolf. He is sitting very still, breathing quickly through his nose, watching my hands as if he is tracking the weather. He says nothing. He is the only person in the room asking nothing of me. I look at the needle.

I want to try a third time.

I tell myself it is because I don't want to delay his care. I tell myself it is because I see a good vein on his other hand. But deep down, in the place where the shame lives, I know the truth: I want to try again because I cannot bear to end this encounter as a failure. I want to redeem myself on his skin.

I open my mouth to ask for the third attempt. The ambition is sharp in my throat. I am about to prioritize my pride over his pain.

He looks at me. He sees the tightness in my jaw, the tremor I am trying to hide, the desperate calculation in my eyes. He sees the student who is terrified of being measured and found wanting.

He smiles, a small, tired expression that breaks the tension like a fever.

"What matters most," he says softly, "is that you feel safe."

The sentence hits me in the chest. I stop. I forget the vein. I forget the tutor. I look at him, really look at him, for the first time.

He is comforting *me*.

I am the one holding the needle. I am the one causing the pain. And yet he is the one offering the safety.

The shame of it burns, but it is a clean burn. It cauterizes the ego. I take a breath, and for the first time since I raised my hand, I let it out.

Reflection

I have wanted to be good at this for three and a half years. Not good in the absolute sense – good in the way that finally puts my name next to an act that matters in the wild, uncurated world of the ward. Our pre-clini-

cal curriculum has prepared my mind to consider differential diagnoses, to recognize patterns and to race the clock of pathophysiology on paper. We have practiced procedures on each other's veins and taken turns being both careful and brave. But this is the first time my carefulness and my bravery write something on someone else's skin.

There is a self I bring to demonstrations, to exams, to skill checklists. She likes metrics because metrics promise an end to doubt. Two successful attempts, zero hematomas, time to fill: seconds counted and compared. She wants the room to see that she understands anatomy, gauge sizes, the order of draw, the angle of entry in a hand vein versus an antecubital vein. She wants the tutor to nod; she wants the group to sigh, relieved, because soon they too will have to step onto the floor of this same narrow stage.

I did not invent this hunger in the room, I grew into it. In the student lounge and in the corridor between rounds, we compare competence the way athletes compare times. Someone mentions how many cannulas they placed on call, how quickly they managed to draw blood from "impossible" veins, which attending let them assist in a more complex procedure. Residents compete in quieter ways – papers drafted at midnight, presentations polished to be noticed, a constant effort to be liked by the managers who will later decide who advances. None of this is evil; much of it is survival inside a hierarchy. But it trains my attention outward, toward the approving nod, and it makes it frightening to stop. In that climate, the patient's arm can start to feel like a test site, and a third attempt can masquerade as dedication when it is really the fear of being ordinary.

There is another self who arrives when the needle slips. She is quieter and perhaps more honest. She knows that beyond the metrics there is a person sitting at the edge of a bed, and that the only meaningful statistic about the encounter is whether he leaves feeling seen and safe. She is the one who hears the sentence – *What matters most is that you feel safe* – and recognizes it as a gift with two faces: the immediate permission to try again, and the wider invitation to reconsider what success should mean now that there is a human being in the room.

These two selves live together. The clinical rotations mark the transition of focus.

In the early years, my instinct is to impress attendings and lecturers – the visible gatekeepers of progress. But at the bedside, the audience changes. The person who matters is the one with the bruised hands, and the only applause worth chasing is the loosening of his shoulders, the steadier breath,

the willingness to meet my eyes. Degrees and prizes are currency inside the hierarchy; in the patient's economy the only tender is trust. To "impress" him is not to be dazzling but to be decent: ask permission, notice pain, stop when enough is enough, know when to call someone better than me. If he leaves without feeling that what I did was for him, then no credential is worth the paper; if he leaves feeling seen and safe, the day is already a success. This is the quiet pivot of clinical rotations: moving from performing competence to delivering care, from collecting nods to earning consent.

One way to perceive consent, as I learned that day, is clarity. I have explained the operational steps to him quickly. However, in retrospect, my explanation has been more procedural than relational. I say what I am going to do; I do not say fully what I will do if it does not go to plan. I do not offer him the comfort of choices (Would you like me to pause? Would you prefer that I ask a colleague? Would warming the hand help?); I do not invite him into the timing. That omission does not come from disregard but from speed – the small, unacknowledged urgency that attends public performance. The open door makes the ward's tempo the background music of our encounter. I match it without meaning to.

His sentence slows the room. "*What matters most is that you feel safe*." It does not absolve me of the obligation to protect his comfort; it merely points out that I cannot do so well if I am clenched around my own fear. Safety, in that instant, becomes a shared project.

In that particular moment, Mr. Wolf did not see a doctor. He saw a vibration.

