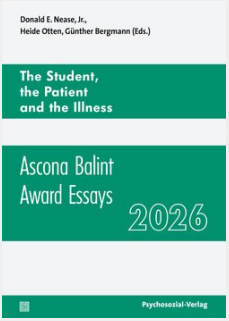
Spartan Nandal

The Shape of Mrs Sharma's Sunflowers



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The Shape of Mrs Sharma's Sunflowers

A Meditation on Love, Loss and Life

Spartan Nandal

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Prelude: Frankenstein's Monster

I first read *Frankenstein* in a high-school English class, long before I had any intention or ambition of studying medicine. What stayed with me was not quite the melodrama of creation nor the gothic theatrics, but a single question my teacher posed as we discussed the opening chapters.

"Why," she asked, "does Frankenstein step back when the creature opens its eyes? What exactly is he recoiling from?"

Students offered some answers: fear, guilt, revulsion.

She shook her head.

"Not quite. Look carefully. He steps back because he does not yet have a framework for what he is seeing. The creature is unfamiliar, unfinished, illegible. Frankenstein retreats because he cannot yet interpret the life in front of him."

There was a silence – brief, but charged – before she continued.

"And that," she said, "is where responsibility begins or fails. Not at the moment of creation, but at the moment we decide whether to move closer, or step back from what we do not understand."

It was an interpretation I did not fully grasp at the time. I was around the age of 16; the idea of being responsible for another person's incomprehension felt abstract, almost theoretical. But the concept lodged quietly

in my mind: the notion that the most decisive moments are often those in which we feel least prepared to act.

Years later – 7 to be precise – when I began clinical placements, that sentence returned with an unnerving clarity.

Because the wards are full of such moments: encounters where a patient's life appears briefly before you in an unfamiliar configuration – unfinished and difficult to decode – and your instinct, trained or untrained, is to either lean closer or to retreat into the safety of structure.

And it was precisely in such a moment, during my placement on an orthopaedic ward, on a random Wednesday in March, that I would meet one of the most remarkable human beings.

Part I: Meeting Mrs Sharma

On the orthopaedic ward, our consultant paused outside Bed 12 and handed me the chart. "This is Mrs Sharma," she said quietly. "Seventy-two. From India originally. Severe hip osteoarthritis. She's listed for surgery tomorrow. Back pain as well. You take the history."

Mrs Kavita Sharma sat upright in bed, her grey hair tied back in a modest plait, a hand-knitted shawl resting around her shoulders as if she refused to relinquish the domestic world outside the hospital. Her eyes were alert, steady – the kind that meet yours fully, not out of confidence, but out of habit, as though she has learned that looking directly at people makes conversations simpler. She greeted me with a small nod. "You're the student? Come, sit. My back is annoying me today."

I pulled up a chair and began with the usual.

"Good morning Mrs Sharma, my name is Spartan and I'm a first year medical student from the University of Sydney. Is it okay if I ask you some questions about your pain?" She nodded with a smile. "When did the back pain start, Mrs Sharma?"

"Hmm," she said, tilting her head as though sifting through her memory. "A few months. Maybe longer. Things blend together when you live alone." She gave a small laugh that didn't feel self-pitying but just factual.

I asked about character, radiation, stiffness. She answered carefully, occasionally pressing her palm against her lower spine, as if mapping the discomfort with her body rather than her words.

Then I moved to red flags.

"Have you had any recent trauma? Falls, accidents ... anything like that?"

She looked at me for a moment, and then said lightly, "No, dear. No trauma anymore. My ex-husband hasn't hit me in a few years since I left."

She said it exactly like that: calm, matter-of-fact, with a faint smile that seemed less like a mask and more like a social reflex. Not humour exactly. But not resignation either. Something in between perhaps?

I felt the consultant's presence behind me, still and quiet.

I cleared my throat gently.

"Thank you for telling me that, Mrs Sharma. That must have been difficult."

She shrugged. "It's finished now. That is what matters." Her tone didn't invite probing, but it didn't forbid it either.

I took a slow breath, steadying my voice.

"Do you feel safe at home now?"

"Oh yes," she said immediately. "Very safe. I have a small apartment, very peaceful. I keep sunflowers outside on my balcony." She smiled faintly. "Not real sunflowers, just little ceramic ones. They remind me of my father's farm back in Gujarat. He used to say that the bees on the sunflowers only sting when they feel trapped. People are similar, I think."

I nodded, though I wasn't entirely sure what she meant.

