Donald E. Nease, Jr.,
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The Student, the Patient and the Illness

Ascona Balint Award Essays 2024

Psychosozial-Verlag

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Awarded by the International Foundation
Psychosomatic and Social Medicine

With a foreword by Tove Mathiesen
President of the International Balint Federation (IBF)

Psychosozial-Verlag

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Content

Part I
Essays of the Three Winners 2024

Part II
Essays 2024

Foreword

Welcome to all new readers of the Ascona students essay book series. Students, teachers, young and old, unexperienced beginners and experienced Balint group leaders.

I want to recommend you this book that will take you to the frontiers of young doctors' experiences in relation to their patients, and their reflections on the many complicated dilemmas they face during their early clinical experience.

We all remember this position, and we also recognise the dilemmas clinical and ethical, that are described, and that we must face during our whole professional life.

This is the reason why the Ascona students essay book is awaited with joy and excitement between experienced clinicians, and the reason why IBF is honoured to join the Ascona foundation in the publication of this booklet's series. The membership in a Balint groups as a basic perquisite for the work as a doctor and for the maintenance of the doctor himself is a long term and appreciated working tool.

I hope that you will enjoy this book, share it with all your young students and your colleagues in the institutes and all over the world where clinical work takes place.

Congratulations to the three winners of the Ascona award 2024. I'm looking forward to meeting all of you at the IBF-conference in Boulder/Colorado September this year.

Tove Mathiesen
President of the International Balint Federation

Introduction

Once again, it is a particular pleasure to be able to present the results of the "Ascona" international student essay competition through this book. There were 36 essays submitted by students from 11 countries, each detailing moving experiences from their relationships with patients.

The awards and presentations by the prize winners will be held at the Congress of the International Balint Federation in September 2024 in Boulder, Colorado USA.

The winners of the Award are (in alphabetical order):
Mateus Menezes dos Santos from Brazil
Julian Neugebauer from Germany
Dikshya Parajuli from Nepal (studying in New Zealand)

As was done with the 2022 Awards, these essays were equally deserving and the jury decided to distribute the price money of 5,000 CHF equally.

The three winners are invited to the 23rd International Balint Congress in Boulder, Colorado. They will present their papers there, take part in the Congress and the Balint group work.

You will find the three essays in Part I of this book.

In Part II we present 10 more essays written by students from different countries, which had high rankings.

An international group of reviewers consisting of experienced Balint Group Leaders from different National Balint Societies performed the initial evaluation and rating of the student papers, by using a scale of defined criteria according to the announcement of the Award. Subsequently, a jury with representation from the International Balint Federation and the Foundation for Psychosomatic and Social Medicine selected the award winners.

Thanks to all who participated in the reviews and award selections. This was a valuable and competent work reading and rating the student essays, a model for our international partnership.

The Ascona Prize is awarded as a partnership between the International Foundation Psychosomatic and Social Medicine, based in Switzerland, and the International Balint Federation (IBF).

It is an important goal of both institutions to focus and improve the student/doctor-patient-relationship. To start early in the training with taking the "Doctor as a Drug" into account is important. As we can see and feel through the essays in early years it is a heartfelt need to understand more about the patients and oneself. This is the case worldwide.

The Foundation and the IBF are pleased to have brought this work together again to an impressive result – the number of works received, the commitment of the students, the impressive encounters and relationships that are presented are evidence of the worthwhile outcomes of the effort to design and offer this prize again and again.

This volume also serves to set a stimulus among the students in and through the National Balint Societies. We are happy to offer them to all Universities. Besides the announcement in the media for the next call for applications for the year 2026 there will be a link or form to order copies of this book on our websites www.foundation-ps.com and www.balintinternational.com

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Part I

Essays of the Three Winners 2024

All the Good Things, but Solitude

Mateus Menezes dos Santos

At the beginning of my second year of medical school, my desire for more opportunities for practical activities and the improvement of human skills led me to co-found an Academic League of Narrative Medicine, based on the principles of Rita Charon. The aim was clear: to establish a space for sincere dialog between students and patients. The conversation takes place at the university's pediatric infectious diseases clinic. Even before the patients were seen by the doctors, our meetings provided a unique opportunity to connect, far from the formality of a medical history. The professors in charge asked for the patients' permission beforehand, respecting their privacy and autonomy. In a private room, we students gave ourselves over to the art of empathetic listening, hoping to understand not only the clinical manifestations of diseases, but the human stories that surrounded them. After these conversations, we wrote chronicles or any other type of literary production about this meeting and then met as a group to discuss and share our experiences.

Longitudinal follow-up of children and adolescents who have contracted HIV through vertical transmission is very common in this clinic. One day, at one of these meetings organized by the Narrative Medicine Academic League, I was introduced to a mother who accompanied her son to all his appointments. I'll call them Eliza and Ruan, who was not in the room at the time of the conversation because only his mother agreed to take part. Eliza, a 55-year-old brown woman, wore a sad, worried expression, with a penetrating, frightened look that revealed the complexities of her journey as a caregiver for a son with HIV. Upon entering the room, the first observation that caught my attention was the fact that Eliza was wearing two N95 masks, even during a period of low COVID-19 contagion and with the boiling heat outside. This behavior clearly reveals her extreme concern not only for her own protection, but above all for the safety of her son.

* * *

As students in the first few years, we have more openness and time for more subjective and in-depth conversations about the non-physiological aspects that permeate patients' lives. However, when I observe older doctors and professors, I realize that this possibility disappears over time as we progress through the course. Medical practice, often shaped by logistical issues and high demand in the single health system, especially in a country of continental dimensions like Brazil, becomes marked by quick consultations focused exclusively on the pathophysiology of the disease. The need to attend to a large volume of patients often limits the depth of interactions, directing the focus towards adjusting drug doses and requesting complementary tests to ensure disease control.

This transition throughout the course highlights the challenges faced in managing the gap between paying attention to the patient's subjectivity and ensuring the efficiency needed to meet the demands of the health system. It is a reflection on how, as we move forward, medical practice can move away from the richness of narratives to the detriment of the flow of care.

There in the room, alone with the patient, I felt enormously responsible. It seemed that the environment transcended the physical space of a few square meters. Although I was aware that my role did not involve prescribing medication or making clinical decisions, the feeling of responsibility was gigantic. It was clear to me that, at that moment, I wasn't just a medical student; to her, I represented the institution and, in a way, a medical professional, albeit one in training. The loneliness shared in that space resonated with the patient's vulnerability. I was alone for the first time with a mother, a guardian who was deeply concerned about the health of the human being she loved most in the world: her son. Even though it was a follow-up appointment, I realized the immense emotional charge that permeated that encounter. At that moment, I viscerally understood the magnitude of the trust that patients place in their doctors.

The patient's vulnerability in front of us, students and health professionals, is a fine thread that connects medicine to the most human essence of existence. In these initial moments, the mother exposed her greatest fears and worries, confiding not only her clinical concerns, but also the emotions echoing in her chest because of her son's medical condition. This experience highlighted the delicacy of this relationship of trust between doctor and patient, showing that, in addition to technical knowledge, the ability to be compassionate and receptive to vulnerabilities is fundamental to truly humanized medical practice. After all, being vulnerable in front of another person is one of the most intrinsically human expressions and, at the same time, one of the most precious gifts that a patient can offer to those who are attending to them.

At the start of the conversation I wanted to understand everything from the beginning, so I asked Eliza how it all began, how she found out she was HIV positive and what it was like to deal with this reality. She shared an account full of emotions and marked by a series of impactful events. Eliza admitted that she wasn't sure how she contracted the virus, but suspected that it came from a blood transfusion she had to have around the age of 30.

Eliza shared with me her journey as a Jehovah's Witness, a faith that forbids blood transfusions. This restriction initially seemed to be an explanation for not revealing the real means by which she contracted the HIV virus. At a delicate moment in our conversation, I decided to ask her if the people in her religious community were aware of her transfusion, and Eliza, in a quick and visibly embarrassed gesture, confirmed it with her head. Later, when discussing it with my teachers, I realized that Eliza had mixed this transfusion narrative with the possibility of betrayal on the part of her partner at the time. The precise details of the infection remained unclear to us. I understood that my role at the time was not to uncover the intimate details of Eliza's life, especially when this information would not alter her condition that had already been established for years.

The complexity of Eliza's situation vividly illustrated the intersection between religious beliefs, personal relationships and health. As a medical student, I was confronted with the importance of understanding and respecting the diversity of patients' life experiences, recognizing that individual choices and beliefs can significantly influence health care decisions. The ethical dilemma that Eliza faced in relation to her faith and her health condition highlighted the complexities that healthcare professionals can encounter when dealing with religious issues. In a diverse society, where religious beliefs shape people's perspectives and decisions, it is crucial to approach these issues with sensitivity and respect. Throughout our conversation, I realized that Eliza was looking not just for a listener, but for someone who understood the multiplicity of challenges she faced. Her willingness to share her story indicated not only the need for medical support, but also for understanding and acceptance. Although the specific details of the infection remained inconclusive, the experience with Eliza highlighted the importance of a humanized approach in medical practice.

So I decided to continue the conversation respecting her space and prioritizing the information she felt comfortable sharing with me.

The starting point of this story, in her memory, was confused with the emotional news of the birth of her son and the simultaneous and overwhelming diagnosis that she was HIV positive. The moment she received the diagnosis was described by Eliza as a dry run. There was no preparation or any kind of welcome. The flood of information, added to the presence of her baby in her arms, left her dazed and with no prospects of seeking help immediately for her own treatment, she confesses. Apart from the fact that at the time, the therapeutic arsenal and prognosis were different, much more limited, the lack of support at this crucial moment deeply marked her initial experience with HIV. Eliza's story became even more distressing when, three and a half years into Ruan's life, she discovered that her son was also HIV positive. This revelation, according to her, is *"the greatest burden she will carry for as long as she lives."*

An overwhelming sense of guilt accompanies her, even though she knows that the bond between mother and child transcends any form of individual responsibility. This emotional weight has become a constant burden in her journey as a mother and caregiver.

Eliza became emotional as she told me this. This simple but deeply symbolic gesture encapsulated the pain and vulnerability that permeated her story. The tears, along with all the stigma presented by society, were silent expressions of a heavy emotional burden, a testimony to the strength and fragility present in Eliza and Ruan's lives. During our conversation, amid the sweltering 30ºC heat in the stuffy room, the only thing that touched Eliza's mask were her tears. At that moment, I kept myself from bursting into tears with her.

The impactful story of how Eliza was diagnosed with a disease that would forever shape the course of her life led me to reflect deeply on the role we play as health professionals. It became clear to me the absurd influence we have on patients' lives. The way we handle the disclosure of sensitive information can cause significant consequences, leaving deep and lasting marks on their life experiences. That's why it was such a privilege just to be able to listen to what this woman had to say. At this point in our conversation, Eliza looked at me with eyes filled with feelings of guilt and anger at herself, but also with a certain relief at being able to share this very honest feeling with someone. It was at that moment that, for the first time during my medical course, I was able to internalize more deeply the meaning of Carl Jung's famous quote: *"Know all the theories, master all the techniques, but when you touch a human soul, be just another human soul."*

This maxim transcended mere academic learning and came to life in Eliza's emotionally charged, stuffy room. By recognizing her vulnerability and allowing myself to be vulnerable as a listener, I discovered that our shared humanity is a powerful bridge in the doctor-patient relationship.

This episode reinforced the importance of cultivating empathy, recognizing the ethical responsibility we bear and understanding that behind every diagnosis there is a unique and delicate human story. I learned that medical practice goes beyond the application of technical knowledge; it's also about the art of caring, offering emotional support and recognizing the power of human connection in the healing journey.

The atmosphere in the room, now calmer, was charged with the words Eliza shared as her gaze wandered, fixed on a spot on the floor. Between sighs, she confessed to feeling like she was paying for sins, a weight she had carried from an early age as she witnessed her family face disagreements, drug use and financial difficulties. Eliza's anguish went beyond her own HIV status; it was a reflection on a vicious cycle of punishment that permeated her life and that of her loved ones. Eliza's narrative, permeated by a sense of fatality, brought back thoughts of the Buendía family from Gabriel García Márquez's *One Hundred Years of Solitude*. The writer concludes the work with the intriguing phrase, "because the strains condemned to a hundred years of solitude didn't have a second chance on earth". This association made me think about how many people and families, unfortunately, can feel trapped in a cycle of adversity that seems destined to last. I found myself thinking that, beyond magical realism, how many families, in fact, are sadly doomed? What is my role in the face of a tragedy that seems to have been announced and expected by so many families? But I'll tell you later why I disagree with Gabriel García Márquez.

* * *

In order to fulfill my role as a student and offer support to Eliza, I tried to better understand the dynamic between her and Ruan. Asking about their relationship, their aspirations, dreams and everyday aspects, Eliza revealed a close and affectionate bond with her son. She said that she is very close to Ruan and is actively involved in all aspects of his life. She said that Ruan has many friends, yet a shadow hangs over this apparent normality: none of his friends, and not all of his family, are aware of his HIV-positive status. Eliza's persistent fear is that disclosure will lead to some form of exclusion, even in contemporary times with wide access to information about HIV. In a moment of vulnerability, Eliza shared her deepest dream: she wants Ruan to achieve independence and follow his own path. However, even though she longs for him to walk life's journey alone, she confesses the difficulty in loosening this maternal bond. The sincere expression of her feelings reveals the complexity of motherhood in the face of adversity, suggesting a duality between the desire to allow her son autonomy and the fear of abandoning him after so many years of being an overprotective mother.

This revealing conversation highlights not only the practical challenges of Ruan's condition, but also the emotional struggles Eliza faces as a mother. In understanding the depth of these challenges, I realized the importance not only of the clinical aspect, but also of emotional support and building bridges to promote acceptance and inclusion, overcoming the stigma associated with HIV, often from the family itself.

But Ruan is not just a diagnosis: he is a boy immersed in the world of the arts. An active member of an artistic group, he has taken part in plays, attends drawing classes and has an affinity for dance and abstract drawings. Ruan is a young man from the world of ideas, as Plato would say. For Eliza, he represents not just a boy with a disease, but her most precious possession, coloring her world and giving a deep meaning to her existence. This portrait of Ruan highlights the richness of his personality and passions, making clear the importance of seeing the patient beyond medical conditions and valuing the uniqueness and potential of each individual.

I began to question her about emotional support over time, asking Eliza if she had ever considered seeking psychological assistance to deal with the complexity of her relationship and emotional dependence on Ruan. This turned out to be one of the most distressing moments of the conversation because, in my attempt to offer help, I noticed a possible momentary unease in Eliza. After I suggested therapy, she asked: "*No, why? Do I need it?*"

A question followed by a laugh shared between us. The lightness of Eliza's laughter dissipated some of the tension I felt at that moment. To soften the impact of the suggestion, I resorted to medical psychology concepts learned in my first year at university. I explained that it's not necessary for something to be wrong to seek the help of a psychologist. It can also be to maintain balance and preserve what is good. This preventative approach, focused on ongoing well-being, offered Eliza a new horizon. She expressed her willingness to see a psychologist as soon as possible, indicating an openness to considering the importance of mental health in her journey.

Another point I was instructed to ask about was the family support network, which is also very important for adherence and staying with long-term treatments such as HIV. With this in mind, I tried to understand Eliza and Ruan's relationship with his father and brother. When I asked her about her relationship with Ruan's father, Eliza was incisive: "I don't know and I don't want to know. It's just me and my son". This statement, although direct, showed Eliza's decision to preserve her own peace, erasing from her memory any trace of a past that could be painful. Her firm response conveyed the message that certain wounds did not need to be revisited, as they had already healed. During the conversation, Eliza shared an old photo, a relic from when her two children were babies. The image, now recently scribbled on by Ruan and his older brother, revealed an affectionate bond between the two. This expression of mutual affection was a source of pride for Eliza, noticeable even behind the masks that covered her smile. As she complimented them, highlighting the beauty of the babies in the photograph, Eliza leaned her head on her shoulder, proud of herself.

The feeling of having contributed to a moment of lightness and wonder in her journey was priceless. Eliza's proud gaze at the photograph reflected not only the love between her children, but also the resilience and strength that permeated her own journey as a mother. This episode highlighted the importance of recognizing and celebrating moments of joy and connection, even in the face of challenges. Amidst the masks that hid part of their expressions, the exchange of smiles and shared complicity reinforced the beauty present in simple moments of recognition and appreciation in Eliza's complex life. It really was an incredible feeling.

Here, I found myself reflecting on one of the greatest pillars of medicine, which appears in the Hippocratic Oath, which I will take in front of my family, teachers and colleagues when I finish my degree.

"To heal when possible; to relieve when necessary; to console always."

I feel that, even with a few years to go before I graduate, I have managed to put into practice this maxim that is at the heart of medical practice.

Towards the end of our conversation, Eliza shared one of the most difficult moments of her life: when Ruan, due to the virus, spent months with severe communication and locomotion difficulties. Even years after that episode, he still carries a sequel that limits the movement of one of his legs, which becomes a challenge for someone who loves to dance and communicate through his body. That's when Eliza, her eyes welling up with tears again, said that:

"All I asked God for was to see him normal. If I had a study, I'd like to cure him."

It was at that moment that I held back my tears as I thought of all the effort a mother makes to see her son well and to make his dreams come true. I remembered my own mother who, from a distance in another city, makes a huge effort to make me realize my dream of becoming a doctor one day. I thought that at that moment, it was up to me to play the role of the person who recognizes all the work and concern that Eliza has had for her son.

With empathy, I explained to Eliza about the accessible and quality treatments offered by the Brazilian health system, pointing out that both of them, with undetectable viral loads, enjoy a practically normal life in control of the virus. Asking permission, I held her hand, fixed my gaze on hers and shared that I can only imagine how challenging it must be to live her reality. I reinforced the message that she is not alone, emphasizing that her and Ruan's follow-up is a joint effort between patient and doctors. I emphasized that neither she nor the health professionals are solely responsible, but rather partners in this process, cultivating a doctor-patient relationship based on transparency and collaboration. This approach sought to provide comfort and reinforce the importance of mutual support in Eliza and Ruan's journey.