"What matters most is that you feel safe" dismantled the hierarchy of the room in four seconds. In standard medical ethics, we are taught that safety is a commodity we provide to the patient: we raise the bedrails, we check the wristband, we prescribe the correct dose. We are the architects of their security.

But in that room, the architecture inverted. I was the one holding the sharp object, yet I was the one who needed steadying. I was the one inflicting the wound, yet he was the one administering the care.

This is the uncomfortable truth I had to metabolize: unexamined anxiety in a clinician can become a dangerous instrument.

Balint once suggested that the doctor is, in a way, a drug. That morning I understood the risk of that metaphor: my tremor, my urgency, my need to prove myself – these were not private feelings. They were an active ingredient in the encounter.

We rarely discuss the physician's need for safety, perhaps because it sounds selfish. We are supposed to be stoic vessels, immune to the adrenaline of the procedure. But my anxiety was not a private feeling; it was a physical variable that traveled down my arm, through the needle, and into his tissue. My fear of failing made my hand heavy and my judgment brittle. By comforting me, Mr. Wolf was not just being kind; he was being pragmatic. He recognized that for the procedure to succeed, the instrument, me, had to be calibrated. He had to curate the environment so that I could hurt him with precision, rather than with clumsy desperation.

There is a profound humility in realizing that my "performance" of competence was actually a barrier to care. I thought I was protecting him by pretending to be confident. In reality, I was asking him to participate in a fiction. I was asking him to offer up his veins to sustain my self-image.

This brings me to the second, darker realization: the temptation of the third attempt.

Why did I want to try again? The clinical justification was thin; there were other hands in the room, better hands. The true impulse was penitential. I wanted to try again because I wanted to erase the shame of the first two failures. I wanted to use his body as a canvas to prove that I was not incompetent.

This is the shadow side of the "learning curve". We speak of medical education as a noble apprenticeship, but we rarely admit that it also creates a moral debt. We borrow experience from the sick. We take their blood, yes, but we also borrow their patience, their time, their skin, and sometimes their pain, to build our own dexterity. The debt is not a reason to stop learning; it is a reason to learn with restraint and to notice when learning slides into taking.

When Mr. Wolf spoke, he exposed this transaction. He granted me permission to be a student – which is to say, permission to be imperfect – but he also reminded me of the terms of the contract. I am a guest in his body. I do not have squatters' rights on his veins just because I am wearing a badge.

The "safety" he spoke of was not the safety of the body, but the safety of the relationship. He was telling me that it was safe to stop. It was safe to be a person who missed. It was safe to drop the exhausting performance of the "doctor-in-training" and simply be a human being attempting a difficult task.

In the end, the lesson was not about phlebotomy. It was about the source of authority. I walked into that room thinking authority came from my

tutor's nod or the checklist on my clipboard. I learned that authority is granted by the vulnerable. Mr. Wolf held the power in that room – not because he could cure, but because he could forgive. He saw the tremble behind the performance, and instead of punishing it, he held it.

I realized then that I cannot force my way into a vein, just as I cannot force my way into a patient's trust. Both must be entered with a steady hand, and sometimes, the steadiest thing a hand can do is put the needle down.

There is another layer to this reflection, one that surprises me later in a debrief. Our tutor leads a brief discussion that focuses on angles and anchoring, on how to secure the butterfly needle so that its weight does not conspire with gravity to loosen the hub at an unhelpful moment. The conversation is useful. It does not once touch the emotional contour of the room. My classmates offer a few practical comments and we move on to the next task. I leave with a sudden loneliness that feels odd, given the crowd.

If I could change one thing in how we teach procedures, it would be this: after the checklist, a ninety-second relational debrief. Not therapy, not confession – just three questions that train attention. (1) What did the patient need in that moment, and did we ask? (2) What did the student need, and did we name it without making it the patient's job to carry? (3) Where was the ego in the room – did it push, rush, or hide behind confidence? We already teach students to narrate the steps of a blood draw; we can also teach them to narrate the point at which an attempt becomes intrusion. A tutor can model the simplest script: "We tried twice. We stop. You haven't failed; you protected the patient." Without that language, the only feedback a student receives is technical, and the emotional economy stays underground, where it continues to drive hands and decisions. Mr. Wolf taught me that the ethical skill is not only how to enter, but how to stop.

Why does it bother me? Not because I want my feelings to be center stage, but because the most important thing that happens in that room is not a technique. It is a sentence, and the silence that makes it audible. It is a patient taking care of a student so that the student can better take care of the patient. It is the discovery that an apology, spoken simply, can make the atmosphere less brittle for both participants. If medical training does not practice naming these things, then we risk training for a world in which they do not exist – and they do, every day, between the bed and the sink.

I think now of that half-filled tube. It hangs in my memory with a weight disproportionate to the milliliters it contains. If the story ends there, I learn

a lesson about stopping, which is its own discipline. But it does not end there, and the way it continues shapes the lesson in a different direction.