Her chart told me she lived alone. No partner, no children. No family in Australia except a distant cousin in Melbourne.

But if she felt the absence of these things, she didn't show it.

"Any numbness in the legs? Changes with walking?" I continued, careful to let the clinical rhythm guide us back.

"Some numbness, yes. But I thought it was age. Everything becomes a little uncertain." She paused. "Tell me honestly, Mr. Future Doctor, will this surgery help?"

I did not know the answer. "I think it will," I said, and meant it.

She exhaled, long and controlled. "Good," she said. "Because I want to walk again to the little market near my home. That is all."

In that moment, the ward felt strangely intimate – not because she had revealed her history, but because she had revealed so little of it, yet trusted us with enough to understand what mattered to her now.

But the encounter unsettled something in me, not quite because of the violence she mentioned, but because of the ease with which suffering can hide inside routine clinical questions. A red-flag checklist had suddenly revealed a life that could not be summarised in any rubric.

And I realised, perhaps for the first time, how close medicine always is to stories we are not fully trained to hear.

Part II: The Orthopaedic Ward

The orthopaedic ward is not, on paper, a dramatic place. It is a geography of repaired hips, plated fractures, prosthetic joints, and rehab plans. But standing in it as a medical student, you begin to notice its quieter architecture: the rhythm of morning rounds, the choreography of allied health, the way certain types of lives seem to appear in particular beds with almost predictable regularity.

Older women, in particular, appear often.

They arrive from apartments and townhouses and aged-care facilities, sometimes from homes they once shared with families who now live in other cities, other countries, other lives. Their notes mention things like "mechanical fall," "decline in mobility," "awaiting placement," words that compress years of shifting roles and shrinking social circles into concise, administrative phrases.

Mrs Sharma was one of them. On the electronic whiteboard, her name appeared in the same font, the same size, as every other patient. Next to it, a few tags: "72F," "THA tomorrow," "lives alone," "no NOK listed."

In handover, she was "the Indian lady with the bad hip," a shorthand that was not malicious, but efficient.

What the board could not show was the balcony with its ceramic sunflowers, or the small market she wanted to walk to again. What the handover could not capture was the way she spoke about her life as if it were an arrangement she had quietly agreed to, rather than something that had gradually narrowed around her.

Hospitals tend to flatten differences. Patients are sorted into bed numbers, listed by procedure, triaged by urgency. We talk about them in clusters: "the NOFs," "the revisions," "the day-three post-ops." Even as a student, you start to absorb that taxonomy. It is how the ward keeps moving.

But when you stand long enough at the foot of a bed, the categories begin to fray.

There is the man whose fall was preceded by six months of drinking alone after his wife died. The woman who delayed coming in because there was no one to feed her cat. The father who kept postponing sur-

gery until his adult children could align their leave calendars. The clinical codes are the same- fracture, osteoarthritis, pain – but the lives behind them are not.

As students, we hover at the edges of this system. We do not write orders; we do not sign discharge summaries; we do not negotiate bed flow. Our only real currency is time. So we spend it where the system is thinnest: at the bedside, in the pauses between obs rounds, in the small pockets of quiet that open after the registrar leaves and before the porter arrives.

It is in those pockets that people like Mrs Sharma come into focus.

On the ward plan, she was a routine case: pre-operative optimisation, spinal anaesthesia, total hip arthroplasty, mobilisation with physio on day one, discharge planning by day three or four. Nothing about her trajectory suggested crisis. If anything, she was seen as one of the "straightforward" ones: cognitively intact, medically stable, polite, compliant.

And yet, in the short stretch of conversation between "When did the back pain start?" and "Do you feel safe at home?", an entire unspoken world appeared. Past violence, present solitude, a carefully negotiated version of safety that depended less on services and more on distance.

What unsettled me was not that such a life existed- I knew, abstractly, that it did – but that it could move so smoothly through the machinery of care without leaving much trace. Progress notes recorded her pain scores, her mobility, her wound status. Social work documented her address and her lack of local family. Nowhere did it quite capture what she herself would later articulate: that safety and loneliness can be indistinguishable; that support, for her, meant nothing more elaborate than being remembered.

Looking back, I realise that Mrs Sharma did not simply occupy Bed 12. She occupied a fault line in the ward's logic: a place where the demands of efficiency, the pressures of discharge targets, and the quiet enormity of a life lived largely alone all intersected.

Standing at that intersection as a student, I could not fix anything. I could not change her discharge destination, conjure a support network, or redraft the structures that made her story appear as a footnote in the medical record.