After this moment of intense emotion with Eliza, I felt the need to take a short break for both of us, to get her a glass of water. As I walked down the corridor towards the water fountain, I saw my colleague engaged in a conversation with one of the children who would probably be seen soon. He looked at me like he was in a moment of mutual learning, a deep connection between student and patient. When I returned to the room with the glass of water, I realized that Eliza was already a little more emotionally stable. However, she chose to leave the glass on the table without touching it, perhaps reluctant to remove the mask to drink. This simple, seemingly insignificant gesture reflected the complexity of the emotions and situation we were facing. The constant presence of the masks during the conversation, as well as being a precautionary measure in the midst of the pandemic, became a symbol of the barrier between us and the vulnerability shared by Eliza. The glass of water, offered as a gesture of care, remained untouched, highlighting the delicacy needed when dealing with the emotions exposed during our conversation.

This brief episode in the corridor, marked by the shared glances between my colleague with the child and me, reinforced the idea that, even in busy clinical environments, there is room to learn from every interaction. Each patient, whether a mother like Eliza or a child waiting for care, has valuable lessons to offer, challenging us to cultivate a deeper understanding of the human experience. The experience reinforced the importance not only of addressing patients' medical needs, but also of recognizing the emotional and social complexities that permeate the clinical environment. The symbolic gesture of the glass of water, even though it wasn't consumed, represented an attempt to nourish not only the body, but also the soul.

* * *

The experience with Eliza not only enriched the more human dimension of my student-patient relationship, but also allowed me to deeply re-evaluate concepts previously ingrained in me. In particular, it questioned a notion that I perceive still haunts many junior doctors, myself included, when they enter medical school: the ego. This quest for absolute control and aversion to death, especially when facing non-curable situations, are aspects that I have noticed shape the medical imagination. The experience with Eliza served as a catalyst for rethinking and challenging these conceptions, offering a more compassionate and realistic perspective on the complexity inherent in medical practice.

I notice that, in addition to preferences for more clinical or surgical approaches, the choice of a medical specialty to follow is often permeated by the desire to achieve curative results. There is an inclination to consider that only the complete cure of a disease is a satisfactory and worthy outcome. Although the desire to fix and solve problems is a characteristic shared by those who choose medicine, I realize that the perspective in relation to this can directly impact the doctor-patient dynamic.

It is crucial to recognize that medicine covers a wide range of challenges and situations, often going beyond the ability to provide a definitive cure. Developing a more holistic understanding, valuing effective management, quality of life and emotional support, can enrich medical practice. This perspective not only reflects the complexity of clinical reality, but also strengthens the connection and understanding between doctor and patient, especially in cases where a complete cure may not be a viable possibility.

As I've said before, I believe that the doctor's primary function, in line with the principles of Hippocrates, is, above all, to improve the patient's quality of life, not just to seek a cure. I recognize that dealing with the feeling of powerlessness in the face of a disease that is still incurable or an irreversible process is challenging. However, I see this situation as a unique opportunity for students and doctors to talk to their own ego. It is essential that we understand that, although we are often charged by society to act as omnipotent, medicine is not an exact science and we cannot always offer definitive solutions. Facing this aspect of medical practice not only demands humility, but also opens up space to explore other dimensions of care, regardless of whether a complete cure is a possibility. This approach reinforces the essence of medicine as a profession centered on caring for the person and humanization, transcending the mere search for curative results.

After experiencing the neurology rotation in the fourth year of college, combined with experiences with patients like Eliza, facing diseases that were not curable but were susceptible to dignified longitudinal therapies, I decided to pursue the specialty of neurology. This journey has reinforced my commitment to providing continuous support and compassionate care, recognizing that even in the face of therapeutic limitations, it is possible to contribute to a meaningful and quality life for those facing neurological challenges.

Having taken part in various conversations with patients with HIV, Multiple Sclerosis and other diseases that, as yet, have no cure, has made me realize that a person or their family is not destined for a solitary existence, reflecting the sad fate of the Buendías in Gabriel García Márquez's novel. I understand that our role as health professionals goes beyond the search for a cure; it is, above all, to offer warmth and comfort so that our patients can live as well as possible, considering their circumstances. I recognize the limitations of medicine in the face of certain conditions, such as in the case of neurological patients, where a definitive cure can be an unattainable goal. However, this awareness does not diminish my satisfaction in providing hope and contributing to the quality of life of these individuals. Knowing that I won't be able to cure all neurological cases doesn't discourage me, as my focus is on the possibility of witnessing meaningful moments in their lives.

I believe that every hug, every piece of abstract art and every scribble on a photo are valuable expressions of affection and vitality. They are gestures that transcend physical limitations and reinforce the humanity of each patient. Maintaining this perspective is fundamental to preserving dignity and hope, not just during medical appointments, but throughout the course of these people's lives. Our mission, then, is to provide support, understanding and an environment that allows patients to embrace life with meaning, even in the face of adversity.

When I chose medicine, my central desire was to cultivate a deep doctor-patient relationship. However, when I started the course, I was confronted with the scarcity of opportunities to improve or even minimally practice this aspect. As we progressed through the course, this finding was corroborated, echoing the findings of the well-known study "The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical Study". The academic path often leads us to a gradual loss of empathy, prioritizing quick, objective care over a deeper connection with the patient. This contrast between the initial aspiration and the reality of the course led me to reflect on how we can reintegrate empathy more meaningfully into medical teaching and practice.

I believe that it is vitally important for the training of every doctor and health professional to have opportunities, throughout their academic journey, to conduct more subjective anamneses, centered on the patient and not just on the disease. The practice of writing about subjective experiences should be commonplace in medical courses, since the profession is, above all, centered on human relationships. This more global approach allows students to deepen their understanding of the patient as a unique being, involving not only physical symptoms, but also emotional, social and cultural aspects that impact on their health. Cultivating this skill from the early years of training not only nurtures empathy and understanding, but also contributes to building more complete professionals, capable of offering more comprehensive and humane care to patients.

As for human relations in medicine, I believe that developing soft skills is the most valuable skill to exercise and polish. This competence encompasses empathy, effective communication and an understanding of patients' emotional needs, essential elements for shaping a medical practice centered on human care. In contrast, even with significant advances in artificial intelligence, there are intrinsic aspects of the doctor-patient relationship that cannot be authentically replicated by machines.

The complexity of human emotions, the nuances of interpersonal interactions and the ability to interpret not only physical symptoms, but also emotional and social contexts, are elements that defy complete replacement by artificial intelligence. Empathy, in particular, is a profoundly human quality, based on experiences, understanding and emotional connections that transcend the capacity of machines. The trust, comfort and security that a patient gains from interacting with a human doctor are products of genuine communication and holistic understanding, crucial elements that highlight the irreplaceability of the human touch in medical practice.

After our conversation, Ruan expressed his desire to continue dancing and began a professional journey creating graphic designs on the computer. Eliza, for her part, decided to take up the hobby of practicing street dance. The end of the conversation was marked by a warm hug from Eliza, who expressed her gratitude for the opportunity to share thoughts she had never revealed before, not even to herself. From that day on, I realized that I had made the right choice for my life. Watching Ruan and Eliza's horizons change, unfolding into new aspirations and activities, reinforced the importance of medical care that transcends the limits of physiology. For me, medicine is not just about diagnosing and treating illnesses, but about promoting quality of life and the emotional well-being of patients.

The positive impact on Ruan and Eliza's choices highlighted how narrative medicine can be a powerful tool for reconnecting patients with themselves and their passions, contributing to a more holistic approach to health. Eliza's heartfelt hug and expression of gratitude were a vivid testimony to the importance of listening to, understanding and sharing patients' stories. This experience solidified my conviction that choosing narrative medicine as an integral part of my medical journey was indeed the right choice. By providing a space for personal narratives to emerge, we can positively influence not only patients' physical condition, but also their emotional journey and the way they perceive life itself.

Finally, I'm curious to know which roles Ruan most enjoyed playing, or which artists were his favorites. I hope the next hundred years of his and his mother's lives are filled with all good things, except solitude.

The Author

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Ausweingärtner[1]

Julian Neugebauer

It is 2:30 p.m. on Friday afternoon. Despite a low turnover on the psychiatric ward, the morning had been exhausting due to spontaneous discharges and a staffing level decimated by COVID infections. I was just looking forward to the upcoming weekend when I received the news that there had been another new admission. Equipped with a laptop for documentation, I accompany the senior physician to the admission interview in our ward room. On the way there, we are briefly informed by the attentive nursing staff that the patient is a medical colleague. When we enter the room, we are greeted in a friendly and direct manner by an obviously hyperactive woman in her fifties, who, when I introduce myself as a PJ student, promptly replies: "Now listen carefully, you could write your doctoral thesis about me!"

1 Exposition

The First Impression

When I met Ms. K. for the first time on that Friday, I had no idea that she would be right in part and that she would trigger so many impulses in me.

At the beginning of the intake interview, everything seemed routine. Ms. K. had been suffering from Parkinson's disease for years and her medication could

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[1] "Ausweingärtner" is a German neologism derived from the treatment relationship described here. It refers to a gardener in a very special garden, namely the "Ausweingarten". An "Ausweingarten" is a metaphorical word creation that plays with the homophony of

explain her hypermotoric. She had also undergone a bilateral mastectomy two weeks ago. She described that a few days ago she was violently attacked by her neighbor, who hit her on the wound on her chest in the stairwell. In addition, something that could be detected by magnetic radiation had been implanted during the mastectomy. Her great fear of being followed by the neighbor was evident in every sentence and she repeated several times that she did not think she would survive the night.

Her eagerness to talk coupled with her technical eloquence made the conversation really special. She was always friendly, but showed no insight into her illness and, due to her background knowledge, often found a way to challenge our arguments with an inconceivable, minimal residual probability of the opposite. As we were firmly convinced that we could help her well with this symptomatology, but there was no basis for forcing her into treatment, we aimed to convince her to stay voluntarily. After almost two and a half hours, during which the senior physician conducted the conversation with the patience of a saint, we finally succeeded in persuading Ms. K. to stay in hospital voluntarily.

Somewhat exhausted, I collected my things after the interview and was about to leave for the weekend when Ms. K. asked me to sit on a bench next to her because she wanted to show me something. I set up internet access on her tablet and she tried to download an app for detecting magnetic radiation. The download process stopped several times, so she decided to tell me why. She knew that her fellow patients had jammers in their cigarette packs that would connect to the part in her chest and cause her terrible pain.

After this, I was finally sure that she was in good hands on the ward. I left the clinic with the good feeling of knowing that Ms. K. was now being treated and with the firm expectation that in her case, for once, the symptoms could be alleviated relatively “quickly and sustainably”.

When I returned to work on Monday morning, I found out that Ms. K. had discharged herself a few hours later against medical advice. This depressed me a little, as not only did all the effort seem to have been in vain, but I was also firmly convinced that we could have helped Ms. K. quickly with good medication. But if there was one thing I had already learned, it was that you usually see each other more than once in a lifetime in a psychiatry …

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crying and wine in German. On the one hand, the term creates the image of a beautiful vineyard and, on the other, of a place where you can cry out your sorrows. The term “Ausweingärtner” therefore refers to the ward doctor and me as a practitioner, as we supported Ms. K. in her work in her “Ausweingarten”.

The Reunion

It happened as expected and a week later Ms. K. was transferred back to us from another psychiatric ward by PsychKG[2]. We found out that she had actually been beaten by her neighbor and had broken two ribs. However, the imaging of her head carried out in a somatic emergency room after this incident was unremarkable. In addition, her breast had become inflamed in the meantime, so that accompanying gynecological treatment had to be sought. All these somatic ailments, which could now be objectified, apparently reinforced Ms. K.'s impression that she had no psychological component. At the same time, this made it difficult for us to convince Ms. K. of the need for drug therapy for her psychological symptoms. She only took some of the prescribed medication and refused to take an antipsychotic. The PsychKG in particular was an enormous burden for Ms. K., as she felt "locked in" and was not used to having to relinquish control in her life. The whole team had numerous conversations with her, reassured her and waited for a change.

Cloud 7

After another week, it became apparent that Ms. K. was becoming increasingly more orderly in thinking. Although she was still refusing to take antipsychotics, she had gained the trust of the ward doctor with neurological experience, who optimized her Parkinson's medication and explained to her in detail the reasons for each individual dosage.

During a visit, she recited a poem she had written herself *(7 strong clouds)* and told us that we had animals in the walls. Ms. K. suggested "objectifying" this with a simple experiment so that she could show that she wasn't crazy and we could finally lift the PsychKG. Contrary to my expectations, the experienced senior physician agreed to this "experiment". So we went into Mrs. K's room and watched as she began to remove the plaster from the wall with a fork. When nothing could be seen at the first spot, Ms. K. changed the spot again and began to pick at another side of the wall with the fork. Nothing was visible here either. Ms. K. then got her SLR camera and tried to photograph the lamps in the room so that the animals hiding there could be seen. But none of the photos produced

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[2] PsychKG is the common abbreviation for the Mental Illness Acts, i. e. German state laws that regulate the detention of mentally ill people in a specialist psychiatric hospital in the event of acute danger to themselves or others.

the desired result. Somewhat disappointed, she realized that we had apparently been right.

Since the “experiment”, Ms. K. seemed to have gained even more trust in us. Two days later, we were even able to lift the PsychKG prematurely, as she was able to give us credible assurances that she would remain in treatment voluntarily. She even started taking the antipsychotic medication “on a trial basis” soon afterwards.

One morning when I had just arrived on the ward, she was waiting for me at the entrance and pressed her poem *7 Strong Clouds* into my hand. It was a gift for me, she said. Because I would have known which cloud was her “Ausweingarten”. I had already been touched by the beautiful poem during the visit, but the fact that she even gave it to me was a special honor and joy!

7 Starke Wolken

Wenn eine eiskalte Hand dein Herz in Schutt + Asche legt,
und niemand mit dir fühlt, was es so fehl-erregt,
dann lehrt es dich durch’s einsam überleben,
daß in all den schönen Zwischenräumen
zwischen Himmel, Erde, Bäumen
in reichlich Platz aus Lust am Leben,
7 starke Wolken kleben.

Die 1. ist zum Ordnen.
Die 2. zum Korrigieren.
Die 3. die kann tragen,
die 4. kann man alles fragen,
die 5. hat ’nen Ausweingarten,
die 6. läßt fließen
+ dann kommt Wolke 7
zum Lieben

(Für meine geduldigen Ärzte mit Team, die mit mir sämtliche Wolken durchmachten, damit meine 7 bleibt)

7 strong clouds

If no one feels with you what makes it so wrong,
then it teaches you to survive through loneliness,

that in all the beautiful spaces
between sky, earth, trees
in abundant space for the pleasure of living,
7 strong clouds cling.

The 1st is for organizing.
The 2nd is for correcting.
The 3rd can carry,
the 4th can be asked anything,
the 5th has a Ausweingarten,
the 6th lets flow
+ then comes cloud 7
to love

(For my patient doctors and team who went through all the clouds with me so that my 7 stays)

2 Reflection

Treatment Relationship with Ms. K. – Poetry Makes Medicine

The poem triggered in me an intensive reflection on the treatment relationship with Ms. K., which was not primarily rational, but rather characterized by emotional understanding through the poetry. For this reason, I would like to use the structure of the poem as a guide when writing down my reflections.

1st Cloud – Organizing

Like Ms. K., many patients are not sorted at the beginning of their stay in psychiatry. As a term used in psychopathological assessment, I had therefore been quite familiar with this term. However, its positioning as the first cloud of the poem made it clear to me that this is not a mere symptom description, but an important and elementary step in the recovery process. Of course, I remember some situations in which things got out of hand and I needed time and peace to collect myself. However, I can in no way measure how intense the feeling of inner chaos must be when you not only lose control and confidence in your perception, but are also forced into a completely unknown environment by a decision of the state authorities. This verse by Ms. K. made her intense fear and mistrust really tangible for me for the first time. In such a situation, sorting things out could only happen within herself and could not be forced from outside. She needed time and the treatment team needed patience. For me, this patience is the central element from which all the clouds, the metaphor for her steps in the recovery process, are woven. Contrary to my impressive experience of an always tight clinical time corset in most internships during my studies, it was a really profound experience for me to have to give Ms. K. the necessary time to start a recovery process and to be able to do this increasingly better.

2nd Cloud – Correcting

In contrast to somatic disciplines such as surgery or internal medicine, where the cause of the illness is treated "from the outside" by the practitioner through targeted intervention, I believe that mental illnesses require a great deal of active processing by the patient. The patient is not primarily – as I have often encountered in clinical traineeships – a passive object in which a broken bone is set or an electrolyte imbalance is rebalanced with medication, but as the main actor must muster the strength to independently integrate the impulses set by the environment into the world view. In order for this correction to be successful, I believe that not only an orderly state of consciousness is required, but in particular the presentation of offers tailored to the individual. Of course, medication can be one such group of offers, but its strengths seem to me to lie primarily in symptom management.

In the case of Ms. K., the right offer was the experiment described in the exposition. How often was I present or active myself when we tried to influence Ms. K. in long arguments? But it was only the patient offer of the senior physician, which gave Ms. K. the freedom to convince herself of the hallucination, that brought about a change in her world view. I personally think that Ms. K.'s need to be convinced through self-awareness was due to her fear, which was fed by the feeling of loss of control. This insight was of immense importance for the further treatment, as we now knew better which offers we could suggest to Ms. K. In a similar manner, I was allowed to accompany her to an appointment with the head physician of the breast center where the mastectomy was performed. As the head physician took a lot of time to answer Mrs. K's questions in detail, I felt that I had a lot of time too. I could literally see with every minute how the inner tension that had been building up in Ms. K. for days was easing.

Impressed by the sustainability of these treatments, my understanding of the role of a medical student or doctor changed. What I thought of as holistic medicine was subject to a point of view error. For me, it previously meant looking at as many areas of a person as possible and developing the most optimal pathogenetic-oriented intervention from this, but always from a perspective where I was the actor, the "problem solver". The treatment relationship with Ms. K. broadened my perspective and showed me that it is more productive – especially in the case of mental illness – to be a companion who offers connectable support – often also as a "Ausweingärtner".

3rd Cloud – Carrying

For a correction to be sustainable, it seems important to me that a fragile change in the world view of the person undergoing treatment is supported by the environment. He or she must experience that the correction is sustainable and reliable. When Ms. K. once saw animals in her room lamps, we tried to capture them with her SLR camera. No matter from which perspective we photographed, the pictures always showed ordinary lampshades. This not only led to Ms. K. being able to distance herself more and more from such perceptions, but in my view also strengthened the treatment relationship enormously by "experimenting" together. Ms. K. built up more and more trust in the ward doctor and me. This trust was incredibly valuable, as it gave us the opportunity, for example, to convincingly supplement the personal support offered with medication. While I had previously believed in the Habermasian coercion of the better argument when giving medication, Ms. K. taught me to appreciate the non-coercive advice of a confidant.