Action

Between the miss and the third attempt, decision-making had to be fast and clean: him first, my pride later. The pressure that flooded me after the butterfly slipped wasn't an excuse to rush; it was the reason to simplify. I narrowed the field to three micro-choices – when, where, and whether to pause – and I made the exits obvious. If stopping would serve him better, stopping had to be easy.

The sentence creates a silence that is louder than the ward corridor. What matters most is that you feel safe.

It is an invitation to stop, but it is also a challenge to continue differently. I look at my hands. They are still the hands of a novice – damp inside the gloves, trembling slightly with the adrenaline of the mistake. If I proceed, I am not doing so because I am certain of success; I am doing so because he has offered me a grace I have not earned.

I have to make the exit visible. I have to give him the weapon to defend himself against my ego.

"I see a vein on your other hand," I say. My voice is lower now, stripped of the "doctor" cadence I had been mimicking. "It looks kind. But I have already tried twice. If you would prefer that I ask my tutor, or the phlebotomist, we can stop right now. You just have to say the word."

I wait. I force myself to wait through three beats of silence, fighting the urge to fill the air with reassurances. I am handing him the authority to fire me.

He looks at me, then at his own hand. He sees the bruise I have already made. Then he looks back at my face, which must surely betray my fear.

"Try," he says. "I trust you."

It is a terrifying gift. His permission does not feel light; it feels like a transfer of responsibility. He has looked at the bruise I made and still offered me another chance. In a competitive training culture, a chance like that can sound like a command: do not waste it. Do not disappoint him. Do not disappoint the tutor. Prove that you deserve to be here. I can feel that pressure in my throat, urging me to turn his kindness into a final performance. But his sentence is not a dare. It is a boundary: the most important thing is safety, and safety includes the right to stop.

I move to the other side of the bed. I do not rush. The "ward rhythm" – the hurried tempo of efficiency – has dissolved. The only time that exists is the time it takes to be careful. I kneel again. I hold his left hand. The vein at the base of the thumb is visible, a faint blue river under papery skin.

I narrate what I am doing, not as a checklist, but as a promise. "I am going to clean the skin. It will be cold. I am going to hold your thumb to anchor the skin."

I pick up the fresh butterfly needle. The wings are plastic and light, but they feel heavy with consequence. I look at him one last time.

"Tell me to stop," I whisper, "if it hurts."

He nods.

I enter.

There is no triumphant pop, no surge of confidence. There is just the quiet, sliding friction of steel entering tissue, followed by the stillness of holding my breath. I watch the tubing. For a second, nothing happens, and my heart hammers against my ribs, certain of another failure.

Then, the dark red bloom appears.

It travels down the line, slow and steady. It is the most beautiful color I have ever seen. I attach the tube. The blood flows.

I fill two tubes. I withdraw the needle. I press the gauze. The entire time, I do not look at my tutor; I look at him.

"We got it," I say, and I hear my own voice shift. It is quieter, less eager, less performative – as if the room has stopped being an exam station and has become, for a second, a clinical relationship. I do not feel triumphant. I feel relieved, ashamed, and oddly grateful. Success, when it arrives after harm, does not taste like victory. It tastes like a debt.

"We did," he replies.

I tape the gauze and clean the tray. I peel off the gloves that feel like they have been on my hands for hours. My hands are free, but they feel different – lighter, yet burdened with a debt I know I cannot pay back to him.

I thank him. It feels insufficient. Since I was a child I've been quick with thank-yous – my way of steadying the air – and here it's the only accurate word I have. I can't get over how essential his help was, even though he only sat quietly and, on paper, did nothing. "Thank you for trusting me," I say. "And thank you for what you said. I needed to hear it."

He smiles, the same small, tired smile. "We all need to hear it," he says.

I walk out of the room. The corridor is exactly the same – the same phones ringing, the same residents rushing – but the noise seems distant. I am not the

same student who walked in. I entered as a performer looking for applause; I leave as a debtor who has been given a second chance.

Over the following week, I find myself changing the way I approach needle encounters. I prepare the same equipment; I place the same gloves on the same hands. But I also position myself in a way that makes eye contact natural rather than an afterthought. I test a simple, clear script before beginning: I'll explain each step. It's a quick draw, but if at any point you want me to stop or ask a colleague to help, please say so. I'll check both arms and hands and pick the gentlest spot I can find. Would warming your hand help?

None of this slows the ward. It does slow me, and that is the point. The draw often goes more smoothly not because the words have magic in them, but because the process of speaking them makes my hands less anxious. Patients respond with the small permissions that make a big difference: a deeper exhale, a relaxed finger, a question asked before tension has a chance to make an enemy of the needle.