What I could do was notice her.

And- though I did not yet understand it fully – that noticing would become the lens through which I interpreted much of what followed.

Part III: Assumptions

I saw Mrs Sharma again three days later. She was sitting by the window this time, her shawl folded neatly over her lap, watching the afternoon sun fall across the carpark. Her hip surgery had gone well. The back pain was still lingering.

"Ah, my medical student," she said when she saw me. "Come. Sit. You look tired."

"I'm alright," I said, pulling up a chair. "How are you feeling today?"

"Like someone replaced my hip with a brick," she said, smiling. "But a good brick. A strong brick."

I laughed softly. She gestured for me to sit closer.

"You live alone, right?" I asked, picking up from my notes.

"Yes," she said. "Very peaceful. Very quiet."

"Do you have anyone who visits? Neighbours? Friends?"

She nodded vaguely. "People come and go."

"And family?" I asked gently.

Her expression changed, nothing dramatic, just a small tightening around the eyes.

"I had a son," she said.

The room seemed to still.

I looked up from my notepad. "You had a son?"

"Yes," she said. "Some years ago now."

She didn't elaborate. We sat for a moment with the weight of that simple sentence.

Finally, she continued. "I lost him before he was born."

She paused. "There was ... an accident."

I nodded, unsure of what to say.

"It was not really an accident," she said quietly. "He pushed me. I fell." She made a small downward gesture with her hand, like dismissing crumbs from a table. "I knew immediately. Women know these things."

I swallowed. "Mrs Sharma ... I'm so sorry."

She looked at me then, not with sadness, but with something flatter, older.

"You are kind, Spartan," she said. "But it was long ago. The body forgets slower than the mind."

I stayed silent. It felt like the only honest response.

She shifted slightly on the pillow. "When I told you the other day

about my ex-husband, you looked worried," she said, almost amused. "You thought you understood something about my life."

I felt my face warm. "I ... I wasn't sure what to think."

She nodded. "Yes. That is the problem, isn't it? People are always quick to think."

Her tone was not unkind, just matter-of-fact.

"You saw a sentence. A small sentence. And you made it a story."

I opened my mouth, then closed it. She was right.

"I don't blame you," she said. "Doctors do this. You have to. You make patterns. You find sense."

She leaned back against the pillow.

"But sometimes the truth is not a pattern. Sometimes it is just ... pieces."

I looked down at my notes, suddenly aware of how cleanly they divided her life into headings – Social History, Past Trauma, Lives Alone – none of which captured the silence between her words.

She watched me for a moment. "Do not feel guilty," she said softly. "Just listen. That is enough."

A nurse came by then to check her observations. Mrs Sharma closed her eyes briefly as the blood pressure cuff inflated around her arm.

Before I left, she said, "You asked me if I feel safe at home. I do. Very safe."

She paused.

"But safety and loneliness sometimes look the same. That is the part doctors sometimes forget."

I stood there longer than I meant to.

I had come thinking I understood something of her story.

But all I had understood was the shape of my own assumptions – the way I reached for meaning before I had earned any right to it.

Part IV: Loneliness

Sir William Osler once observed that "the practice of medicine is an art of probabilities and an art of observation."[1] The line is often quoted for its humility, but what is overlooked is its implicit warning: that illness is shaped not only by biological processes but also by the social ecologies in which people live. In recent years, loneliness has emerged as one of the most potent- and least visible – of those ecologies.

Far from being a purely emotional state, loneliness is now recognised as a determinant of health with measurable physiological signatures. A landmark meta-analysis by Holt-Lunstad et al. demonstrated that social isolation increases mortality risk to a degree comparable with established risk factors such as obesity and smoking.[2] Neuroendocrine research reveals chronic loneliness to be associated with heightened hypothalamic–pituitary–adrenal axis activity, elevated basal cortisol, and impaired diurnal recovery.[3] Social neuroscientists have described it as a state of "hypervigilant social monitoring," wherein the brain, anticipating threat, amplifies pain perception and disrupts immunological homeostasis.[4]

Yet loneliness remains largely invisible in clinical encounters.

It does not appear on drug charts.

It is not quite captured by vital signs.

And it seldom receives the interpretive attention given to hypertension, glycaemic control, or fracture risk.

This is not because clinicians are indifferent, but because loneliness resists the classificatory logic around which modern medicine is organised. It is diffuse rather than focal, chronic rather than acute, and revealed most clearly in the negative space of a patient's history: the absence of emergency contacts, the hesitations around discharge planning, the silence when one asks who will be home after surgery.