4th Cloud – Asking

If you have a lot of (specialist) knowledge like Ms. K., there are all the more points of contact for uncertainties, so I could empathize with her great urge to ask questions. I remember too well the phase during my studies when, after reading almost every clinical picture, I thought that the symptoms actually applied to me too. After a while, however, the habituation effects were so strong that I switched to the opposite and ignored my own body signals in a feeling of inviolability until I finally had to go to the clinic as a patient with a serious illness myself. I had a déjà vu with Ms. K. and saw myself again in the same clinic, where my dangerous half-knowledge constantly fueled my fear and I inwardly doubted every treatment approach because there was still a study there that did it differently or the pharmacology slide said that you just shouldn't take a certain combination of drugs. For this reason, I was able to empathize with Ms. K. particularly well. It was easy for me to answer her numerous questions with patience and to the best of my knowledge, as I was well aware of the great reassurance potential that answers and empathy can bring.

In the course of reflection, I then asked myself whether I show the same level of commitment to others, even though I sometimes find it more difficult to emotionally relate to them. Unfortunately, the answer is quite clear, as I invested significantly more time than usual in the relationship work with Ms. K. Just because other patients don't demand as much time and perhaps can't formulate as many questions doesn't mean that their illness is any less complex, let alone less painful. I would therefore like to take away from Cloud 4 that there are many sufferers who are unable to express their inner fears and tensions in any questions or words and that this should not be a reason to assume that they are absent.

5th Cloud – "Ausweingarten"

Ms. K. was particularly proud of this cloud. For me, the neologism of the "Ausweingarten" stands for a place where you feel safe and protected and where you can sort out your thoughts. For me, this atmosphere of trust and security is the prerequisite for being able to cry at all. Linking this place with the idea of a garden really appeals to me. I am a person who feels a great sense of connection and peace in nature. For example, when I go mountain climbing, I feel very humble before the vastness of nature and feel part of a larger whole. This often leads to my own problems and needs fading into the background in these moments, sometimes even seeming very small and unimportant. Combining this feeling of nature with a place to cry and creating such a space in the clinic seems to me to be a very noble goal.

I also find the metaphor very successful because the elixir of a magnificent garden is not expensive gold, but water. Perhaps even the very water that is released when we cry. This interpretation applies well to Ms. K., because in my opinion, she drew the strength from crying to be able to stand up again.

6th Cloud – Flow

For me, flow has something dynamic about it and goes in a certain direction. For this reason, the 6th cloud can be understood as the actual (minimum) goal in the recovery process. For me, this is where the rigidity and constriction during an illness is dissolved.

In relation to Ms. K., this cloud also has an intensely physical component. She suffered not only from hyper-, but also from hypomotor phases as part of her Parkinson's disease. I find it hard to imagine the feeling of being trapped in one's own body. It is perhaps most comparable to the sleep paralysis I experienced some time ago. I can still feel the fear from back then, but my immobility was in a dream world in my head. In Ms. K.'s case, this helplessness existed within interpersonal interaction. It is understandable to me that she was incompliant with such a wealth of experience and preferred not to take too much medication in order to get into the hypermotoric phase. The sensitive approach of the ward doctor, who determined the medication together with Ms. K. almost every day and in this way guided her step by step into the optimal setting, seemed all the more exemplary to me.

Cloud 7 – Love

For me, loving means being able to do something for someone else. However, when you are ill, you have to concentrate on yourself and focus all your energy on recovery. Helping a person to regain so much strength that they can not only give something back to themselves, but also to someone else, i. e. to be able to love, is the most beautiful goal of treatment for me.

In psychiatry in particular, the environment is closely linked to the patient's situation, so the treatment work often has a far-reaching effect on an entire social structure. The treatment relationship with Ms. K. made this very clear to me. Her husband suffered greatly from seeing his wife in this state. At the beginning of her treatment, Ms. K. was very suspicious of him and often accused him of not supporting her properly. When her condition gradually improved, a few days after she had presented her poem to us on the ward round, she came back from a walk around town with her husband wearing a beautiful new necklace around her neck. The necklace was adorned with a large, blue, drop-shaped gemstone set in silver, which drew the eye to her breastbone. She told me that it was a gift from her husband, who normally didn't buy her such expensive things on the spur of the moment. For her, this necklace is now a symbolic “declaration of war” against all the things that have happened to her since her mastectomy. Now she wants to tackle them. Whenever I met her in the corridor in the days that followed, she would simply tap the necklace with her index finger and I noticed how a broad smile always spread beneath my mask.

To be seen as someone who has made a small contribution to her being able to love again by dedicating her poem flatters me and makes me very happy!

The Team – All for One

In my clinic, I was lucky enough to work in an interdisciplinary and multi-professional treatment team that managed to work together as equals.

This credit goes above all to the senior physician and the nursing management, who created an atmosphere in which everyone was able to contribute their skills and was appreciated for it. In Mrs. Ks. poem, this treatment environment is well reflected in the image of the “Ausweingarten”, because if you see the patients as plants in this garden, it takes more than just a gardener to make the flowers grow again. Social services could provide sunshine, medicine could fertilize the soil, psychology could provide a supporting skeleton, nursing could water, etc.

Nevertheless, I know that this kind of collaboration requires a great deal of effort to structure and organize. Being part of the many meetings – with their different compositions – and experiencing the enormous communication skills required for such a round of talks made a lasting impression on me. I have a vivid memory of how the senior physician once put her point of view aside and decided against her own position in favor of the majority opinion, even though she was the one who was solely responsible.

I could literally feel how I had arrived in the team after a while, when I was able to make my first contributions and contribute my student perspective. Thanks to my good treatment relationship with Ms. K., I was not only listened to, but was also able to use this to help the others in the treatment team better understand Ms. K’s actions.

The relationship with my ward doctor was also particularly formative for me. We shared responsibility for Mrs. K’s case and I enjoyed the luxury of being able to invest a lot of time in a complex case like Mrs. K’s in psychiatry. We had long discussions, pored over the literature to better narrow down a possible etiology and developed treatment ideas, as we had learned from Mrs. K’s “experiment” that an experiential approach could be very effective for her. Thanks to the constant exchange and direct feedback on my ideas, Mrs. K's treatment was very exciting and productive for me. It was not uncommon for questions to arise from our conversation that touched on my own ethical ideas. Suddenly it wasn't just about Ms. K., but about a general understanding of how you want to fulfill your role as a doctor. The critical openness and willingness of the ward doctor to discuss this not only on an abstract level, but also to incorporate his feelings and experiences from his clinical work, gave me a lot of food for thought. Once when we were discussing the thresholds of a possible forced medication of Ms. K., I was impressed by his tireless optimism that Ms. K. would take her medication voluntarily. Based on this conviction, he initially stopped the Parkinson's medication for over a week, in daily consultation with Mrs. K, until she had gained enough trust in him to voluntarily try taking another antipsychotic. I was very impressed by his willingness to choose the ethical path over the more comfortable one – despite the great effort and rather low chances of success – and to draw so much patience from this.

3 Action

While I had been thinking about Ms. K.'s poem for a few days, I discovered a reminder of the Balint-Prize in my mailbox. The first sentence that Ms. K. had said to me immediately came to mind. As many threads of thought were still buzzing around in my head and I was still very moved by the poem, I plucked up my courage and described to Ms. K. my idea of writing down our treatment relationship pseudonymously and submitting it. I was surprised that she not only immediately gave her consent, but was also immensely happy about it. We then talked at length about my interpretation of her poem and the lessons I had learned from it. Two major goals emerged for me: to become more patient in treatment relationships and to pay more attention to people who are less able to articulate their fears and needs.

Patience

Ms. K. confirmed to me several times how important the patience shown by the treatment team had been for her. In a situation in which she was largely deprived of her freedom, at least allowing her the autonomy to make her own decisions about her medication was a very important support. I would also like to try to provide this support in the future and support such experiences of self-efficacy.

In two months' time, I'll be moving on to my surgery tertial. The high time pressure there seems to me to be an ideal testing ground for practising patience under systemic pressure. Of course, I realize that I will encounter different time corridors there than in psychiatry, but I believe that a patient attitude can be felt quickly in the high-frequency, somatic hospital routine, even on a small scale. Whether it's in the information session, where I try to ask questions to make sure that the procedure has really been understood, or in the emergency room, where I don't want to interrupt the first answer after 10 seconds, but want to leave time to tell the story. Particularly when it comes to prescribing medication, I see great potential for increasing compliance through patient education. I have the feeling that due to the unanimous professional evidence – e. g. for some long-term medications – there is often little empathy on the part of doctors for those being treated, or at least this is not expressed due to the performance-oriented time pressure. This is why, in my opinion, patients are given (too) little time to accept the need for medication and thus convince themselves of its relevance. I would like to counter this form of persuasive education with patient persuasion and learn to endure the fact that medically indicated therapy proposals can also be rejected (for the time being). For me, this also implies being open to unusual treatment methods in further training in order to have more individually tailored treatment suggestions in my repertoire and to be able to offer them as an alternative.

Quiet Waters

When writing down the reflection, I realized that I am very involved in treatment relationships in which a lot is demanded of me. However, those who do not express their fears and are perhaps not even aware of their needs are neglected. In future, I would like to be more proactive in my approach to these patients and take them into consideration. In concrete terms, this means that I want to take the time to put myself in the other person's shoes in every treatment relationship and find out what emotions are currently guiding their actions.

This was very easy for me with Ms. K., but when I subsequently tried to do the same with more reserved people, I noticed how difficult it could be to grasp the individual emotional state. Although I had diligently given items in the psychopathological assessment that described the affect in a structured way, I could not say why someone was depressed or what the hopelessness arose from. For this reason, a huge range of connecting factors remained closed to me in these treatment relationships.

4 Progression

Disturbances Have Priority

Ruth Cohn's postulate "Disturbances have priority!" from Theme-Centered Interaction (TCI) seems to me to be very important for responsible medical action. It can be easily adapted to treatments, as the disorders are often not at the content level but at the relationship level. In everyday clinical practice, the focus is usually on the professional dimension and the relationship level is minimized through distanced behaviour in the understanding of professionalization. Especially with people like Ms. K., this seems fatal to me, as the relationship level is a necessary condition for a substantive discussion. In my opinion, it would be desirable to adopt more perspectives in both medical and student activities in order to include the relationship level more strongly.

For me, empathizing with another perspective begins with the common use of statements in doctors' letters such as "The patient introduced himself …", "The patient reports …" "The patient was … under treatment" or "We recommend the patient …". These phrases seem disrespectful to me. From my point of view, they do not express the necessary appreciation for another person who has a name and a story. I think such formulations contribute to reification, which is also emphasized on the ward when a distinction is made between "room 266 window or door". In the end, this reification culminates in the allocation according to certain disease categories, when only "the gall bladder", "the liver" or "the appendix" are mentioned.

I would like every practitioner to regularly try to empathize with the patient's perspective before making a decision and to critically reflect on their own position in this regard. Simple questions such as "How do you feel when you meet Mrs. Müller?", "How does it feel to be on dialysis for years like Mr. Müller?", "How do you feel when you think about Mrs. Müller's future?" can be used to get a sense of the emotional situation. This complements the purely functional dimension, as you are involved in the treatment relationship as a person who is capable of feeling. Just as it is routine to inquire about certain areas in the medical history, such questions should be an integral part of a treatment routine.

Persuasion Medicine

Reflecting on the clouds from Mrs. K's poem made me realize that the doctor's role includes both the active problem solver and the supportive companion. Here

I see a connection to argumentation theory, where the distinction between persuasion and convincing has existed since antiquity. While persuasion is done with manipulative intent, persuasion aims to persuade an individual to adopt an attitude to action by means of testimony. The similarity lies in the perspective. Just as the listener is the decisive subject in argumentation, who convinces himself of something and is not convinced, it is the treated person in (psychological) medicine who is not talked into recovery, but heals himself through support that can be connected.[3]

For me, this means that medical practice needs to be aware of this dual role of problem solver and companion, even in specialties that are not oriented towards conversational medicine. Because as soon as a somatic illness is coupled with a stressful, psychological component, such as in the case of tumors or chronic illnesses, both roles are needed for the recovery process. For training and further education, I would therefore like to see more training on when the focus should be on active (problem) solving and when we should see ourselves more as companions who provide individuals with resources that promote their health and well-being.

Structures

Based on the realization of the great potential that can be found in involving oneself with one's feelings in a treatment relationship and the awareness of having to meet the requirements of both a problem solver and an accompanying insight helper, I believe that new spaces for this emotional reflection are needed in everyday clinical practice. Of course, some of these spaces already exist (Balint groups etc.), but the decisive criterion for me would be integration into the daily work routine. Just as a physical and psychopathological examination of the patient is part of the standard toolkit, a kind of mini-emotional status of the practitioner seems to me to be an enrichment in order to professionalize a more empathic attitude in the treatment relationship.

I am very surprised that there are a number of AWMF guidelines, but not a single one that deals with the culture of communication in medicine across disciplines. As deeply differentiated as the professional content level is in evidence-

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[3] In Socratic maieutics, this becomes particularly clear linguistically, as this technique literally means midwifery. The rhetorical insight helper and the midwife both have a supporting function in something that originally comes from itself.

based medicine, the relationship level in medical contexts seems to be superficially illuminated. For me, efforts are therefore needed to establish evaluable communication structures in order to create resonance spaces for empathy and joint reflection and ultimately make communication in treatment relationships more successful in this way.

The entire reflection on and with Ms. K. convinced me that it is personally beneficial for me to integrate a mini-emotional state into my routines. The experience of how my own emotions brought into the treatment relationship can enrich it has permanently changed my whole attitude with which I now enter into further treatment relationships.

My challenge now is to translate these insights into appropriate attitudes and actions on a daily basis.

Epilogue

I read this report together with Ms. K. on the day it was handed in. It may not have become a doctoral thesis, but it worked on my understanding of "being a doctor". Wrestling with certain formulations in the writing process brought me to a level of reflection that I would not have reached through purely cognitive analysis. However, being able to reflect not only on my own or as part of the treatment team, but also to engage in a metacommunicative exchange with Ms. K. about the patient's perspective, was a formative experience that had a lasting effect and for which I am very grateful to her! We found a common projection surface in the "Ausweingarten". Here, Ms. K. was able to forget her worldly worries, gather strength and feel free. Similar to the biblical Garden of Eden, the "Ausweingarten" is a paradisiacal, utopian place of refuge for Ms. K. By allowing me to go with her to this place, I was able to support her in a different way than in the usual role relationship of a treatment relationship. This form has lasted far beyond the initial meeting and has formed the basis of our contact ever since. Using the power of metaphors, both Ms. K. and I were able to express our respective feelings, make them understandable to the other person and thus become effective. As an example, I would like to mention the fantastic idea of the "Seelenkompost"[4]. After Ms. K. had shown this text to her family and friends, we received initial feedback and tried to process it together. As expected, the "Ausweingarten" triggered the most response, so we reflected on the impulses. Suddenly Ms. K. said that for her,

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[4] Another neologism that can be translated as soul compost.

it was not the cross-references to the Garden of Eden, Adam and Eve or a painted paradise that were in the foreground, but the small riches of the garden, such as a "Seelenkompost". This is a source of new growth for those who have enough patience to nurture and care for the garden. Here, what had once blossomed and then withered could become something new. The whole wealth of different life events, which are presented in the numerous plants in the garden, could blossom anew with a little (gardening) work and time on the "Seelenkompost". In addition, sometimes a good digging is needed to keep the compost fertile.

This metaphor describes our treatment relationship so impressively and wonderfully, and has since then influenced me to use the power of figurative language. Thanks to Ms. K., I often think of the 7 clouds of the poem in difficult moments with patients, especially of the "Ausweingarten" and the "Seelenkompost". They remind me that sometimes a patient gardener is needed to help with the "Seelenkompost". But also how arduous and persistent it is to try to be one every day.

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As Much an Art as It Is a Science

Dikshya Parajuli

"Inferior STEMI, 87 y/o female. Metastatic cancer, recent aortic dissection. Do not resuscitate, for palliative cares only" cubicle three's ambulance notes read.

I was on my emergency medicine placement as a final year medical student. I strolled over to cubicle three, where an elderly female who I'll refer to as Edna met my gaze with glassy eyes and a tired smile. Her emaciated body was surrounded by doctors and several nurses. She had been discharged from hospital back to her rest home for end-of-life cares only three days prior. With widespread breast cancer metastases, she was on huge doses of opioids and had been under the care of hospice for some time. After an episode of unrelenting chest pain that morning, Edna had decided it was all too much and had asked to return to hospital for what would inevitably be her final days.

When questioned by the doctor as to why she wanted to die in hospital and not her own space, Edna replied: *"I feel more safe dying here. I will get better care here".* She spoke with poise and certainty. Tinged with the acceptance of a life well lived, she possessed no denial in the futility of further medical treatment. Although her organs were failing, her desire to maintain dignity over the body that remained was still burning fiercely. She wanted to die with dignity. In a place she felt safe. *Safe to die.*

A nurse walked in with a vital signs monitor, and immediately turned around on hearing the doctor say *"no observations, she's palliative".* The doctors words and the nurses actions appeared so devoid of emotion.

One by one, everyone left.

A room that seconds prior had been full of minds skilled and dedicated to *save lives* was abruptly empty, leaving only a dying patient and a medical student behind.

Edna's enfeebled skeleton was visibly exhausted. As she lay there in tremendous discomfort, the weight of her suffering became palpable. The knowledge I was armed with on the clinical aspects of her presentation felt not only inapplicable, but brutally irrelevant to the visceral nature of her suffering. Medical school had taught me about many ways to keep a patient alive, but very little about how to comfort them as they die. I felt idealistic, inexperienced and unprepared for the strength of my own emotions.

Edna's desire for someone's emotional presence was obvious. As her youth filled eyes turned to me, uncertainty engulfed my mind. For a moment, I wondered if I even belonged in the room. A familiar feeling of unease took hold, as if I was suddenly swimming in waters out of my depth. I had spent the last several years learning the intricacies of human biology, disease and pathology. I had worked hard to develop my clinical competence and confidence. I had a lot of theoretical knowledge. However, when face-to-face with a dying soul for whose illness an obvious panacea did not exist, I felt *helpless*. I longed to swim back to shallower water.