I keep the two-attempt rule and add a corollary: if I reach the second attempt and the next step is not obvious, I invite a colleague with more experience. Sometimes that is the ward phlebotomist, whose efficiency has its own grace. When she takes over, I ask her to narrate aloud what she is feeling for, not to memorize her technique but to model for me the way experienced hands talk to skin.

I start practicing the art of stopping – on myself first. Instead of competing with myself to prove I can, I choose not to do it at a patient's expense. Twice that month I pause after the first attempt and suggest we try later or elsewhere. Those patients thank me more than when I succeed on the second try. It makes me suspect that what people prize isn't speed but discernment – the willingness to trade momentum for judgment.

Progression

The lesson did not turn me into a perfect phlebotomist. I still miss. Veins still roll; valves still shut their doors against the needle. But the geography of my failure has changed.

Later that same week, still on internal medicine, I was asked to draw blood from another patient with pneumonia – a woman in her forties whose veins were ordinary, generous even. There was no technical excuse available to me. If anything, it should have been easy. That is why the moment mattered: it re-

vealed how quickly my body returns to performance when the stakes are social rather than clinical.

I missed. Once. Then again. The familiar narrowing arrived: sweat inside my gloves, a tight chest, the urge to chase the vein and force a success before anyone could label me incompetent. I could feel the room beginning to watch. And then I remembered the half-filled tube from Mr. Wolf's bedside – the weight of evidence that perseverance can become intrusion. I put the tourniquet down before my pride could ask for a third attempt.

"I don't think I can do this safely for you today," I told her. "I'm going to find someone whose hands know more than mine." She did not reassure me the way Mr. Wolf had. She did not need to. She simply accepted the handover, as patients do when we finally make the exit visible.

It was a small, humiliating admission. In medicine, walking out of a room having done "nothing" feels antithetical to our action-bias. I felt shame first – then relief, and then a quieter pride that surprised me: I had chosen her over the performance. As I left, she didn't look triumphant that the ordeal was over; she looked protected. I realized then that the two-attempt rule is not a technical boundary; it is an ego boundary. It is the line where my desire to be competent must surrender to the patient's right to be unhurt.

I have stopped thinking of "informed consent" as a legal signature. It is a temperature check. I now carry Mr. Wolf's sentence with me like a second stethoscope. Before I touch a patient, I check the room's temperature: Is it safe here? Not just "is the rail up" or "is the brake on," but is the air between us steady?

I realized that day with Mr. Wolf that I had been trembling. Not visibly, perhaps, but with the vibration of a student desperate to be seen as a doctor. He saw that tremor. His offer – "What matters most is that you feel safe" – was a reversal of roles that still burns with a quiet shame. He, the patient, had to steady me, the provider, so that I could hurt him.

That shame is useful. It reminds me that I am a guest in the patient's body. I am not entitled to their veins, their stories, or their trust. I have to knock.

Now, when I teach younger students, I do not teach them "micro-scripts." I tell them about the tremor. I tell them that the needle is sharp, but their anxiety is sharper, and that the patient can feel both. I tell them that if they find themselves gripping the plastic wings of the butterfly needle too tightly, they are no longer holding a tool; they are holding onto their pride.

I tell them to let go.

I see Mr. Wolf often. I see him in the 87-year-old with the paper-thin skin

who flinches before I even move. I see him in the angry businessman who checks his watch while I palpate his arm. In those moments, the "third attempt" tempts me – the desire to be the hero who gets the blood in one impossible shot. But then I hear the silence of that open door. I remember that safety is not a metric I deliver; it is a permission I am granted.

Medicine is often described as a fight against death, or a puzzle to be solved. But in the quiet moments between the bed and the sink, it is mostly a negotiation of touch. It is the art of asking, again and again: Am I safe for you?

And when the answer is silence, or a flinch, or a half-filled tube, the progression is not to push harder. The progression is to stop, to breathe, and to let the patient be the one who saves us from our own need to be good.

Coda

I sometimes replay the scene as if from the doorway: winter light, the hush over the sink, the particular geometry of a student on her knees before a man's hands. The first tube half-filled on the tray, a punctuation mark that looks, from a distance, like an ellipsis. Then the small shift – the angle of the chair, the choice of the other hand, the sentence that rearranges the room.

I keep that sentence close, not as a talisman but as an instruction: What matters most is that you feel safe. It does not turn me into a flawless practitioner. It does not eliminate the small, useful nervousness that attends procedures. It gives me something better: a way to decide, in the middle of a ward's ordinary noise, how to make a private space inside an open door, and how to act there.

The butterfly is a poor metaphor for medicine – too delicate, too pretty. But as it settles the third time, the tubing full and certain, the image suggests something true: a light touch is not a lack of skill; it is its companion. The man looks at me, a half smile, steady. I thank him for trusting me with his hand and, more than that, with his sentence. I carry both. And in the rooms since then, with curtains open or closed, I try to make the space where safety is not assumed but made – together.

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