In many ways, loneliness functions as a kind of background pathology: a condition that shapes the trajectory of other conditions without announcing itself as primary. It alters pain thresholds, delays help-seeking, interferes with rehabilitation adherence, and modulates the emotional bandwidth with which patients absorb complex information.[5] Unlike traditional risk factors, however, it often presents through narrative rather than symptom: through the asymmetry between what is said and what is withheld.

As a medical student, I initially recognised loneliness as a social problem; later, I came to understand it as a biological one. But only in my exchanges with Mrs Sharma, did I begin to see it as something else entirely: an epistemic problem.

Loneliness shapes not only how a patient feels, but how they are able to tell their story, how much of their life they can place into language, and how much the clinician is permitted, or able, to know.

This reframing has consequences. It means that clinical listening is not simply about extracting facts; it is about recognising the constraints under which those facts are offered. It means that disclosure is not synonymous

with comprehension. And it means that a patient's narrative is not merely incomplete but structurally conditioned by the relational deficits that surround them.

This is the analytical terrain that Mrs Sharma's case returned me to: not trauma, but the distortions produced by solitude, and the way a life lived largely alone thins the boundary between what can be said and what must remain implied.

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Part V: Origins

A day or two later, I found Mrs Sharma sitting more upright than before. A paperback rested on her lap, folded in the middle as though it had been paused rather than read. She looked up when I approached.

"You walk loudly," she said, a small smile creeping across her face.

I sat beside her. "I didn't mean to disturb you."

"You didn't," she said, adjusting the edge of her shawl. "I was only thinking. A dangerous activity at my age." Her tone was light. "You said you have a younger sister," she continued, waving a hand for me to sit properly. "Tell me about her."

I described my sister – her interests, her uncertainty about what she wants to do in life, and some other things in between. Mrs Sharma listened with an attentiveness that made the story feel weightier than it was.

"She is lucky," she said softly when I finished. "To have so many beginnings."

She pressed her palm against her hip with a slight wince, then looked out the window, following something only she could see.

"I was the oldest of four," she said. "Three younger brothers. Always shouting, always running. My mother used to say raising them was like trying to keep birds inside a house."

A faint amusement warmed her voice. "I was quiet. Or maybe just observant. My father grew sunflowers in Gujarat. I think I told you this already. In the summers, the whole field would turn its face towards one direction."

She paused, as if listening for something inside the memory.

"We were poor. Very poor. But it did not feel like poverty then. We had noise. We had people."

She glanced at me. "Noise hides many things."

"What did you do before coming to Australia?" I asked.

"I taught primary school," she said, straightening slightly. "Class Two. Children with handwriting like earthquakes."

Her eyes brightened for a moment. "They would bring me marigolds from their gardens. Always crushed a little from the walk. Always given with so much seriousness."

"And why did you stop teaching?"

"I married," she said simply.

"And you moved here with him?" I asked gently.

"Yes. He had an uncle in Sydney who sponsored us. I thought it would be temporary. I thought we would return home after a year." She laughed quietly. "Life enjoys tricking confident people."

"What was it like when you first arrived?"

She looked straight ahead. "Quiet. Too quiet. Australia felt like someone had pressed mute on the world. No neighbours calling out. No children tugging at your sari. Just wide streets and polite people who never asked too many questions."

She shifted the shawl again.

"But enough of me," she said abruptly, turning the conversation. "Tell me, what do you want to become? Surgeon? Cardiologist? Something that sounds impressive at parties?"

I hesitated, then gave her the truth. "I'm not sure yet."

She smiled, approving.

"Good. People who know too early become rigid. Allow yourself to be changed."

She leaned forward conspiratorially.

"Do you want to know something?"

I nodded.

"When I taught children to write their names, the first thing they did was grip the pencil too hard. They pressed and pressed until the letters looked angry. But when they finally learnt to loosen their fingers, the name became clear."

She looked at me knowingly.

"Don't grip the future too hard. Loosen. It will write itself."

Then she surprised me again.

"Do you fear growing old?" she asked.

"I ... haven't thought about it," I admitted.

"You should," she laughed. "It is the one future you can rely on. Well ... that and taxes of course"

Her voice softened into something philosophical. "And what about death?" she asked suddenly, her tone almost curious. "Do you fear that?"

"I suppose I'm not sure?" I said. Then I corrected myself. "Yes, sometimes."

"Why?"