"Not a very exciting one is it?" one of the ED doctors asked me as I walked over to prepare a cup of tea. Determined to not let him see the tears that I was fighting back, I nodded and with tea in my hands, I walked back to Edna's room. Though I felt like there was little I could do for Edna, the thought of leaving her alone in that cubicle ached me. My presence emerged as the only solace I could offer her. I handed her the warm drink and accompanied her as I waited for her palliative care team to take over care. Maybe I was merely treading water, but I felt driven by a naïve urge to extend empathy and a desire to diminish discomfort.

Whilst we waited, Edna drank her tea and shared with me her wishes and worries. In that time, I saw Edna's fear turn into trust – trust that although her illness could not be reversed and her life could not be saved, she *could* and *would* be cared for here. An unspoken bond had formed between us, instilling a sense of trust and vulnerability that transcended the limitations of clinical interventions. I realised then that even as a medical student, I was and could continue becoming someone who belonged in the room.

Eventually, an orderly from the patient transfer services came to transfer Edna to the west wing of the medical ward. The place where comfort cares would be initiated for her. A place where death would neither be hastened *nor* postponed, where she would get the dignified ending she so deeply desired.

Over the next few days, I continued to visit Edna. I soon learnt that apart from her palliative care team, I was her only regular visitor.

Each time I entered her room, her glistening eyes would turn to me, beseeching me as to whether I had any time to lend her. Any length of undivided empathetic presence was enough to make her smile. On days I had time, I would sit down to her level, and I would listen. On days I didn't, I would pop in, say hello, top up her water, open her window; do *anything* to remind her that she had not been forgotten.

And each time I left, I would close the curtains that separated her from the chaos of the medical ward. Though flimsy and fragile, the curtains preserved Edna's dignity. *Dignity is all she wanted,* I would remind myself.

Just as the flowers on her windowsill that slowly began to wilt, Edna grew weaker and weaker with each passing day; her wrinkles becoming more defined, her breathing becoming more laboured. Her medical progress notes validated my observations that every organ in her body was slowly withdrawing *bit by bit* from life. Watching Edna dwindle amidst a backdrop of withering flowers served as a sobering reminder that death is an inevitable part of every life cycle. Someday, we all approach an end. No matter how resisted and refused, death is the most certain thing in *all* of life.

Each sunset does *not* bring the promise of a new dawn.

Everything, including life itself, is temporary.

Over the days I visited Edna, mortality became less of an abstract concept and more of a defined and truthful reality.

Some consultants treat ward rounds like an authoritative and ritualistic task; towering over patients, reciting questions on autopilot and hurriedly running off to their next review. The patient meek or mute, trusting the doctor wholeheartedly, ready to bear whatever suffering was necessary.

Edna's palliative care doctor on the other hand, was the opposite. By weaving together strands of empathy, expertise and experience, she treated her time with Edna not as a compulsory task, but rather an opportunity to forge a relationship founded on understanding. She listened and acknowledged, and by doing so she made Edna feel seen and heard. She found out what was important to Edna and fought hard to respect her wishes. It was as if she deeply understood that although she would not save Edna's life, by virtue of her actions alone, she *could* become a conduit for healing. She was simply incredible.

As I watched her truly care for Edna, I could not help but reflect on how throughout my entire academic career, I had been trained to value objective performance. Grades, numbers and percentages had equated to progress and the promise that I could be a good doctor. However, in the face of Edna's insurmountable suffering, the skill that appeared to matter the most was the very one that had never been assessed or taught objectively; *empathy*. At this realisation, medical school felt like a dress rehearsal for the real responsibility that lay ahead in my future as a doctor.

On one of my morning visits, Edna whispered *"Can you spare me a little longer today, dear?"*

My emotions, which had already begun retreating inwards at noticing how much weaker she looked, were acutely wrenched back into the present. Her desire for someone's emotional presence was tangible. I looked down at my clipboard; a long list of uncompleted academic tasks glanced back at me. However, the only thing that felt right in that moment was to sit by Edna's side. As a student, I had something that her doctors did not. *I had time*. And there *were* things I could learn, even from a dying patient.

I smiled, sat down and turned away my clipboard.

That day, Edna recounted a vibrant timeline of her life's events. From college, to family, love, parenthood, illness and age, I learnt many things about the magnificent tapestry that had been her life; the rich and royal hue with which her 87 years had been woven. The lucidity of her recollections served as a poignant reminder that patients at the end of life *are still living*. Whilst a component of their individuality becomes lost the minute we exchange their clothes for a hospital gown, and their name for a room number; they are still individuals with stories, identities *and* emotions.

As I listened to Edna, I found myself questioning who I was to witness her at this moment, *the most fragile and vulnerable she had been in all of her life*. I recalled a quote from Dr Paul Kalanithi's book *When Breath Becomes Air; "All of medicine, not just cadaver dissections, trespasses into sacred spheres"*. In that moment, I felt like I had finally grasped the essence of Dr Kalanithi's message. Perhaps this is what was meant to be taught in the *hidden curriculum* mentioned repeatedly in medical school.

I genuinely think Edna realised how truly privileged I felt to be in her presence and to give her the gift of my time, and I think she also understood that she was giving me a lot too. It was as if she already knew that although this was the end of her, it was only the beginning for me. The beginning of a career in service and I think she could see that I was determined to learn how to serve well.

I visited Edna again the day before my two week vacation. A sense of vacuity settled into my stomach as I realised then that it was my time to say goodbye – *goodbye, forever*. Despite knowing all too well that it would likely be the last time I would ever see her, I could not bring myself to tell her this.

A kaleidoscope of emotions crept in and took root within – sadness, guilt, fear and frustration. Unsure of how to navigate the balance between being professional and being human, I loitered next to Edna like a shadow. Visible, but not fully present. Paralysed by the thought that I might say or do something wrong. Never before had I farewelled a dying patient. Abruptly, I was in uncharted waters, in unfamiliar territory. However, this was a first like no other. I found myself wondering if there was room for humanism and empathy in this stoic profession that by default fosters distance and emotional detachment. As my mind searched for answers, I felt tears well up in my eyes, and slowly drift into my respirator mask. A subtle expression of connection that inherently felt bold, an expression of what it means to be human. Unable to hold Edna's gaze, I turned to face the window, her withering flowers framing the periphery of my blurry vision.

I said goodbye like any other day, daring hard to not lull my words with a sense of finality. I remember wishing that day that I could have been half as strong-willed and composed as Edna had appeared.

I never saw Edna again.

On my first day back after my vacation, I made my way up to the west wing of the medical ward where I had walked many times to visit Edna. I probably could have walked that route in my sleep. However, this time, the room label outside Edna's room had a new name on it. My shock initially became confusion, and then turned into discomfort. Her absence became acutely apparent.

A nurse who had regularly cared for Edna walked past and confirmed for me what I already knew deep down. I learnt from her that Edna had died two days ago. She told me that Edna had been comfortable at the time of her passing and right throughout, she had received care that aligned with her values, guided by a doctor whose only goal was to respect these. All of her wishes had been honoured. *"It was the dignified death that Edna had wanted all along"* The nurse said softly.

Upon hearing this, the pangs of sadness and guilt I felt slowly lifted and I found myself smiling.

In medical school, we have been reminded time and time again by our professors, tutors and lecturers that our best teachers will *always* be our patients. I have never once doubted this, for knowledge delivered to me about suffering and illness has paled in comparison to the lessons I have gained from directly witnessing, comforting and caring for patients. Edna reaffirmed this understanding in every aspect.

My encounter with Edna was deeply moving and served as a raw illustration of nuances of the human condition; life, emotion, identity and death. Confronted with the fragility of life and bearing witness to the suffering of a dying woman whose fate that could not be changed, I found myself searching deeply for ways to alleviate her suffering but realised that time and empathy were the only things

I could offer. The profound connection I built with Edna has forever coloured how I view the purpose of my profession; medicine is more than just the privilege of saving lives, it is also the privilege of attenuating pain and suffering even when lives cannot be saved.

Witnessing the joy my visits brought Edna shattered an illusion I had naïvely and unconsciously crafted as a medical student; that caring for patients meant solely *fixing* problems. After all, as doctors we are trained to fix and solve. Our identities are formed on our ability to cure. The corollary, therefore, is that a failure to *cure*, is a failure to *care*. However, Edna taught me that patients are not merely broken objects that require fixing and death is not always a failure. Nor is death always a battle, at least not one that we can always win.

Through the act of holding space for empathy and compassion for Edna, I realised how transformative these values can be when helping patients navigate the difficult terrain of emotions presented by illness. When I had first met Edna in the emergency room, the interactions between her and healthcare providers in the department had appeared to lack emotion. In a field where exposure to pain and suffering forms the crux of virtually every encounter, it is not surprising that healthcare professionals sometimes subconsciously engage in a degree of emotional desensitisation. Perhaps a means of self-protection, detachment helps us to not feel too deeply for patients who are hurting, and especially those who *cannot* be healed.

However, complete emotional disengagement, particularly when interacting with those at the end of life, diminishes our ability to care and is contrary to our promise to *do no harm*. In such a sacred space, expressing anything other than compassion *feels* inhumane. And this *is* okay – as long as we have processes by which to let go of this emotional residue and mitigate compassion exhaustion.

We owe empathy to those whose health is entrusted to us. Whilst they live, whilst they suffer *and* whilst they die.

The physician-patient relationship is a unique one and interactions between the two tread on a delicate tightrope – an intricate juxtaposition of science *and* art, of opportunity *and* obligation, of professionalism *and* humanity. I am constantly awed by the vulnerability and trust patients endow upon physicians. In palliative medicine, the connection we get to form with patients feels even more raw; in this space, connection has the potential to alleviate suffering in ways that pills and ventilators *cannot*.

In the realm of end-of-life care, both fortes and deficiencies of clinicians become exaggerated. Throughout my clinical years, I have seen many times where a patient's death has brought clinicians a deep and palpable sense of defeat, despite their death being expected *and* inevitable. The heaviest burden of the clinician's deficiency in these cases fell on those whose lives and identities were already under threat; for it was the patient who was subjected to further suffering and undignified interventions for minimal gain in their quality or quantity of life. A diminished ability to accept death and dying as meaningful aspects of life sometimes drive clinicians to cure-driven interventions and futile prolongation of life. Though modern medicine is captivating, powerful and has tremendous capacity to heal, at times it also strives for life *at all costs*.

I cannot help but wonder what difference might have been made to those patients' lives if their clinician's had recognised that their role was not to *fight* fate, but simply to improve the quality of their patients' lives, for as long as their lives existed. In those moments, I remember wishing desperately that they could have had a death like Edna's.

On the contrary, I have also had the privilege of witnessing doctors deliver timely, high-quality and holistic care to palliative patients; care that was directly concordant with patient values *and* priorities. These physicians treated their patients as people, and not merely problems to be solved. They cared for their patients deeply, even when giving them life-altering diagnoses. They stood by their patients' side as they came to make sense of their illness, reshaped their identities and made difficult decisions about what kind of life was worth living. They were empathetic, eloquent and passionate to do right by those they were caring for. Edna's palliative care doctor did all of these things.

These doctors showed me that engaging in our own humanity in service of our patients is not only possible *but necessary.*

They fuelled my desire to learn not only how to *fix,* but also how to *care*. They taught me that compassion does not need to be dispensed frugally out of fear of blurring the boundaries of the physician-patient relationship and that being good at this work does not require the suppression of our humanity, but rather the expansion of it.

During my time in paediatrics, I had a few days of placement in the regional neonatal intensive care unit (NICU). End of life discussions took on a different moral lens when they were not about 87 year old individuals who were rendered a life-limiting diagnosis, but rather cherished premature infants who were at the *beginning* of life. The neonatologists at the unit however delivered exemplary care; they guided families through difficult shared decision-making and they navigated the ethical dilemmas of futile care with equipoise and moral clarity. I was simply in awe of them. *How did they know which lives could be saved, which lives couldn't and which lives shouldn't? Like me, did they too take home the suffering and* *sadness exuded by families who had lost a loved one too soon?* Surrounded by tens of infant incubators, each attempting to provide a budding life with a second womb, I would often find myself questioning whether I would ever learn to lead and live with such responsibility, or if I was even cut out for the tremendous responsibility of medicine. My time in the NICU left me pondering many questions, but it left me certain of one fact; that doing this profession the justice it deserves would require more than only clinical excellence. If medicine truly is a moral endeavour and its goal is to truly care for people – then I needed to develop more than just my knowledge. As such, learning how to balance the science and art of this sacred profession has become not merely an aspiration for me, but an imperative.

Every time I reflect on what I have learnt from these incredible clinicians, I feel a deep sense of respect and appreciation for my future colleagues in medicine and a newfound motivation to grow into a doctor who one day can care for patients exactly as I have seen them do.

Palliative medicine has led me to the end of many lives and in doing so has uniquely highlighted the power of informed choice. Some patients will consent to any intervention or drug, if it gives them any chance of a longer life. Others think instantly about what kind of life is worth living for them, and will forgo quantity for quality. As clinicians, we may have the knowledge and expertise to manage illnesses, but it is not up to us to single-handedly make decisions about what level of care is enough. We may not always be able to save our patients lives, but we can and should ask questions to understand our patients wishes, values and priorities for care. Nathan reminded me of this.

Nathan was a 25 year old male I met on the same emergency rotation I had met Edna. He had a rare form of epithelioid sarcoma with pleural metastases and bilateral pneumothoraces. At a very early stage in his cancer journey, Nathan had been offered surgery and radiation therapy – both of which he had declined due to religious beliefs. His past admission notes were complex – with strands of ethics, illness and self-determination interwoven to create tension between the principles of beneficence and autonomy. However, it was deemed that Nathan had full decision-making capacity and that he understood the consequences of his choices. As such, his ultimate right to refuse treatment was respected. Now, the ceiling of treatment for Nathan was palliative – health professionals caring for him would do everything to keep him comfortable, but would not actively treat his illness or aggressively manage him if he was to become more unwell. And this was exactly the kind of care that aligned with Nathan's wishes, values and beliefs. This is all Nathan wanted.

I once heard him listlessly explain to a healthcare assistant who had questioned his choices whilst nursing his wounds, *"My life is not truly mine without me, and with this cancer, I am not me"*.

When I first was introduced to Nathan's story, I was initially taken aback by how someone so young had chosen to forgo beneficial treatment and allow cancer to invade his body. In the context of young Nathan's inevitable death, I could not help but think about the vastness of the chasm between the life he may have had if he had consented to cancer treatment, and the life he would soon no longer have because of his choices. The vastness of this chasm served as a powerful reminder to me that whilst patients have the right to life, they also have the right to be autonomous and make decisions about what kind of care they wish to receive. Healthcare providers have a duty to do everything they can to provide beneficent care and to first, *do no harm*, but competent, fully informed patients, *can* refuse standard medical care. Nathan reminded me that there is more to living than just being *alive*.

As doctors we are the doers, the ones who act; as patients, we are simply done and acted upon. When we are the ones who act, we may have an idea of what it is like to be a patient, but most of the time, we do not know what it is *really* like. I personally came to first grapple with this realisation only a few months ago when I too traversed the line from being on the side where one acts, to being on the side where one is acted *upon*.

Earlier this year, my ten year old younger sister was abruptly ill with an acute abdomen and required two emergency surgeries back to back in the span of a few days. At the time, I was miles from home and in the midst of a busy medical rotation. However, on hearing the news, I requested urgent leave and caught the next flight home. Little did I realise at the time that this would be one of the most difficult times in my life as a sibling, and one of the most *transformative* as a student doctor.

Throughout my years at medical school, I had made trips to the operating room and watched the induction of general anaesthesia at least a hundred times. I could recite the intricate details of the stages of *induction, maintenance* and *emergence.* However, when I walked my sister in for her emergency laparotomy, I was now on the other side of the operating table, the other side of the anaesthetist's needle and the consent documents. In that space, every word and every action of the medical practitioners surrounding me seemed to carry with it a different mountain of significance. The power imbalance between the patient, and the doctor has never been so evident.

How little do we understand the ordeals we subject our patients to? I found myself wondering. I recalled learning in third year medical humanities that the

English word *patient* originally stemmed from the Latin term *patiens,* meaning *"the one who suffers and endures".* The present particle of the verb, *patior,* translated into *"I am suffering".* This time, it was my sister and I who were suffering, and it felt visceral. I ached to my core.

As a student in the operating room, I was very calm and level headed. As a family member of a patient, I was fearful and weak. As I watched the sedative drugs take effect over my sister, my heart trembled with each beat. My eyes could no longer see clear through the dusk of tears that flowed unrestrained. The last thing my sister asked me before succumbing to the unopposed effect of propofol was *"Sis, will the surgery hurt?".*

I was then ushered out of the operating room. The two hours whilst I waited for her to come out of her operation felt like a lifetime. In those moments, the remainder of the world ceased to exist in my fragile recollection. My vast existential worries, deadlines and tasks became infinitesimal. Time passed slowly as I waited for her to come out of her operation.

I spent the next three weeks by her bedside, attending to her every need. Feeding her, braiding her hair, helping her as she relearned how to walk and play again. As a medical student, I was trained to view suffering through a professional lens; I was trained to cure. However, when faced with a loved one's illness, I naturally assumed my role of a caregiver; entwined with heartfelt emotions – fear, hope, love and deep yearning for recovery.

Thankfully my sister was okay. She continued to make triumphs in her recovery in every aspect and after 24 days in hospital, she was on her way back home; her laparotomy and laparoscopy surgical sites appearing insignificant in the grand scheme of the suffering she had endured. She is now healthy, happy and is healing at home and I feel blessed beyond belief to have her with me. What I learnt from my experience as a family member watching a loved one navigate the challenges of illness will always be an unshakable part of my foundation, informing a myriad of future learning and a relentless drive to serve others with compassion as a medical practitioner.

Although I was constantly surrounded by stories of suffering in my academic life, it was when suffering infiltrated into my personal life that the tenuousness and fragility of life became profoundly obvious. In that brutally painful period of my life, I too drowned in the labyrinth of emotions I had seen patients and their families navigate amidst illness many times before. It was in that space that I came to understand through direct experience that firstly, that privilege and responsibility go hand in hand and secondly, illness evokes some of the darkest days a patient and their families will ever see.

Illness and death are certain in life for no one is exempt from humanity's ultimate destination. However as doctors, we have the opportunity of honouring and respecting these processes, and transforming something that is unavoidably painful and devastating into a meaningful life event. We may even be able to plant seeds of empowerment. In this space, we hold immense power to alleviate fear, suffering and pain that patients and their families experience. What an immense privilege this is.