"Because you lose things?" I said, but it was more of a question than an answer.

She tilted her head.

"Ah. That is what young people say. Older people understand that death is not losing things –" she paused, searching for the right phrasing, "– it is returning things. Your worries, your disappointments, your unfinished dreams ... all given back to the world. The good as much as the bad."

Her eyes drifted toward the window.

"What remains is only how you touched people while you were here."

"And what remains for you?" I asked softly.

She considered the question with tenderness.

"A few students whose names I still remember. My father's sunflowers. And the knowledge that I have survived more than I thought I could. A marriage that made me happy for a time. A husband that I loved for a time. A son that I had for a time ..."

A long silence unfolded.

Finally, she lifted the cold hospital tea, took a sip, grimaced, and set it down.

"Terrible," she said. "Hospital tea tastes like punishment."

I laughed more loudly than I meant to.

"And ageing," she added, her eyes brightening mischievously,

"tastes exactly like hospital tea. Bitter, but survivable."

I stood to leave. She adjusted her shawl one last time.

"Go," she said, waving me away. "See the other patients. Learn other stories. If you listen only to me, you will become old before your time."

I turned to go.

But as I reached the doorway, she spoke again, very softly:

"Just don't forget what I told you ... about loosening your grip. Life is easier to hold when you hold it lightly."

She wasn't looking at me anymore. She was gazing at the late-afternoon light on the window, as if remembering a time when it warmed an entire field of sunflowers.

Part VI: Mrs Sharma's discharge

When I returned to the ward later that week, Mrs Sharma's bed was already half-stripped, her belongings packed neatly into two small bags arranged with the precision of someone accustomed to managing with little. A nurse was removing her cannula. The chart sat at the foot of the bed, folded open to the discharge summary draft.

"You're escaping," I said gently.

She gave a tired smile. "Hospitals are good places to visit, not to stay."

I pulled up a chair. "We're organising some physiotherapy for you. And community supports, if you'd like them."

She waved a hand lightly. "Supports are for people who have families to disappoint. I'll manage."

I hesitated. "There are services that don't require family, like home visits, outreach physiotherapy, social work follow-up –"

She shook her head. "Dear, all those people are very busy. For someone like me, it is simpler to just cope."

I tried again. "Is there anyone we can notify? Anyone who should know you're going home today?"

She paused, her fingers brushing the edge of her shawl.

Then: "There is one person," she said. "But he won't come."

"Who is he?" I asked softly.

"My son's father," she said. "He lives near me now. Two suburbs away."

I blinked. "Your ex-husband?"

She nodded slowly.

"You still have contact with him?"

"No," she said. "Not really. But I see him sometimes. At the market. At the pharmacy. On the footpath. He still buys the same brand of rice as when we met."

She looked at the window rather than at me.

"He pretends not to notice me. I pretend not to notice him. And this … this is what counts as safety now."

There was no bitterness in her voice.

I then recognised that safety, for her, was not an absolute state but a negotiated distance.

"Do you feel comfortable going home?" I asked.

She nodded. "Yes. He is more scared of aging than I am of him. Time changes the balance of things."

Then she added, almost absent-mindedly, "He used to say I was too weak to live alone. So every day I stay alive by myself, I win. And I like winning."

I didn't answer immediately. I wasn't sure what to really say.

"Mrs Sharma," I said finally, "we want you to be supported. Not just safe, but supported."

She looked at me with a gentleness that felt like a small mercy.

"You are a good student. But you think support means someone must come into my home."

She shook her head.

"No, dear. Support is simply someone knowing I exist. Someone remembering my name."

She reached for the discharge papers and scanned them with surprising decisiveness.

"Everything is here," she said. "Pain medication, physio referral, follow-up appointment."

I cleared my throat. "If you ever need any sort of help, you should really come back. Or call. Any time."

She touched the back of my hand in a gesture so light it barely registered.

"Thank you. But I have lived alone long enough to become very good at not needing."

The orderly arrived with the transport chair. She gathered her bags. As she was being wheeled toward the lifts, she turned back slightly, as if to say one final thing.

She smiled – small, still worn, but unmistakably sincere.

"Take care, doctor-student. And especially take care of those who live alone"

She disappeared around the corner. I never saw Mrs Sharma again.

Part VII: The Room With No Monitors

A week after Mrs Sharma went home, I presented her case in a small-group teaching session – one of those late-afternoon tutorials where the fluorescent lights feel a fraction too bright and everyone is a little too tired to pretend they are not thinking about going home.