Processing my encounter with Edna has given me the opportunity to reflect on many thought-provoking patient interactions I have encountered as a medical student. Undoubtedly, witnessing patients at their most weakest and vulnerable comes with emotional costs. There were days where I do not know where to even begin unpacking the complex emotions born out from my time on placement. There were times where I too took home the turmoil I see patients and their families face. There were moments of uncertainty, fear and confusion I found myself reliving.

However, through such experiences, I have discovered a shared vulnerability that unifies me to patients I have learned from and cared for; whose beautiful, sometimes painful narratives I have had the privilege of immersing myself into. Such challenges have also offered me the opportunity to cultivate a repertoire of strategies to cope with the challenges of this work, which I will no doubt use in my future as a junior doctor. I have learnt to ask for advice from my seniors when in need, to take time to debrief, cherish my time with loved ones and to look after my own wellbeing. In doing so, I am learning how to care for myself better, whilst I learn how to care for others.

Through the mundanity and intensity of it all, I have not once questioned why I chose this career or whether it would be worth it. Medicine; rich with its complex emotions and responsibilities, is *absolutely* what I want to do. Encounters with patients like Edna humbly remind me of this.

Even months later, I still find myself wondering about Edna. On the day she arrived into the emergency room, she knew that she likely had days to maybe weeks to live. She was constantly aware of her mortality, but she did not seem to fear it once. She taught me a little about dying, but a lot more about living.

Months later and I continue to feel immense gratitude for all that she taught me during her final days. Because of Edna, I have in fact truly come to appreciate patients, their experiences of illness and stories of suffering as both windows *and* mirrors. Windows to better understand intrinsic aspects of the human condition; biology, mortality and suffering, mirrors to provide a platform for deep moral reflection and a glimpse of the moral dimension of our sacred profession. Patients give us the unique privilege of both *seeing out* and *seeing in;* they offer new understandings, whilst offering reflections.

I will always remember Edna. I'll remember how her aged skin starkly contrasted her eternal youth-filled eyes. I'll remember how she shared the most special parts of her humble life story with me; for me to learn from and to cherish. I'll remember her vulnerability, her integrity and above all; her desire for dignity.

Thank you Edna for being both a window *and* a mirror. You deepened my understanding of the science and art of medicine, and you also gave deeper meaning to my own sense of place within it.

I see you in every 87 year old I have seen since, in every dying patient who does not have family at their bedside and in every palliative individual who faces death with strength. It has been months since I first met you, but I have still not stopped learning from you.

Because of you, I now find myself taking more time with my patients, seeking to understand the experience of their illness, not just their symptoms.

I aim to listen, without rushing.

I allow my patients to teach me to *see out* and *see in.*

I err increasingly, on the side of *compassion*.

I try really hard to not become too emotionally detached that I lose touch with humanity, and not too emotionally involved that I lose my ability to assess objectively.

I embrace the notion that caring extends beyond curing.

I slow down and make time for patients so they too, like you, feel seen and heard.

These actions, though small, are helping me to build a humanistic perspective into my craft of doctoring. As I progress further on in my medical journey and closer to becoming a doctor, actions that seek to achieve humanisation feel equally as important as clinical aptitude.

In learning that this work is sacred, and is as much art as it is science, I feel humbled and honoured by the opportunity to pursue a career in caring and aspire to do right by those whose health is placed upon my hands.

Caring for patients, particularly in the face of overwhelming suffering and at the end of life can be painful and raw, and it is a *huge* privilege. Thank you, Edna, sincerely, for letting me be a part of your ending, and for shining a new light to the power of empathy and the art that is medicine.

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Part II

Essays 2024

Precious Moments in Time in Between the Solitude

Sophia Babnigg

On this Thursday morning, I asked myself how much I knew about Leukaemia. It wasn't that much because I was a second-year medical student still learning about the non-pathological processes of our bodies.

Before my acceptance at university for starting my medical career, I did an apprenticeship in anaesthesia nursing. I thought this apprenticeship would be the best foundation to study medicine. After a time, I discovered my interest in the pharmacological aspects, the whole process of anaesthesia in different professions but I also realized that the patients I meet are most of the time asleep and that our communication time is really limited, which was frustrating after working on my patient communication skills. The Covid-19 pandemic had started, and everyone was experiencing a lack of communication. We all got a little lonelier isolating ourselves from another.

I asked myself what the patients who already had lonely times while lying in the hospital would need in this difficult time. I thought that they really needed to be visited and someone they could talk to.

So, I decided to become a palliative care volunteer. I did classes at another hospital to get a degree and started my volunteering in psychosocial palliative care to talk to people who needed it the most at a time where only hospital employees were allowed to enter the building.

Remembering how I started is one of my rituals. I like to remind myself of how I began every time I volunteer because like every other medical student I have a lot of work to do, many pages that need to be read, and lots of flashcards to review.

But now on this Thursday morning I was a medical student volunteering in the palliative care unit and not a medical student in front of a desk. I tried to remember all I knew about Leukaemia, made sure I had the right name of the patient I was going to see, and took a breath.

I knocked at the patient's door and entered the room. Mrs. B. was a woman in her early sixties. She was lying in a bed that seemed way too big for her. She was small and thin and appeared very tired. Not only that, she had obviously not had enough sleep in the last few days as there was also a kind of a weariness that emanated into her skinny limbs, a weariness that restricted her field of vision and prevented her from being awake even though she was not asleep.

I smiled and hoped that she could see the glint in my eyes because we still wore FFP2-masks on this unit.

"Good morning Mrs. B. We do not know each other yet. My name is Sophia Babnigg and I am a medical student. On Thursdays I volunteer here. May I sit down for a little while and join you?".

Her eyes fixed on me. She did not say a word but nodded slowly.

"Thank you", I said, and took a chair and placed it in front of her so she did not have to move her head to see me.

After two and a half years of volunteering, I still was not happy with how I introduced myself to the patients. Being a medical student makes many of them insecure about my competences and intentions. If I only introduced myself as a volunteer, they do not know that for example I can also disconnect an empty IV and call for the nurses, which always disrupts our conversations flow.

Top of Form.

"Before starting my medical studies I did an apprenticeship as an anaesthesia-nurse. Then I qualified for psychosocial terminal care during the pandemic, and now I am a 2nd-year medical student at Witten/Herdecke University."

Mrs. B. did not react, which was not uncommon. Many patients do not know what psychosocial support is or what they would do with someone who offers it.

"How did you sleep last night?", I asked her.

"Badly", was her answer.

Her voice was as quiet and dry and tired as her appearance.

I asked, "Why did you sleep badly?"

Mrs. B. did not answer. The room was full of the noise of the bubbling oxygen flask behind her bed. I gave her some time to respond and found out that she had problems falling asleep and got up often because of the noises in her room. She did not use many words and I tried to figure out if I had interrupted her trying to sleep and whether she was just too polite to ask me to leave or if she just did not want to talk.

I had a feeling that she might just need a little more time to join our conversation. While figuring it out, I asked some personal questions such as if she also had problems sleeping at home, if she grew up in Witten where the hospital was, if she was married, who the last person was who met her in hospital, and how she spends the time in her room. Her answers were really short, but she always answered. Her eyes seemed tired, often closed while talking so I concluded that it might be time to leave.

"Mrs. B., you seem very tired to me, it is absolutely fine if you want to be alone."

She was quiet.

A split second before I got up to leave she said, "I have plenty of time to be alone before I die."

Immediately I had goose flesh all over my skin. Her words hit me like an oncoming train and I felt unable to react, shocked by the frankness of this innermost revelation.

"You can stay if you want to", Mrs. B. said calmly.

"May I hold your hand for a while?", I asked.

For the first time, I experienced not only being seen by Mrs. B.'s eyes but being connected to her. She nodded and so I held her hand a little tighter. I did not know what to say. I knew that she was right, that all the nurses are doing their very best to take care of the palliative patients. Although Mrs. B. is visited every day by her husband, most of the day she was alone in her room, alone with her lack of sleep, her final thoughts, her pain, her sickness, her grief.

I did not know what to say but I was by her side, and it felt enough in this special moment. After a while she asked me to help her to drink. She was able to hold the glass on her own, but opening the bottle was easier for me. After drinking a few sips, she started to tell me about her current situation.

I was glad that I stayed and did not leave early. I listened to her fears, her sadness about her diagnosis at the beginning of the year, her weight loss, the loss of feeling female because most of the time she just felt ill. I got to know her patients' dimension. I got to know her from her perspective as a patient. She provided me with all this information voluntarily, without feeling like it was an anamnesis quiz.

Long sentences strained her. Every little break was filled by the bubbly sounds of the oxygen tank.

"Is it cold outside?", she asked.

"It's not really cold but pretty windy", I replied.

She told me that she would like to go outside but felt too weak. I suggested asking if I was allowed to take her out in a wheelchair for a little walk.

"That would be great", she answered, and she gave me a warm smile.

I went to the Senior doctor and told her about my meeting with Mrs. B. and our growing connection. I reported that Mrs. B. asked for something that would help her to sleep in the evenings so that this information would be noted in her file. Something I only found out because I paused and waited a little while.

I asked if I was allowed to take Mrs. B. for a walk. When they told me "Yes", I found a wheelchair and a mobile oxygen tank.

Back in her room, Mrs. B. seemed much more alert. Because of the wind outside I dressed Mrs. B. warmly. Standing in front of her wardrobe, I wanted to choose some socks. Some of them were colourful, some were not. One pair seemed very sweet to me; it had sloths on it. I asked Mrs B. if she wanted to wear this pair of socks.

She answered, "You're really mean. Just because I'm slow you do not have to call me a sloth."

Before I had time to react, she laughed out loud. I could see the amusement in her eyes. This was the second time when I experienced a genuine emotion, and she allowed me to participate in it. I joined her laughter, and we shared another special moment together.

A moment later, her husband entered the room. He brought a lot of good spirit and joined in our laughter not even knowing what we were laughing about. We introduced ourselves to each other and I suggested leaving them alone to take a walk on their own, but both agreed that I should go with them.

While dressing for the cold we talked some more. Mr. B. brought some good humour to our conversation and I felt really comfortable staying with them without feeling as though I was stealing some of their precious time together.

As a group of three, we started our little excursion. The lifts in the hospital are very small and only two people could fit, so we split up. As Mrs. B. and I entered the lift, I complimented her choice of husband.

"Yeah, we are pretty happy. He always tries to make me laugh, although some days it is really hard. I would like to laugh even when I do not feel like it, but I become weaker every day. I don't want him to feel bad about me not laughing at his jokes."

It was her longest sentence in our conservation so far, and her first really clear confession.

"Why are we not on the ground floor yet?", Mrs. B. asked.

"Oh, I forgot to press the button because I was listening to you.", I replied.

"It's fine, we are not in a hurry", she laughed again with a bit of sadness in her soft voice.

"My husband might think we got lost."

It was her way of showing that she felt ready to tell me about her feelings but did not want to go any further, which was totally fine. I know what it is like when you just want to be heard but do not need a response because you are not yet ready for it.

Once downstairs, we joined Mr. B. again, who was joking with his wife. It was really sweet seeing them together. After so many years of marriage, they still seemed so in love. Even when Mrs. B. feared that he might be disappointed by her lack of laughing, to me, she seemed very loving. Of course, it was also clear that she was in deep grief but who would not be in her situation? At least she was with a supportive partner, which is not everyone is fortunate to have. This bittersweet thought stuck in my head for weeks.

Mr. and Mrs. B. told me about their relationship, their favourite vacations, about how he handled the diagnosis, and about him suffering with her and also with being alone at home. I was impressed and grateful that this couple was that honest and open with sharing their thoughts with me. Mrs. B. seemed to blossom. Still tired and weak but much more awake, she absorbed every word from her husband. When she spoke or sadness appeared in the conversation topic she grew more introverted, looking down to her hands, but when her husband joked or remembered how happy they used to be at the sea, she reached for his hand.

After a time, I wanted to say goodbye so that they would have some time for themselves until Mrs. B. needed to sleep again. I got up and let he know that she would get some medication that would help her sleep if she asked for it.

“Thank you for the walk. My wife appeared much more awake than in the past days to me”, Mr. B. said.

“Thank you for letting me participate in your walk. It was a pleasure and I’m really grateful that you felt comfortable enough sharing that much out of your life with me. If you want to, I´ll come to visit you again next Thursday.”, I said.

Mrs. B. answered that she would appreciate this. I smiled and hoped that she would see my eyes smiling above the mask. At this moment I felt fulfilled.

Before I could turn around, Mrs. B. grabbed my hand and squeezed it with an amount of strength I did not expect. She said, “Thank you for coming and being with me. And especially for staying at the beginning.”

I felt tears coming up, crouched down and squeezed her other hand on her lap.

“I am really grateful you felt comfortable enough to let me stay with you. And I am really looking forward to seeing you next week.”

It was one of the most intense encounters I had ever experienced in a hospital. On my way home, I replayed the morning and noon again and again, especially the part when Mrs. B. told me that she will be alone enough before dying. Without knowing her at all, I sensed the fullness of her grief and loneliness.

Many people know the feeling or can at least imagine being a patient in a hospital, watching the hands of the clock ticking slowly, being bored, and waiting for their release so they can go on with their life. Out of my own experience as a patient, I remember this time being tough and depressing, on top of the pain, nausea, lack of sleep, and the feeling of sickness.

What it means to feel the pain, the nausea, the lack of sleep, the feeling of sickness, the breathlessness, and the new bodily feelings with all the additional tubes attached to your body without the prospect of leaving, no one can imagine in its full impact without being a patient with a terminal illness.

In different conversations I heard many perceptions of death. The hands of the clock do not tick equally for each person. Some describe it as excruciatingly slow and others as dizzingly fast, while others were just staring and hoping for a quick ending or even a miracle healing.

Before I enter a patient's room I do not know much about the person except for their basic medical data (and some of those I still cannot interpret fully). It is very individual if they like to have a conversation or how they would like to spend our time together.

When I first met Mrs B. I was unsure whether she wanted time for herself. Her fatigue enveloped the whole room. It is not easy to describe if my intuition told me that she might like to talk if we had more time together, which made me stay and ask more questions and continue our conversation. It is not easy.

The first information she gave me without a direct question was that she knew she would be alone more than surrounded by loved ones until she would die. She used few words, but they were so accurate that the meaning of her confession was understandable without her saying it.

I was really glad that I did not stand up immediately after announcing I was leaving but gave her a moment to speak. Now we were at a point where she wanted to share information about herself and her emotional and health status. By sharing with me I was able to listen and respond to her needs.

Of course, she noticed that her sentence, "I have plenty of time to be alone before I die.", deeply moved me and that I needed a moment to react. She gave me that moment. Giving each other moments created a real connection in our conversation. This genuine connection made it possible to hold hands with a stranger and laugh together, like the moment I suggested wearing the sloth socks.

It was also important that our connection enabled her to tell me that she wished for some medication that would help her to fall asleep. When I knew it

I was able to tell the senior doctor so that she could do an order for the nurses, which also strengthened my relationship with Mrs. B. by making me seem reliable.

The moments we gave each other developed our connection so much in that short amount of time that Mr. B. was happy for me to accompany them on the walk without knowing me, just by perceiving the dynamic as he entered the room.

While inside the elevator, it was important for me to share my initial impression of Mrs. B.'s husband. This led to a profound revelation about her worries and the current dynamics of their relationship, where she expressed concerns about not meeting her husband's needs due to her progressive weakness. My ability to empathize without personal bias allowed me to grasp her fears, especially considering her earlier discussion about the loss of her feminine identity. The complexity of her role as both a female patient and a wife became more apparent. This interaction was so compelling that I momentarily forgot to press the elevator button, affording her the time to open up. It was another instance where time played a role, allowing her to express herself naturally. Following this, she chose to limit the conversation after sharing her comfort level, signaling that she didn't want to delve further at that moment. I believe this brief elevator exchange laid a solid foundation for the subsequent conversation I witnessed between Mrs. B. and her husband.

I really loved Mrs. B. s. reaction to holding my hand as we said goodbye. It felt like the circle of esteem after me holding her hand earlier in her room and made me very grateful and fulfilled.

The following Thursday, I got up early and with a pleasant anticipation, I went to meet Mrs. B.

While putting on my scrubs, I began my ritual of remembering the start of my medical studies. As I walked up the stairs, I replayed my conversation with Mrs. B. and the little details she and her husband have shared with me. I wondered if her sleep had improved and if she was feeling any better.

When I arrived at the station, I asked a nurse for the patient plan and said that I would start with Mrs. B. because we already knew each other.

Sadly, I was told that Mrs. B. had passed away that morning alone in her room. Her husband had been informed but had not yet come to the hospital.

Hearing that Mrs. actually died alone exactly like she feared made me feel profoundly sad. I was also saddened that I had missed opportunity to meet her again and let her know that I really came back to see her again.

It was a very busy day and I talked to two other patients. Between and after the conversations, I asked the nurses if Mr. B. had arrived, but he had not. Unfortunately, I did not get to meet him that noon either.

I did not know if I was allowed to go into Mrs. B.'s room and because everyone was so busy that morning I didn't feel comfortable asking someone from the team. I did not feel ready to explain that we had a connection, and that I would have liked to say goodbye.

After the two other conversations, I stood in front of Mrs. B.'s room with everything I was feeling about her death in my mind, hoping that my thoughts would somehow go through the door and follow Mrs. B.'s. spirit to let her know them.

Feeling frustrated that I also missed the chance to speak to Mr. B., I went home and wrote about the day in my journal to process my emotions. The next day, I wrote a short letter and put it into my "Missed opportunity box", the box that reminds me of things I wanted to say in a certain situations so I would not miss the opportunity again.

Where Did I Go from There

I often replay my encounter with Mrs. B. and my journal writings give me a lot to think about. It is important to reflect and understand the lessons from my meeting with Mrs. B. and what they mean to my personal growth and development. However, we should focus on teaching medical students to reflect on their individual role in every student-patient or future-doctor-patient conversation. All our studies in anatomy and pathology prepare us to be doctors and to do good diagnosis and interventions but it is just as important to figure out how comfortable one feels in conversations to be the person you can trust that your health and well-being are in good hands.

Get to Know the Treatment Options

At my university there are many classes about Patient-Doctor-Conversations and how to stay emotionally healthy. Although these classes are really good, I do not know if something like "How will I feel when a patient dies?"-class is coming up in the next few years. As a medical student, it is really important to ask yourself this question before you find yourself in this unavoidable situation. You probably will not get close to the actual feeling but at least you will know if you are the kind of person that wants to say goodbye or perhaps say a little prayer can help you may lead you into questioning the hospital's standards about how the deceased are dealt with, such as whether you are allowed go back into the room before the relatives, can help with washing or other tasks.