There were eight of us, plus a general physician who facilitated the group. The stated aim was "clinical reflection," which in practice meant bringing a patient to mind and examining, together, what had happened, not just medically, but relationally.

I started with the basics.

"Seventy-two-year-old woman," I began, "originally from India. Severe hip osteoarthritis. Admitted for elective total hip replacement. Also complained of chronic back pain."

I described our first conversation, the red-flag questions, the remark about her ex-husband "not hitting her anymore." I described the second encounter, the history of the fall, the son lost before birth. Then I quoted her sentence: "Safety and loneliness sometimes look the same."

There was a brief silence when I finished.

The facilitator leaned back in his chair.

"What made you bring this case?" he asked.

I hesitated. "I think it unsettled me," I said. "I thought I understood something about her after that first conversation. But I didn't. And I'm not sure what I missed, or what I should have done differently."

He nodded once, then turned to the group. "What are you all hearing in Spartan's description?" he asked.

One student said, "She sounds incredibly resilient."

Another said, "I'm worried about her going home alone. Did anyone check on domestic violence risk?"

A third pointed out, "She declined extra services. Maybe we have to respect that."

The facilitator let the comments accumulate without judgment, then

turned back to me. "What story did you make, after that first day?" he asked.

I thought for a moment. "I suppose I decided she was a survivor," I said. "That she had escaped something dangerous and built a life around being safe."

"And after the second conversation?"

"I realised I'd simplified her," I answered. "I'd turned her into a narrative about resilience when, actually, her life is … messier. Less resolved."

He smiled slightly. "That's an interesting word – resolved. What makes us so keen to resolve other people's lives?"

No one spoke for a few seconds.

Finally, another student said, "Maybe because it's easier to live with a simple story than with fragments."

The facilitator nodded. "Especially when you're tired. Or scared. Or busy."

He looked back at me. "What did you feel when she told you about the pregnancy? Not what you thought. What you felt."

I searched for a precise word and came up short. "Ashamed," I said slowly. "Not of her. Of myself. For thinking I'd seen enough of her to know what her life meant. For treating that one sentence about her ex-husband like a key that unlocked everything."

"Did she ask you to understand her?" he asked.

"No," I admitted. "She told me not to feel guilty. She said, 'Just listen. That is enough.'"

"Sometimes," he responded, "our job is not to interpret the patient. It's to notice our urge to interpret, and not obey it too quickly."

He drew a small diagram on the whiteboard: three concentric circles.

"In here," he told us, shading the centre, "is what the patient tells you in words. Around that is what they cannot or will not say, because of fear, habit, culture, language, loneliness. And around that is what you imagine you've understood."

He circled the outer ring.

"This," he said, "is where students and doctors alike regularly get into trouble."

We laughed, but it was the kind of laugh edged with recognition.

"What Mrs Sharma seems to have given you," he continued, "is a glimpse of the middle circle, the gap between what she lives and what she can offer you in clinic-friendly sentences. You can't close that gap. You're not meant to. But you can be aware that it exists."

On the tram home that evening, I thought about the three circles. I thought about the way Mrs Sharma had watched the world from the window-side of her bed, how she had spoken about her ex-husband without anger, how she had defined support as "someone knowing I exist."

I realised that my discomfort was not just empathy; it was the friction between my desire to make sense of her and her quiet refusal to be summarised.

In that small teaching room with no monitors and no obs to chart, the case I had brought as a story about domestic violence and resilience shifted into something else: a lesson in how easily a well-intentioned listener can overreach. How quickly we can turn a patient into a parable, a metaphor, a test of our insight.

What stayed with me was the facilitator's final comment before we left.

"Your task," he urged us, "is not to be the person who finally understands her. Your task is to be one of the people who did not step back when her story became difficult to bear."

'Frankenstein', I thought to myself.

On the ward, that had felt abstract.

In the classroom, it felt like a quiet directive.

And for the first time, I began to see that reflection in medicine is not about cleaning up the story until it aligns with theory.It is about learning to live with what remains unresolved, and letting that discomfort change how you stand at the next bedside.

Part VIII: The Anatomy of a Medical Student

Medical students, I began to realise, inhabit a small approximation of stillness. Not because we are inherently reflective, but because we have not yet accumulated the internal momentum that makes clinical life move quickly. Our attention remains unarmoured, uncompressed, porous by default. We do not know enough to filter out what is "irrelevant," and so nothing fully is.