Initially, I was a bit frustrated not knowing if I was allowed as a student to enter someone's room after their death. A few moments later I discovered that my anger was my coping strategy to not feel the oncoming sadness of Mrs. B.s, death. After my missed opportunity I was fine with writing a letter and adding Mrs. B.'s name to my "Patients that changed something"-booklet but for any similar upcoming situation I want to be prepared. Knowing myself as emotional and interested in connecting authentically to patients, for me it is important to know if I am allowed to say goodbye if I want to. I learned to ask about how to handle it in the hospital where I volunteer, and now I take this into every hospital where I will work during my medical studies.

Thinking about Reconnecting Options

I am afraid I wasn't able to talk to Mr. B. after losing his wife. I would have liked to share my condolences and support his grief, and not just vanish after the connection we built and being part of one of the last days he spent with his wife.

Like the question of how you will react to a patient's death, in my opinion, it is important to consider if you want to give your patients or their relatives an opportunity to reconnect with you beyond the required medical information, so that in case of vacation or something else, another doctor could give the contact information. I think it depends on the specialty you will work in, but for myself, I can imagine leaving an email contact, such as a second work email address I will not read into if I am on vacation but after, to get in touch and talk if it is emotionally needed, especially if I choose to go into Paediatrics, Gynaecology and Obstetrics, or Palliative medicine.

Intuitive Listening

It is not easy to understand a patient's mood. It could be part of the illness, a change of character, a bad daily condition, a reluctant personality, or real denial. It is important to act with caution to find out where to sort in to clear your own concern and offer something over and above. It is always an option to tell what you perceive and wait for the reaction or to leave someone offering to come back later at another time. I have learned to trust my intuition as far as I cross someone's border of denial. To trust my intuition for me it was very important to gain as much experience as possible by talking to patients. From my own beginnings I know that you might feel insecure about talking to patients but like tying surgical knots you only get better by practicing. Many universities offer voluntary classes to practice conversations and get feedback. I experience those offers as a precious possibility to become a communicative student and a good doctor that I liked to be spoken to. I would recommend every other student to practice conversations as often as possible to train their own intuition based on real-life experience. If time allows, I would additionally recommend volunteering as a student somewhere in health care to improve in conversation skills but also in character development. Plus, you get insights in professions you would not get as a normal medical student, and it is a very fulfilling time and a nice counterbalance to the intense everyday life of a medical student.

A Patient Is Always More than Their Illness

In Germany, the average time of a conversation between patient and doctor is around eight minutes. In eight minutes, you hopefully find out the most important medical information. But every patient is much more than their illness. In my opinion, it is very important to understand how the illness affects each patient individually in their lives. Some are for example very affected by flatulences while others are not at all.

Mrs. B. suffered a lot from her huge weight loss and the loss of feeling female and being too weak to feel connected to her husband. Like everyone, patients want to be seen as individuals and treated with empathy. That is why it is important to get as much information about your patient as you can. As a medical student you might have more time with the patients, which should be seen as a privilege and to take a really precise medical history and ask in-depth questions to get the full picture of the patient. As above in awareness of the patient's limits.

To get more than the own collected information a good multi professional communication is key. Every profession like nurses, therapists, dieticians, midwives, volunteers, etc. get individual information. If this information is assembled together you make sure to have a multidimensional picture of your patient. To get that information from other professionals it is really important to talk to each other in multiprofessional ward rounds and the most important is to know what your neighbours profession is about.

As someone who did an apprenticeship before studying medicine and who has worked with many doctors I wished that they had been more interested in how our working fields become more combined than ordering and assisting for our common patients' feelings.

At my university there are classes and placements shadowing other professions that are in touch with patients but no doctors. You can attend for example midwives or art therapists or even the cleaning staff to get impressions about your future co-workers and their jobs. In my opinion these classes are extremely invaluable. Before attending one of those classes I would have not been able to write half a page about the job of a dietician. I only had ideas like talking about diabetes and what not to eat during pregnancy. That dieticians are also much more into parental nutrition and even work in science I did not know before I shadowed one of them which was a very great experience.

So, I really would wish that more doctors had the opportunity to join those classes where you talk about interprofessional work so that they would evolve an interest in attending other non doctors professions.

If I know now that a patient is craving for special food I can take a call and ask for options I do not know about. The patient is seen in its dimensions, and we work together to reach most of them and not only to cure their illness or palliate symptoms.

Thinking about Sloths

As I wrote above, generally we are prepared to meet the patients. We know their names, their diagnosis, and maybe an assessment by colleagues before we actually meet them. In contrast, the patients do not know anything about us and they are not prepared for us to enter while they are dressing themselves, showering, or vomiting. They are not prepared for our information and even less so for their emotional response. It is important to remember the time we give ourselves to prepare, like breathing in or checking the correct name one last time. I wish for more classes that would teach us that we should not only focus on giving information but how to wait for a patient's reactions and responses. In my personal ritual to replay my medical path before talking to a patient, I added a picture of a sloth to remember to give patients time to respond to what I said or asked. When I think about sloths, I think about all the important information I would not have gotten if I rushed over something because I had time to get prepared for this conversation. Moreover, I am reminded of Mrs. B. and enter the room with the same warm feeling as if I were wearing sloth socks.

Time Is a Factor but Moments Are Precious

At the end the most important thing I learned about meeting Mrs. B.:

As a future doctor, I'm aware that I will not have as much time for the patients as I do now as a volunteer. Working in a hospital is tough and we all have many things that need to be done. It probably will get very stressful. Besides that, it is really important to remember that the stress and lack of time is our issue.

Patients deserve our time and even if it is short, we are responsible for giving them moments to make sure they are seen by us. They deserve our attention and to feel seen because our established routines may feel repetitive to us, but for them, it's new every time.

An authentic smile, taking their hand, some kind words, or just standing side by side in comfortable silence are the keys to build a relationship that is not just patient-doctor but human-to-human. I believe that I will have many fulfilling encounters when I remember that patients are alone a lot and take this as an opportunity to create special moments with them.

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The Celestial Gaze

Vivian Lu

I

“I want to meet the Grim Reaper,” the patient said to me after I asked him his goals. He was 95 years old and a firecracker. I was 25 years old and an anxious MS2 on my internal medicine clerkship. He was here with pneumonia. We fell into a routine – I would bring him 2 cheese sticks and a coffee, black, when I came to pre-round and ask him the usual questions. I’d watch him drink the coffee through a straw, afraid he’d spill hot liquid on his thinning, almost translucent skin. Then I would order his breakfast from the cafeteria over the phone, since he had difficulty hearing. His daughter and son-in-law would visit from a few hours away, often in time for the team to round in his room. In the afternoons, I would check in on him, bring him another cheese stick. Before I left the hospital in the evenings, I would put his hearing aids on their charger.

He wanted to go home, where he had a large, marbled bathroom and a wooden chair his buddy had built by hand. His buddy had been dead for a while and his widow was happy that someone was enjoying his chair. He closed his eyes when he talked about that chair, how comfortable it was. I imagined him watching the news in that chair, surrounded by picture frames and knickknacks, snow falling thickly outside the mountain home where he lived with his daughter and son-in-law. His wife of decades was long gone and before she died, she had forgotten who he was.

He also wanted to go to his eternal home. But no, he wasn’t suicidal. “I’ve lived a good life. A long life. I’m so tired now.” He said that a few times. He had been an instructor in the military, saying, “I turned those boys into men, goddamn good men.” He laughed when he recalled one of his trainees at the end of the course saying, “Sir, at times I wanted to shoot you. At times, I had a mind to do it. But thank you Sir, thank you.”

When his pneumonia became an empyema, I watched as he got a chest tube placed and he gave me two thumbs up. When it was time for him to be discharged, it was my day off but the senior resident contacted me, knowing we would want to say goodbye to each other. Not in his blue and green hospital gown anymore, he wore a flannel shirt and slacks. We said goodbye. And we talked and laughed so hard that the senior resident down the hall texted me, saying he thought I was going to give him a pneumothorax.

Later when checking his chart, I found he had called the hospital, requesting aid in dying. I left that rotation site soon after and no longer had access to the medical records. But I did leave with vague knowledge now of Medical Aid in Dying (MAID), legal in Colorado, and an indelible memory of a patient who wanted to die. It was comforting knowing he likely soon reached his goal of meeting the reaper, finding peace.

II

“Breathing may become more rapid or shallow or irregular; breathing may stop for short times, and then start again. Sometimes there is a moaning-like sound when the person breathes out. This does not mean distress, but is just the sound of air passing over relaxed vocal cords. Snoring noises may be heard as the throat muscles relax.”

In November, now an MS4, I began a palliative care and hospice elective. I had always wondered what happened in their meetings after sending a consult. The teams worked on the 10th floor and their room filled with light from the large windows. Thank you cards hung festively on a garland. I sat at a workstation near a table where people brought in goodies, like bread and chocolates. Social workers, chaplains, coordinators, and providers filled this space. In the mornings, they checked in on each other. If they said they were green, they were doing peachy. Orange meant they were not doing great, but powering through the day. Red meant not well – people talked of ill family members, of harrowing stories of patients they had cared for.

On my first day, I went with a team to meet Maria, a new consult, hospitalized after a prosthetic hip infection. We entered the gently lit room and a woman was crying over the patient in the bed. “Nobody told me. Nobody called me.” I looked to the physician to say something. Then the patient took a breath again.

"I thought she had died while I was away." The woman introduced herself as the patient's daughter. She said her brother was coming soon. We went to a conference room to have the family meeting, since their mother was unable to participate.

This was a family deeply connected with the spiritual world. They believed in signs from beyond. Once Maria had felt two droplets of dew appear on her hand in the kitchen and said a gift of two was coming. Maria's daughter learned she was pregnant with twins a week later. When Maria's other son had died, she thanked the nurses for spraying the room with rose fragrance. They hadn't. The chaplain mentioned in the workroom that this could be the sign of St. Padre Pio, with his spectral scent of roses. The family was Catholic after all.

The son and daughter smiled as they recalled how their mother had met their father. Maria had traveled to visit a sick uncle and the small town took note of her. Her future husband overheard his dad telling his brothers there was a beautiful woman at the hospital, perfect for marriage. He hopped in his car and beat them there, and as Maria's daughter said, it was truly love at first sight. This love lasted in an earthly space for 17 years until her husband died from liver failure. But in a way, he never left.

Maria saw visions of her husband. Other members of the extended family also saw her husband, and this would happen shortly before they died. "He was coming to take them home," Maria's daughter said. Before Maria's hospitalization, she had made up the couch with blankets and pillows, saying, "He told me he's coming home." Her daughter asked who, and Maria said, "Your father."

While I never spent more than ten minutes in person with Maria, I felt I knew a little part of her core from the cumulative reminisces of her son and daughter. When we visited her the next day, she was surrounded by multiple generations of family. Her eyes were closed, her brow unfurrowed. She did not rouse to voice. Her daughter smiled and said that her time was coming close. I told Maria as we left her room that she had left such a legacy.

She died two days later. The note from the chaplain prior to her death read, "Family is ready for Maria to make safe passage. They will sing her "happy birthday" as her heart stops, a family tradition." I liked the phrase "safe passage." It implied she was going somewhere worth traveling. That she would not be gone, merely elsewhere.

After Maria, there were more consults, more meetings. In one, I remember a mother who said to her son at the end of his life, "I fought for you to come into this world and I will fight for your death." In another, a woman barely older than me talked of wanting to go on a cruise and also to Vegas. Looking at her, you wouldn't know she had metastatic cervical cancer and this breathing, vibrant woman who talked about her career as a deputy would be ashes in maybe three months – she wished to be cremated. Later, her sister brought in a device that overlaid the tiled ceiling with ripples of ocean waves. “I can’t bring her to the ocean but I can bring the ocean to her.” At night in the hospital, she would lie looking up at the waves, pressing her PCA intermittently, until she fell asleep. I hoped at these times she was far from this hospital, somewhere she could smell salt air, feel fine sand under her feet, and hear waves cascading onto shore.

Not every patient was end of life, or near it. Some had chronic, barely manageable pain. Others were waiting for a liver. But I was drawn to those who qualified for hospice. Six months left, or less. I believe I was fascinated by this demographic because we had spent so much time in medical school on learning about pregnancy, birth, and the rest of life. But end of life and, finally, death had only been briefly mentioned. But I saw it now as meaningful as a birth, something that should discussed and processed. I believed now that one should plan as much for the casket as for the crib.

I noticed planning for death started late. Nobody likes to think of death after all, for oneself or loved ones. The palliative care team was there to help with the process. They were emotional surgeons, working with the viscera of guilt, regret, anger, relief, love. They talked deftly. They knew when to be blunt, when to guide gently. When they misstepped, they corrected course with ease. They untangled turmoil of patients and families as they faced end of life. They referred patients to hospice, clearing up misconceptions or reassuring families who had a previous unfortunate hospice experience. Most often, they talked about hopes and worries, two sides of a coin that every patient carried in their pocket.

For a team often working with patients who were dying, the palliative care notes were filled with life. They wrote of patients before they became patients. The notes were biographies of sorts. They spoke of fishing, baking, raising families. They mentioned beloved pets and favorite foods. These notes stood out in the electronic files of patients, a glimmer of meaning among the others that listed a host of medical issues, medications, plans of action, checklists, labs.

III

I often didn’t know what to say when leaving the rooms of patients on palliative care. “Have a good day” seemed banal and wrong. I did hope their pain would get better, but “I hope your pain gets better,” didn’t seem to work well as a farewell. I settled on “I hope you have a peaceful day.” As always, with the word “hope,” there was the opposite side of the coin. "I hope *this*, but I worry *about this*." That was the phrasing the care team members always used. While I hoped for peace for all the patients, I worried they would not have that.

The palliative care team members had no trouble with banter. They could go from discussing the existence of dragons to last night's football game to talking to a patient about their PCA dosages. They built rapport fast. And when that rapport didn't quite come as easily, they still managed. A chaplain told me that when there was a strong emotion in the room, to name it. Naming frustration, anger, and sadness helped. People want to be seen. They want acknowledgement of their emotions, bubbling over like champagne in the face of the inevitable.

While most specialties didn't sit down since they would be out of the room quickly, palliative care had time. We rolled office chairs into rooms and sat with patients and families. We got on their level. Sometimes that was a vulnerable thing to do. I uncomfortably wore the luxury of youth and of health in front of patients in blue hospital gowns. Untethered by IVs, I could leave the hospital and return home to my soft, sweet cat and eat any foods I wanted. I could sleep in my own bed without pain awakening me. If you opened me up on the operating table, you would find a smooth liver, arteries only beginning to show signs of atherosclerosis, clear lungs with grape-like alveoli tempting to pluck, a pulsating heart ready to donate. Of course, this wasn't about me then. But I have the gift of being able to reflect on these moments.

IV

A while before my palliative care and hospice elective, I was taking care of a patient with liver failure of unknown etiology, along with a host of other issues. She had been transferred to us from the ICU but I felt she was inappropriate for the care on this floor. AOx0. AOx1 occasionally. Every specialty I consulted, from liver to infectious disease, asked if I had considered consulting palliative care. I asked the senior resident if we should consult palliative care in light of the patient's condition and the other specialties recommending it. And she answered, no, since the husband who sat by the bedside day after day had not requested it. I also asked if we could use an interpreter, as English was not the patient's nor husband's primary language, but I was also told no, since the husband had not requested it.

The husband was hopeful. Sometimes the patient moved with meaning. She was able to say her name at times. But she was clearly not on the road to any meaningful recovery, at least how I defined it. She would not be the way she was before she entered the emergency department, or close to it. And it became clear she was at the end of her short forty-something years of life.

After days of futile consults and efforts, I made a stronger stand that she should be transferred back to the ICU and the attending agreed this time. A resident from the ICU disagreed, but ultimately the ICU attending overruled her. The patient was intubated within 2 hours of arrival in the unit. Her chart continued to bloat with notes. Each one showed a deteriorating woman from a different perspective – nursing, nephrology, neurology, liver, infectious disease, wound care. "Husband at bedside" was a common phrase in these notes. Her edema went from 1+ to 2+ to 3+ to unclassifiable. She required dialysis.

Palliative care was finally consulted. They came to a decision with the husband to use an interpreter. Her two children were brought to see their mother at the hospital – they had been kept away previously by her husband. Other family members, I saw from the notes, were "shocked" at the condition this woman was in. "She walked into this hospital, how is she like this now?" they asked. And I could see how it seemed as if this place had killed her. Her "discharge deceased" note was brief, devoid of any sense of who she was as a person. She died with family at the bedside, and that is all I know.

I regret everything I did not do. I have told this story again and again in residency interviews when they ask about something I have failed at. While at the time I had a sense that consulting palliative care early on could have helped, after taking the elective, I am certain this patient and her family were failed by us not consulting them. Now I know they could have facilitated conversation. They might have been able to discuss matters with her husband in a way that led to the most peace for our patient instead of prolonging life to every extent possible. This is perhaps something she would have wanted had she been able to speak. Or perhaps, what happened is exactly what she would have wished for. I understand it is not my place to impose what my own preferences would be, but it will be my duty as a physician to offer options, to start a dialogue.

V

"Has anyone ever talked to you about talking about code status?" A palliative care physician asked me this in the morning one day. I told her yes, someone had taught me about DNR/DNI, but I knew there was more to learn. "How do you ask someone about code status?" she asked. And I repeated what I had heard a resident say once to a new admit, “If your heart were to stop beating and you were to stop breathing, would you want us to do everything?” The physician smiled and told me that was often what was said, but it was an incorrect approach.

She explained. Of course everyone would say yes to “doing everything.” And treating code status like a buffet was not ideal – after all, in a code, the patient would most likely be intubated, so being full code but no intubation made little sense. She pulled out a PowerPoint. Oh no. But it was blunt and short, showing the statistics of surviving with CPR after coding in the hospital and the rate of disability and levels of function status if one survived. They were shockingly low, even though I knew they would be low. I asked if she ever showed patients the numbers and she said no. “Everyone always thinks they will be the 1%.”

She said she does guide patients on deciding code status based on their medical context and their goals. For example, survival and morbidity rates with CPR in patients who have metastatic cancer are dismal. She would say to such a patient, “It would not make sense for you to be full code, for us to perform heroic measures if you died, as it would not cure the underlying disease that caused you to die.”