Our ignorance, which feels at times like a liability, is also a peculiar vantage point: it leaves us receptive to aspects of a patient's story that lie outside clinical priority- tone, asymmetry, small hesitations, narrative omissions. These subtle inflections rarely survive the pace at which experienced clinicians must work.

In cognitive anthropology, such receptivity is sometimes termed "open monitoring": a pre-structured awareness that perceives patterns before assigning meaning.[1] Students live in this mode almost unconsciously. Before we learn algorithms, before experience thickens into tacit knowledge, we hover in the pre-diagnostic space where patients appear not as problems but as presences.

That state is temporary.

Left unexamined, it decays.

But recognised early, it can be cultivated into something durable – a deliberate, disciplined version of what once occurred accidentally.

This became clear only after Mrs Sharma's discharge. Her story unsettled me because of the ease with which I had attempted to shape it. I had taken the fragments she offered and begun constructing an interior narrative, confident that attentiveness alone justified interpretation. What I had mistaken for clinical intuition was simply the mind's intolerance of ambiguity.

Students are vulnerable to this impulse- to confuse receptivity with comprehension.

But the answer is not to abandon that receptivity; it is to refine it.

To preserve enough uncertainty to let a patient remain partially unknown.

What patients like her reveal is that the early years of training are not merely the prelude to competence; they are a distinct cognitive phase in which the capacity to apprehend the human dimensions of illness is at its widest. The challenge is to prevent that width from collapsing as knowledge accumulates.

To carry that unguarded attentiveness into senior years – to resist the pressure to see only what is clinically necessary – is, in many ways, the challenge of modern medicine. Not anachronistic sentiment, but the preservation of perceptual breadth amid the narrowing demands of expertise.

And perhaps this is the real work of becoming a clinician: not the acquisition of certainty, but the preservation of a mind wide enough to perceive what certainty cannot fully explain.

Part IX: Mrs Sharma's Note

Two weeks after she was discharged, an envelope arrived at the ward clerk's desk. It was small, the edges softened by travel, the handwriting narrow

and deliberate. It had been addressed simply to "Orthopaedic Team: For Whom It Concerns."

The consultant slit it open during morning handover and unfolded a single sheet of lined paper. She read it silently, then passed it across the table toward me without commentary.

The note was written in blue ink with the most beautiful cursive handwriting you had ever seen.

> To the doctors and nurses who cared for me,
> I wanted to say thank you for my treatment and for the attention you gave me while I was in hospital. My hip is improving every day, and I am doing the exercises as instructed.
>
> I also wish to thank the young medical student who spoke with me during the afternoons. You may not realise this, but your visits made the days feel shorter. It is not often that someone has time to sit with an old woman and ask questions without rushing.
>
> Please continue your good work. And of course, don't work too hard!
>
> Yours sincerely,
> Mrs Kavita Sharma

There was nothing elaborate in it.

No revelation, no confession, no sentiment beyond what was carefully chosen.

Yet the brevity carried a weight that theatrical gratitude never could-because it came from a woman who had so rarely been given the space to thank anyone at all.

I folded the note and slid it back into its envelope.

The consultant moved on to the next task; the ward resumed its usual rhythm.

Mrs Sharma had left the hospital exactly as she had lived: self-contained, undemanding,

dignified in her solitude. But she had also left an unexpected trace – a reminder that even the smallest fragment of attention can alter the texture of someone's loneliness, if only for a few days.

And in the end, perhaps that is the part of care we never learn formally, the part no curriculum can codify: that sometimes the most meaningful effect we have is not in solving someone's pain, but in briefly accompanying it.

Part X: Who Was Mrs Sharma, and What Did She Teach Me?

I have often tried to reconstruct the exact moment I last saw her, not out of any particular sentimentality, but because it feels important to know whether I recognised it as a final moment, or whether I let it slip past me like so many things in the hospital do.

I remember the shawl.

The bags lined neatly at her feet.

Her smile, tired at the edges but still steady.

The way she touched my hand, briefly, lightly, as if to confirm that I was real, and not another passing figure in a corridor she would soon forget.

And then she was gone.

In the weeks that followed, I kept her note folded in the back of my binder, as though proximity could preserve something. Yet the hospital absorbed her absence with the indifferent elasticity that institutions develop out of necessity. Another patient filled the bed. Another chart replaced hers. Another story demanded its turn.

But I did not absorb her absence so easily.

Because the truth is that I still do not know who she was- at least not fully, not with the coherence we often assign to the dead or the departed. I know only the fragments she allowed me to hold: the sunflowers, the marigolds, the son she lost, the marriage that thinned her life into silence, the quiet strength with which she inhabited her solitude.