As a result of TV shows and movies, combined with optimism, many people who are not in the medical field don’t comprehend the violence that CPR is. It is squeezing the body hard enough to physically make the heart pump blood to the body. Ribs will crack. The body jerks from the force. CPR rarely “works” if the goal is to bring the person back to the way they were before their heart stopped, before they died. Before I knew all of this, I had taught CPR to elementary schoolers when I was in college. “This might help save a life one day!” I had said.

I respect patients’ autonomy to make decisions on their code status, whether they want full code or DNR/DNI. I also believe they have the right to know the facts about the likelihood of survival after resuscitation, and what that survival could potentially look like. I’ve heard patients say, “No I don’t want to be hooked up to machines and be a vegetable” and others say, “Do everything possible.” Ultimately, I will uphold what they choose.

VI

My dad was in a bad car crash when I was little. When my mom told me, I asked if my car seat was okay. This was not a marker of psychopathy, just a sign I was too young to understand death. A while after the accident, I asked if we could buy a new dad at the store and my mom said no, we could not. I was disturbed by this. If he had died in the accident, it meant it would have been permanent and it also meant he was irreplaceable.

In college, a friend showed me pieces by artist Adrian Piper, which involved the phrase *"Everything will be taken away"*. There were blackboards with the phrase written over and over in cursive chalk, like a student's punishment. Then there was the follow-up project with the phrase tattooed in henna on volunteers' foreheads, and they walked through the streets provoking all kinds of responses. Finally, a series of photographs with the phrase imposed over altered, blurred figures.

The idea that everything will be taken away was ominous. I oscillated between believing in its totality and trying to think of what could not be taken away. I decided I wanted to build a life for myself in which there would be immense meaning and enjoyment, even if everything was to be taken away anyways at the end. In a way, the idea that everything will be taken away is reassuring. It means go ahead, make mistakes. Say the truth. Shoot your shot. Live your life the way you want. It is all ephemeral.

During end of life, there is much that is taken away. Memories, energy, bodily functions, privacy. The desire to eat or drink. The body is shutting down. The kidneys are ceasing to produce urine, the lungs are working erratically. The heart is slowing, sometimes irregular. Blood is shunting away from the extremities to more vital organs and the fingers, toes, and knees turn a mottled blue-purple color. Oxygen levels are decreasing. The brain may be hallucinating, or suddenly become clear-headed. The person is "transitioning," the note always say. Changing. Not being taken away, not being obliterated, just becoming a different form.

For all that is taken away, there are remnants when one dies. The corporeal shell on the bed. The photographs, clothes, and knickknacks in their home that someone will throw away, donate, keep, pass down to next generations. The memories will linger, until the last person that remembers them dies. One's legacy will not be gone as soon as one's physical self gives out. But eventually, everything will be taken away.

VII

"The person will enter a coma-like state before death. There may be moments when they are more alert; those moments will decrease as death nears. Assume they can still hear you and feel your touch."

I anticipated the hospice part of my rotation to be bleak. Instead, I found a one-story building, surrounded by trees and flowers, and filled with cozy hotel-like rooms in contrast to the sterile hospital rooms I was expecting. There was a TV, comfy armchairs, no beeping machines. Light entered strongly through windows that looked out to shrubbery or small gardens.

I went rounding with Dr. T. A kneejerk response crossed my mind – I wondered the purpose of a physical exam on patients who were dying. He showed me how their limbs become so cold that I could feel my own warmth seeping into their skin, how their breathing becomes irregular and accompanied by the gasping, gurgling sound I was well familiar with.

When I was younger, I associated death with dirt, worms, cracked stones in cemeteries, and (the myth) of fingernails continuing to grow inside the casket. Death was the worst thing that could happen, unimaginable. But here, it was expected, sometimes welcomed with relief from both patients and their loved ones. A sign with a blue-winged butterfly hanging on the door meant to check with the nurses before entering a room, because someone had departed. A metamorphosis. At the university hospital, they used a hummingbird. Death is associated with flight, the iridescent wings of a delicate creature, a lifted spirit.

VIII

The hospice facility followed Catholic ideologies and their physicians and nurses signed a contract that prohibited them from providing medical aid in dying (MAID) information to patients. Fortunately, they did allow a physician to come in for a MAID visit with Laura, a patient who had initiated the process before arriving in room 211. She had already had her first MAID visit and was awaiting the second required visit, from a different physician.

Under Colorado law, a person qualifies for MAID if they are a resident of this state, if they have capacity to make that decision, if they are at least 18 years old, if they have an illness with a prognosis of six months or less to live, and if they have not been "coerced or duly influenced" by others. They must have a visit with a physician willing to prescribe the medications and must make an oral request for medical aid-in-dying medication. Then, they must have a second visit, fourteen days later, with a second consulting physician to ensure they still meet these criteria, with a second oral request. A form must be signed with a written request. Then the aid-in-dying medications are prescribed, picked up from a pharmacy, and taken by the patient at a time of their choosing. Or not. Some patients like having the security, to have that choice in their back pocket, even if they never use them. It represents the ultimate autonomy.

On a Tuesday, Laura was in incredible pain. Her son waited restlessly in her room. Dr. T had been withholding morphine per her and her son's wishes since last night, so she would be lucid for this meeting. I took up my stakeout outside the room, since I wanted badly to sit in on the MAID meeting. The consulting physician arrived at 1:30 p.m., dressed as if she were going on a hike, with sturdy boots and a backpack. She agreed to me joining her and we walked into Laura's room. She pulled up a chair beside the bed, her back to the window. She spoke frankly about the process. The conversation was raw. I have memorized the essence but remember only a few exact snippets and phrases.

Laura was certain she wanted MAID. Her voice was low and she was weak. "This, this is not living. I am already dead."

The physician asked a few more questions before discussing the medications, which she described as lethal. No euphemisms here. They came in a liquid formulary. "I recommend a sorbet with the meds. The taste is, what is the word I am looking for? It is bitter."

The alternating sips of bitterness and of sweetness would be the taste of death. She advised that the transition would occur about an hour after drinking the meds. Sometimes, longer. She said it would be possible to linger as long as overnight.

Laura understood and consented. She seemed relieved. The physician wished her well on her journey.

There was still another hurdle to surmount – Laura would not be able to complete the process at this facility. She would need to be transferred to either a facility that supported MAID or her home. Fortunately, her son was prepared to move heaven and earth for her to die the way she wished, and arrangements were made to move her home tomorrow. Almost as soon as the meeting was over, her morphine was readministered. She had been so brave. After half an hour, she was still in pain, her anxiety exacerbating pain and then pain exacerbating anxiety. A positive feedback loop.

It struck me that a key aspect of MAID was Laura being capable of drinking the medications herself. She needed to physically hold the cup up to her lips and drink the bitter liquid. Her son could legally pick up the prescription for her, prepare the medications, yet it would be illegal for him to help her drink them. I thought about patients, for example some with amyotrophic lateral sclerosis, who could meet all the criteria of qualifying for MAID, yet be unable to drink without assistance. I don't fully understand the distinction between this step and all the other steps needed to reach the point – all are critical to achieving death, but people can assist with the other steps to varying degrees. Why is the final step in the chain of events, the lifting of a cup of medications to one's dry lips, illegal, and by that legal classification, deemed morally wrong? I don't know. Possibly because it is a momentous event. Someone is assisting another human in consuming a lethal mixture. Maybe the courtroom would call that euthanasia, something I do not believe in. But if one has capacity and wants MAID, I believe that reasonable accommodations should be allowed for those unable to physically complete the task.

As it turned out, Laura would never have a strawberry sorbet with the bitter medications. Her brow was furrowed the next morning in pain and she was not lucid, let alone capable of drinking the medications herself. She would not be able to go home and die the way she had hoped.

Colorado voters approved "Access to Medical Aid in Dying" in 2016. However, it is still difficult to find a physician to initiate the process, as MAID remains controversial and information on concrete options is elusive. With a Google search, I was unable to find any specific physicians to contact about initiating MAID. Only 316 patients in Colorado received aid-in-dying prescriptions in 2022 under the Colorado End-of-Life Options Act, though this is a 44% increase from 2021. Of these, 93% were classified as "White, non-Hispanic." The place of death for 81.5% was classified as "Residence."

There is reasonable concern that MAID could be utilized maliciously. This issue should be protected against and monitored, as people who qualify for aid in dying are often vulnerable in emotional and physical aspects. It is a class 2 felony for one to "coerce or exert undue influence" on a person to request aid-in-dying medication. There is also understandable worry about MAID as a weapon against marginalized populations. Yet interestingly, and not entirely surprisingly, studies so far show that this legal right is mainly utilized by educated non-minorities diagnosed with cancer. Overall, these individuals have the resources to search for a physician who would prescribe the medications, the money to pay out-of-pocket costs for these medications, and a support network to facilitate this process. Dying in peace is a luxury.

IX

Henry could not get comfortable. The problem was not with the hospice bed. The problem was with his spine – cancer had invaded his vertebrae. Possibly his liver too, as he complained of a pain on his right side, under the rib cage. He constantly shifted around and Grace, his nurse, kept attempting to ease his body into a tolerable position.

Henry asked about MAID later that day. Wasn't there some way that he could die sooner, so he didn't have to live in this pain?

The physician, bound by his contract, answered that this facility followed Catholic ideologies and that they did not support MAID. That was the end of the conversation. No referral to another physician, no information provided on the subject. Even though this physician believed in the right to MAID, I expected this reaction – he could lose his job, his ability to serve the patients at this place.

But I was not an employee and I had not signed any contract. And I believed in MAID. Even if I didn't, I like to think I would believe he had a right to know his options. Without any of the staff present in the room, as they could not be per their contracts, I offered Henry and his wife basic information on MAID and a website. I don't know if he ever initiated the process. I don't know if he was even able to find a physician that would perform the initial visit, as his primary care physician, when I called him, was unwilling to offer MAID. I don't know when Henry died. He could still be shifting around on his bed, searching for relief from his diseased vertebrae. But I do not regret anything I did, even if it amounted to a ripple in the pond.

X

During the height of the COVID-19 pandemic, I started medical school. For anatomy lab, a rite of passage, we did not dissect the cadavers, to minimize contact between each other. They were prosected professionally. I preferred it this way, even if I lost the experience of dissection. Muscles were displayed neatly, nerves remained intact under the skillful hands of the anatomy lab team. Everything was greyer than I had expected and the formaldehyde smell made us all strangely hungry. We craved burgers and tacos as we examined the brachial plexus.

I noticed our donor had scoliosis, like me. I held her uterus, amazed at its smallness. Her brain was submerged in liquid in a white bucket and we pulled it out to look at the gyri and sulci, feeling the intricate ridges and grooves that contained her experiences, knowledge, memories in neurons that no longer sparked connections. My classmates and I kept her draped and her body tissues moistened with a spray. There should always be dignity in death, whether one ends up six feet under, in an urn on the mantle, or on a stainless-steel table with medical students gently lifting intestines from the abdominal cavity.

After our anatomy course finished, we had a virtual ceremony to honor donors and their families. One donor's son-in-law talked about how he had spent ages picking out the perfect birthday card for her. He wrote in it with meaning, and on her birthday, his mother-in-law opened it, read it, said "That's nice," and threw the card away. But she meant no malice, he explained. That's just how she was. Practical. Of course she had donated her body. She had no use for it when she was gone, he said, repeating her words. Just like the birthday card after she had read the sentiment.

There were also letters for us to read. One donor's story written by her family started off talking about how they were surprised she had donated her body to science, but that they never understood why she did anything even while she was alive. She had been born on a dirt floor "with delusions of grandeur." I admired that. Even with their bodies in the anatomy lab, opened up, cut, and separated, everything had not been taken away.

XI

After my experiences, I strongly believe "Death and Dying" should be a more substantial part of the curriculum at medical schools across the US. With a growing aging population, medical professionals must be prepared for conversations around this weighty topic. Without seeking out the palliative care and hospice elective and winning the lottery pick to be enrolled in it, I would not have all the things I now hold in my heart and mind.

I would not have been exposed to the conversations that laid open the messiness of impending death or felt secondhand the visceral emotions rushing in to fill in the practiced silences of the team. The anger from daughters who did not realize the brain damage that had occurred during their mother's strokes. The relief of a family when the team explained the choice had already been made by their loved one's failing body – they would not have to decide. I would not have had the honor of being present during the ends of Maria's or Laura's lives and learning about who they were before they were in hospital beds.

I would not know a better way to discuss code status. Or understand much about MAID, except that it exists in Colorado and some other states. I never would have had the chance to provide Henry with information about a process that could allow him to die the way he wanted and was entitled to under the law. Everything would be different for me and the care I hope to provide.

XII

I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.

Most patients I saw were religious or spiritual. They believed in a higher power, welcoming the chaplains, praying in bed, receiving the Anointing of the Sick. Me? I hope for myself a deep and dreamless sleep when I die, the same as when I have gone under anesthesia. One minute there was a surgical team around me, the next, nothing. And there would continue to be nothing if the anesthesia team was not so skilled. I don't want there to be *something* when I die. But I respect those who believe there is something more and find happiness when they find happiness in the comfort of a beyond. And most believed there was something more. They talked of reuniting with family and friends on the other side. Some could feel God calling them home.

Religious or not, spiritual or not, at the end, many of us want the same thing. To die with dignity. To be around loved ones. To be comfortable. During my elective, I filled out the "5 Wishes" booklet. Wish 1 designates someone to make my health care decisions in the event I cannot make them myself. Wish 2 delineates the kind of medical treatment I want or do not want. Wish 3 lets me decide how comfortable I want to be. Wish 4 describes how I want people to treat me. Wish 5 determines what I want my loved ones to know. Two witnesses signed it, a classmate and a palliative care provider.

I want to be prepared for anything, especially end of life. It is my wish that my future patients will also feel more prepared and that I can guide them to think about their end-of-life plans. I want them to have MDPOAs who will respect and advocate for their wishes even if they don't agree with them. I hope my patients will be able to die with clean sheets, loved ones speaking to them (as they say hearing is the last sense to leave), and the absence of pain. I hope for them a good death. Above all, I hope for them peace and I have less worry now about my ability to facilitate that.

"This is what we call the 'celestial gaze,'" Dr. T said to me during rounds once. The woman's eyes were fixed upwards, looking beyond the ceiling. "We see it a lot at the end."

Celestial. That implied the heavens. The pinprick stars, glowing orb of the bitten moon, or the orange sun sinking under still waters. Perhaps she could see her loved ones, alive or deceased. Perhaps she was in awe gazing at her idea of heaven. But after all, I think it is futile to wonder what she was seeing. This was hers, hers alone.

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The Healing Process Provided by the Doctor-Patient Relationship

A Case Report in the Amazon Rainforest

Laura Mota Vieira Lima

Introduction

Here in Brazil, we have a unified public healthcare system. It was established 32 years ago with the goal of providing free healthcare to everyone, now known as the Unified Health System – commonly referred to as SUS. This system shares the same principles as the National Health Service (NHS) in the United Kingdom, advocating for free healthcare for all citizens, with equity, promoting accessibility, and universality. However, with a population of 214 million people and a vast geographical territory, the quality-of-service delivery varies significantly between states. Consequently, private health insurance is prevalent nationwide. Thus, we divide our healthcare between public services and private insurance, ensuring that no one is left without assistance if they cannot afford their own treatment.

Within SUS, healthcare is distributed across basic health units, typically staffed by doctors, nurses, and other service providers. These units handle routine check-ups and some spontaneous demands. Patients receive both chronic and acute medications for free, and if they are unable to reach the healthcare system, home visits are provided. These visits aim to assess bedridden patients, for example, or to evaluate family situations and living conditions. In case of emergencies, the entry point is through emergency units until transfer to larger hospitals occurs.

At this current moment, I find myself at the end of the first part of this journey. I have completed six years of medical school (here in Brazil, it includes the internship), fully dedicating myself to my studies. Looking back and reflecting on all these years, I see how I committed to becoming the best version of myself by the end of my course. I engaged in numerous activities, participated in volunteer work, conducted research, but among all these endeavors, I believe that what shaped my current professional self within the medical field was understanding my limits, acknowledging that it won't always be easy, realizing the need for continuous updates, and renewing my vows with medicine. I constantly remind myself that learning is a lifelong process. Of course, I refer to this as my first professional version because with each stage of learning that comes, I aspire to transform into new versions of myself.

Over time, I had the opportunity to embark on my first expedition. I was selected to the Amazon Mission, organized by my institution, where I lived on a hospital boat, provided medical care to populations in vulnerable and riverside areas, faced extreme situations, explored new environments, lived alongside my professors and colleagues in the same space, and learned that I can deliver patient care and facilitate the healing process literally anywhere. I had eagerly wanted to live this experience. Embarked on this ship, I have experienced a huge emotional and technical growth gained in a short period of time and realized that I want to do this multiple times throughout my life. I found comfort and purpose in these extreme environments.

Exposition

The case of this patient was one of the most difficult, if not the most challenging, that has crossed my path to date. I have always sought to step out of my comfort zone, believing that it allows me to gain a different perspective on life and college experiences, and this time was no different. In this context, the case emerged this year, during my final semester, while I was working on a humanitarian mission in the Amazon Rainforest. As one of the principles of our healthcare system is accessibility, the government provides a hospital boat to deliver medical care to populations living in hard-to-reach areas in the forest. However, as there is not always enough workforce available, my university has a project that sends students to live on this hospital boat called "Abaré," which translates from the Tupi-Guarani indigenous language to "Friend who cares," for 15 days, providing healthcare alongside professors to these communities.

However, even within a mission that occurred five times during the year, we all experienced an atypical situation. It was the first time the expedition took place during the dry season, categorized as the most severe in 40 years. Therefore, the team's access to patients for external consultations and their access to the boat for internal appointments were quite challenging, making the entire logistics more complicated. On the day this patient lived this consult with me, it started as the most challenging day of the mission.

On the Tapajós River, winds are scarce, and the heat is intense. On that day, I woke up to the most beautiful sunrise I had ever seen. I felt complete, loving what I was doing and incredibly well. However, it turned out to be one of the most difficult days for accessing medical care due to the dry season. Besides the patients not being able to reach us, the boat couldn't get anywhere near the shore. We had to take a canoe on a 40-minute journey with all the equipment, walk over 1 km in the sand and mud, and venture into the dense forest to reach the unit we were going to work. In this process, my group of students and I couldn't identify the correct path and got lost for a good amount of time inside the forest. Filled with heat, a sense of despair and helplessness, and fear of encountering an unexpected animal, we eventually found our way and reached the basic unit of health. The stressful environmental situation significantly influenced our quality of attention and the care we provided, and the situation I was experiencing was completely atypical. From an inhospitable environment and frustrated by getting lost, it was in this context that I encountered the patient in question.