I know she feared ageing less than she feared being forgotten.

I know she believed that safety and loneliness can look identical from the outside.

I know she understood survival as a kind of biography: the record of what did not break you.

Everything else remains beyond my reach.

And perhaps that is the point.

Perhaps the purpose of meeting her was not to assemble her into a coherent narrative, but to confront the limits of my own desire to do so. To learn that not all stories come with revelations. Not all lives can be organised into lessons. Not all patients can be "understood" in the way medicine quietly encourages us to try.

Some must remain partially unknown, not because they were concealed, but because understanding is always incomplete.

What she taught me, I think, was something quieter. Something I had not realised I was learning until long after she left.

She taught me that patients do not enter our lives as characters in need of interpretation.

They enter as people who existed long before we arrived, whose losses were already carved, whose memories already patterned, whose silences were earned through years we did not witness.

She taught me that accompaniment, not comprehension, is sometimes the highest form of care.

And she taught me that the stories patients offer us are not gifts; they are risks. Risks taken in the hope that someone will hold at least a corner of their loneliness, even briefly.

There is a line I once read – I cannot place where – that said:

"We remember people not as they were, but as they felt beside us."

Mrs Sharma felt like a late afternoon light. Dim, but steady. A presence that asked nothing except that I sit long enough for silence to do some of the speaking.

In the end, what she taught me is painfully simple:

That medicine is an unending act of letting go: of patients, of certainties, of the illusion that empathy can ever be complete.

And that what hurts the most is not the letting go itself,

but the realisation that you rarely know, in the moment,

what it is you are letting go of.

I think about her more often than I admit.

Not out of grief, but out of gratitude, a strange, quiet gratitude that she let me witness a part of her story, however small, however incomplete.

Who was Mrs Sharma?

A schoolteacher from Gujarat.

A survivor of quiet devastations.

A woman who carried her loneliness with dignity.

A patient who trusted a stranger with fragments of her life.

And what did she teach me?

That I must hold my future lightly.

That survival is its own form of authorship.

That accompaniment matters more than interpretation.

That, in medicine, the most important stories are those we may never fully know.

And that in the end, through love, loss and life, all our borrowed worries

and apprehensions are returned to the same stardust from which they were conceived.

Epilogue: Forgiving Frankenstein

When *Frankenstein* ends, Shelley leaves us with the creature standing over his maker's body, speaking not with vengeance, but with something closer to grief. He does not ask for absolution; he asks only to be understood- and recognises, in the same breath, that he never was.

But what has always interested me is the moment just before the ending, when the creature describes his long search for companionship. "I was benevolent," he says, "and good; misery made me a fiend." It is the clearest articulation in the novel of what loneliness can shape in a person- not monstrosity, but distortion. Not violence, but estrangement from one's own voice.

For a long time, I assumed the novel's lesson was about responsibility.

But after meeting Mrs Sharma, I see that it is also about forgiveness.

Not moral forgiveness, but epistemic forgiveness, an acknowledgment that we will always fail, to some degree, to understand the full interiority of the people before us. Not because we lack compassion, but because human lives exceed the interpretive tools we bring into the room.

Mrs Sharma never asked me to understand her life.

She asked only that I sit close enough that she did not disappear inside it.

And that, I think, is where the forgiveness lies: in recognising our limitations without retreating from them. In resisting the instinct- Frankenstein's instinct – to step back when something or someone appears in a form we cannot immediately decode. In accepting that our task is not comprehension, but proximity; not certainty, but the willingness to remain with another person in the unsettling space before their story becomes legible.

If the beginning of this essay asked what it means to face the unfamiliar- to look into a life that has not yet offered its meaning – the ending offers a quieter answer. The work of medicine is not always to master that unfamiliarity, nor to resolve it into clarity, but to move toward it without the expectation of mastery.

This, I have come to believe, is the clinician's version of forgiveness:

to remain close, even when understanding is imperfect;

to listen, even when the story arrives in fragments;
to accompany, even when the path ahead remains obscure.
In medicine, we are asked again and again to choose:
to step back from what we cannot yet understand,
or to step forward into the space where understanding may never fully arrive.
The difference may seem small.
But in the lives of patients like Mrs Sharma, it is everything.
And perhaps that is the forgiveness Shelley hoped for:
not that we become perfect interpreters of another's suffering,
but that we learn, with humility, to stay.

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