Arriving at the consultations, there she was – I'll call her MJ. A 15-year-old girl who couldn't even make eye contact with me, accompanied by her mother and brother. She presented with anxious symptoms, and during the consultation, I noticed that her mother didn't place much value on her complaints, trivializing these feelings and consistently downplaying them. I sensed in the patient's lack of eye contact, in the difficulty of lifting her head, and in her defensive stance about expressing her true feelings that it was time to speak with her alone. I politely asked for permission from the mother and continued the consultation on my own.

Throughout the entire consultation, I tried to establish eye contact, but I found myself speaking to the top of that girl's head. Her leg trembled every second, unable to stop. I realized that if it was challenging for me to get there and stay focused after getting lost in the forest, imagine for her, who lacks support and has such limited access to healthcare. I held her hands, allowing physical touch to make a difference and alleviate some of her pain. We breathed together, listened to the birds, felt the intense heat in the room, noticed the sweat trickling down, and then, as I listened to her, I discovered that her father didn't recognize her as his daughter, that her symptoms were not just anxious but involved hallucinations. I realized that her mother was overprotective and isolated her from everything she liked, causing her to breathe in these negative feelings. I learned that people at school treated her poorly, precisely because of the isolation imposed by her mother and the perception that she had love relationships with girls. I heard that the only person she trusted, a distant cousin, had moved far away.

It was a lot. And it was a lot all at once. I felt like the world of that teenager was slowly crumbling, and at that moment, all she had was my support and my willingness to do whatever I could for her. So, I made a pact with this girl based on what I believed could help, and she agreed without hesitation. Most of the time, when a patient asks for help, they communicate with their entire body before verbalizing, if they even get to talk about what they feel. I gathered this information and asked for the preceptorship.

If it was a stressful day for me, it was also challenging for the volunteer professors dealing with all the cases of every student. However, as we were the only option for the patients, we remained steadfast and willing to provide care. So, when the preceptor entered the consultation room where I was attending, even she was struggling to think clearly. The energy inside was so heavy, so stagnant, that she had to step out to breathe and consult with another professor. It was when I was alone again, and MJ's mother returned to discuss instructions and treatments.

I left the room the first time. I couldn't feel so much anymore. I asked for permission to consult with the preceptor and cried. I hid and cried. I cried a lot, for the first time in my life, during a consultation. I do not know if it was because of the story, the girl's lack of support, her family's lack of assistance, getting lost in the forest, or the intense heat – I just felt everything. I felt all the helplessness, the sadness for not being able to do more, and I felt everything all at once. But, 2 minutes later, I recovered. I stood up, washed my face, and stopped crying. Sometimes showing the patient that we can also cry is not a sign of weakness but a sign of strength. However, in this specific situation, I realized that I needed to be the stronghold and support for MJ. I needed to have the strength to give her the courage she needed to break free from the spiral of anxiety and schizophrenic episode.

In that wave of realization, I returned, sat down, and began talking to the mother. I explained explicitly how confining the patient at home would hinder her recovery. I suggested close contact with the cousin who provides support in the capital, explained the use of medications and mindfulness in anxiety crises, and referred her for psychological counseling – all before prescribing the indicated medication provided by the public healthcare system. Since the mother didn't want to take her to the psychologist on previous occasions, I sought out the local nurse to deliver the referral and ensure this assistance. I spent over two hours with this patient in consultation, in a hot and enclosed room, alone. And it was incredible what happened after it all ended.

After talking extensively, discovering what was really happening at home, understanding symptoms and contributors, after crying and regaining composure, the consultation concluded. I walked out with her and her family from the room and handed over the referral. She looked at me, into my eyes, with fixed and sustained eye contact for the first time in two hours, and she hugged me. She hugged me tightly and thanked me for helping her in that moment. She looked into my eyes again, held my hand, and left. It was at that moment that I turned around, entered the unit, and started crying again. Crying a lot for not being able to do more but having done everything I could. Crying because I was able to connect with that girl to the point that, after a whole consultation looking at the top of her head, I earned her trust enough to deserve eye contact and a hug. Crying because I could rewrite a part, perhaps, of that story that could have had a different ending. And I think I only had the courage to show my emotions thanks to the professors and colleagues who were there with me.

Reflection

I absorbed this patient encounter as a challenging moment but also as a time when I felt a lot of support. I felt protected, in contrast to the helplessness I had experienced when I got lost in the forest. There were abrupt emotional variations in less than 4 hours that influenced my perception of this consultation.

It might have been due to the environment, the patient's complaint, or the feeling of powerlessness that often accompanies the medical profession, but it was the first time I cried during a consultation. More specifically, I had to leave the consultation room to cry copiously.

To provide context, here in my country, we are familiarized to dealing with very difficult situations. Many regions of poverty, hunger, and abandonment surround our patients, especially in the region where I live (Northeast) and where I encountered this patient (North), as these areas are more difficult to access and face government neglect. Therefore, I had already dealt with cases of abandonment, violence, and lack of family support. I've attended to homeless individuals, people without food, and those with little or no hope. Do not get me wrong; it's not that I didn't feel bad or even terrible attending to these cases. It's just that here, you learn that separating your emotions will help you think more clearly about the case and your patient, learning to stay strong in difficult situations. With that in mind, I had never cried during consultations before.

So, my reflection will revolve around why I felt so much that I cried, as I believe it defines the essence of how this doctor-patient relationship reflected upon myself.

On that day, reflecting on the consultation afterwards, I felt content with what I had managed to gather from MJ's history. I was pleased to have gained her trust to the extent that she confided to me – after all, this is the essence of building a good quality doctor-patient relationship. However, something within me caused a great deal of pain. As mentioned earlier, pain due to a sense of helplessness and the inability to maintain close follow-up with that patient there and then. This is how I defined this experience – a demonstration to myself, as an almost-graduated medical professional, that I could handle such a situation independently in the future, but that, at that moment, I didn't need to. It showed me that even if I choose to specialize in psychiatry, I am prepared to support a patient to the point of eliciting their confidence. It demonstrated that, even in stressful situations and inhospitable environments, I can make decisions that benefit my patient and advocate for them until the end. Perhaps more importantly, it revealed that I have developed the intuition to know when I need to speak with the patient alone and learned to be who they need me to be in a specific situation.

After discussing with the professors and reflecting on my feelings, I understood why I decided to leave the room. Besides being something ingrained throughout my entire medical education, I knew she needed to remember me as a figure of support and strength so she could navigate through crises and face her daily challenges. It was necessary for her healing process, which was the priority.

If every instance of patient care involved attentive listening, a genuine complete understanding of the patient, and the true freedom for them to make active decisions about their treatment, the healing process for each individual would be clearer. They speak – verbally and non-verbally, with gestures, retractions, expansions. They ask for what they need. This does not mean you won't prescribe the recommended treatment; it means that, depending on the type of patient, the way you communicate influences the quality of adherence and comprehension of the treatment.

Upon realizing this, after reflecting on why I had cried, I understood the catharsis of this experience. It was, in fact, a healing process for me. It healed me from six years of medical school, repeatedly stating that the approach was person-centered, but it still had much focus on the disease. It cured my perception of the patient, demonstrating how much I can achieve with just conversation and support. It allowed me to experience placing her as the protagonist, and the greatest gift was her eye contact and my first experience of feeling without barriers. Feeling as I should.

There are times when stories are genuinely challenging. There are times when you cannot hold everything inside. But there is always a chance to seek help, support, and understand our own limits.

On that day, not a single person among the 40 on that boat failed to approach me. Everyone hugged me and offered support, wanting to know about the case to understand what had made me so sensitive. The professors walked alongside me towards the boat. I remember passing through the forest, seeing the river in the background, and one of the professors explained what could be done while listening to my vents. She advised me to speak with the local nurse on the boat, provide the patient's name, request a home visit, and ask them to monitor the family situation, alleviating my sense of helplessness.

The mission environment was distinct. We had the preceptors as friends, as equals. We literally lived on the same boat, shared meals every day, felt each other's pain, and exchanged hugs throughout the day. I felt free to be as human as possible, to give my best every day, to be myself. In just a few days, I learned that sometimes we cry with the patient, and that is not wrong. I know that when I felt what I felt, I had support. Having this support changed my perception and made me feel things more intensely, helping me process everything I experienced during the consultation. Even though I was warned that we would face challenging situations, and I was prepared for it.

Nevertheless, this experience of grappling with my emotions made me understand that I can feel more during consultations, that I do not need to detach so much. While knowing what belongs to you is beneficial for maintaining mental sanity without carrying everyone's problems simultaneously, feeling a bit of what the patient experiences daily exercises the art of understanding and has made me a better doctor.

In the end, I felt strong. I felt that I could be a doctor, that I was ready for it. I remembered that we cannot do everything, but we do everything we can. I felt like I tossed that star, my patient, back into the sea, and I needed her to cross my path to feel ready to graduate.

Action

I felt exposed to a patient in need of attention, a plea for help. She was demanding freedom: the freedom to see her cousin or even openly acknowledge her attraction to girls; the freedom to leave home and live her own life; the freedom to play the guitar and play soccer, the freedom to do what she enjoyed.

She demanded attention: from a mother who did not value her symptoms and feelings, despite suffering from the same anxiety symptoms; from a mother who was overprotective and tried to prevent her from having female friends, to avoid dating girls; from a mother who would not take her to a psychologist because she did not want a daughter labeled as crazy; from a father who always told her that he did not recognize her as his daughter, so he simply pretended she did not exist at home.

She demanded understanding in terms of health: recognizing that her symptoms were stemming from an anxiety crisis and that they were not imaginary. Understanding that she also experienced hallucinations, which were not fabricated, that it was reasonable to feel fear, given the organic explanation for these symptoms, and, most importantly, there is a perspective for improvement and treatment available.

She was seeking help: to be able to trust other people, look them in the eyes, and to be able to socialize and create strong relationships. Thus, she needed support from the school, as she was a patient who was bullied because others believed she was gay. As also required guidance due to her mother's overprotectiveness, which already kept her away from socializing with friends.

She sought family support: since the patient only had the support of a cousin, whom her mother allowed her to associate with and talk to, being the one she trusted the most and shared her thoughts and feelings with. However, he had moved to a distant region and had stopped having close contact with her. In addition, she only had younger siblings unable to provide concrete support, and her relationship with her parents was already strained.

She sought tools: ways to deal with anxiety crises so as not to trigger unfavorable outcomes, such as self-harm or suicidal planning. Means to calm the mind and promote self-awareness, as leaving the family context was not a plausible option at that time.

And she demanded treatment: medical treatment to keep neurotransmitters regulated and reduce anxiety symptoms. Furthermore, medications for hallucinations and therapy to develop self-awareness and the ability to make decisions independently, as the environment strongly influences her symptoms. Within this framework, she demanded longitudinal care, one of the principles of the Brazilian health system (SUS), which ensures continuous patient follow-up according to their needs, something almost impossible to achieve in these hard-to-reach regions.

I believe these were the main demands I identified in the consultation; there were many areas to cover within a spectrum of complaints, and, of course, not all patient's needs would be addressed by me. From there, comes my perception of the need for a multidisciplinary and diverse team to achieve the effective improvement of this patient. Understanding that many of the demands presented are uncontrollable, therefore everything I could do was listen, demonstrate support. So that's exactly what I did.

I asked the mother to leave the room at the beginning of the consultation to try to create a safe environment for her to tell me what she really felt, without interruptions or hostile remarks from her mother. When I found myself alone with MJ, I asked questions about the home situation together with how she felt. I did something that I always like to do with adolescent patients with anxious complaints, which is to ask what they enjoy doing. I discovered that she loved to play guitar as well as play soccer but was prevented from doing so by her mother. I asked how doing these things made her feel and if that reduced her crises, planning on incentivizing them. I took her hands and taught her the mindfulness technique, focusing on external concentration. We focused together on everything around us, such as sounds, smells, and touches, and it was the first time she stopped shaking her leg and felt her heart slow down. I taught her to use this technique in her routine as a tool to calm anxious feelings when she felt them at home.

I explained her symptoms, how they were caused, and how they were not imaginary. Making it clear that it is something with treatment but that she needs to do what she likes and surround herself with people she trusts, like a new friend at school or the cousin she mentioned. I encouraged the presence of this family member in her life and reinforced this when talking to her mother, showing that visiting him would bring various benefits to the evolution of her treatment. I also explained why she needed psychological support and how regularly talking to someone, like she did with me, could help her understand her symptoms and create strategies to deal with them.

Thus, when calling MJ's mother back into the room, I explained all of this to her. I conveyed how her daughter had real symptoms and required attention as well as how she should not assume the position she had taken, always concerned about what her mother would think or do, always afraid of her reaction. I explained the importance of her assuming her role as a mother and not placing this responsibility upon her daughter. I mentioned that one of the most important things now was to allow her to have leisure, to resume playing soccer and playing the guitar. I advised that soccer would help with anxiety symptoms and that it would create another support network for her, with new friends. Furthermore, I emphasized the importance of this freedom and attention so that her daughter would not remain isolated within her own negative feelings and breathe only that every day.

I was very clear about the treatment, recommending therapy along with informing the local nurse that this consultation had taken place and that the referral to the psychologist had been made. I also said that I recommended psychological support in the capital, so that she could be with her cousin again, providing greater support. I explained the importance of having trustworthy friends and how certain freedoms were necessary for her personal growth.

At the end of the consultation, I contacted the local nurse, explained the significance of the case, and expressed my concerns. I asked her to ensure a home visit to understand the family context and how the patient was assisted and treated at home. Additionally, I requested close monitoring of this girl to assist her closely until the critical period of crisis subsided, ensuring as much as possible the longitudinal care proposed by the Brazilian Unified Health System (SUS) and effective treatment.

Furthermore, everything was documented in the medical record so that the next team which attended to her could continue with the instituted measures. I maintained the medications for continuous use, adding those specifically for schizophrenia. I explained how to use them and emphasized the importance of continuous treatment.

Despite many issues to be addressed and my feeling of burden and difficulty, I genuinely believe that MJ understood everything I explained. Both she and her mother seemed willing to do whatever was necessary for the patient's improvement. It was a complex situation, but I feel that my duty was fulfilled, and I managed to address all the demands, both those explicitly stated and those implicit in a consultation full of social variables.

Progression

I believe my growth was significant in these small moments when I could understand this case. As mentioned earlier, I internalized that I could cry and learned to recognize the moments when the patient needs me to represent something for them.

In the future, I want to practice the virtues which I believe are essential in medicine, as reflected in this encounter. Hopefully, more tools will be developed to keep the flame of empathy always burning within my journey. Keep the understanding that many times I am all the patient has, thereby I need to embrace them with tenderness.

In various instances, routine may make me forget this calmness, empathy, and necessary patient support. Therefore, I want to always reflect on this case, remembering how a comforting conversation and quality listening can heal. Medicine is a holistic discipline, addressing not only organic complaints but also the broader aspects of patient experience.

Always keeping in mind my limitations. Aiming to discern better a favorable environment for conducting a consultation would benefit my future patient interactions. I acknowledge that I was in a stressful situation and that I will likely face such circumstances again, given my intention to maintain contact with humanitarian expeditions. In that context, we were providing care with limited resources, often sitting on the ground. However, even with few resources, I could have chosen an open area, a cooler environment, to enhance the consultation experience. Instead of addressing a challenging complaint in an environment that did not favor concentration and was uncomfortable for both of us.

Furthermore, in terms of understanding my limitations, I realized that I was not doing well after getting lost in the forest. So perhaps, talking to someone I trust before the appointment, or taking a few minutes to breathe or walk, listening to calming music, would be something to incorporate into my daily medical practice. It is a lesson to carry into my life: I have time to take care of myself and make small gestures which will protect and prioritize me, enabling me to provide the best care to my patients.

Also, learning to receive support is always a delicate matter for me. Often, I try to navigate difficult situations alone, and in medicine, it's no different. Incorporating into my practice that I can – and often need to – consult more experienced individuals is crucial. Remembering how being vulnerable felt reminds me that allowing myself to be helped is beneficial. For my practice, it's essential always to recall that I can ask for help, and it benefits not only the patient but also me.

This patient showed me the kind of doctor I aspire to become in the future and taught me that I always need to keep learning. As I aim to pursue a residency in psychiatry, acquiring more experience will expand my tools to facilitate effective clinical treatment. Nevertheless, even with all the specializations, maintain alive the primary instrument of healing in every patient – empathy – is essential. With empathy, I can precisely identify the patient's needs, being a characteristic to be developed as much as – if not more than – any technical knowledge.

In this regard, the focus of future medical training should revolve around creating situations that foster empathy, humanized care, and support. Providing opportunities for direct patient contact from the beginning of medical school and discussions about difficult situations would be valuable. This goes beyond clinical case discussions, including attitudes and tools to increase patient protagonism, such as open-ended questions, letting the patient speak uninterrupted for the first 2 minutes, and other person-centered medicine techniques.

Additionally, offering opportunities for travel and humanitarian expeditions, with scholarships and benefits for students, would be beneficial. Even though not everyone will travel to serve at-risk populations, the curriculum could include mandatory volunteer projects, increasing students' exposure to diverse populations, preparing them to become empathetic, resilient physicians with greater awareness. Truly teaching the creation of self-awareness mechanisms that make students internalize the need to be well to heal others.

In any healthcare system, a humanized approach, placing the patient as the protagonist and relinquishing the exclusive power of treatment choice to the physician, benefits patients, improves adherence, and reduces professional pressure. I believe that students who could encounter cases like MJ's would redefine medicine along with undergo immeasurable personal growth.

Conclusion

After this experience, I intend to pursue my specialization in a setting with a public healthcare system that still allows and encourages participation in humanitarian expeditions. Among the various moments in university that could justify my choice, I believe what weighs most is patient protagonism and the healing process through empathy as well as quality listening. It is in this context that I find myself today, with this vision of medicine.

During the specialist training, the priority will be to gain more experience, to acquire the necessary knowledge to handle cases like MJ's, also to be reminded of why I chose medicine.

I have a specific goal to pursue specialty training in London within a public system – the ideology of public health strongly appeals to me – with the intention of learning in a universal system like mine that emphasizes humanization and a horizontal relationship with patients. I aim to have more resources available to provide quality care and feel more confident in making independent decisions. However, as I promised myself during my graduation week, I want to continue stepping out of my comfort zone to learn more, understand the world and different cultures, as I believe that will be my differentiating factor in patient care.

I want to remember that I can do a lot with resources, but I can also achieve much without them. And, finally, to treat patients as I would like to be treated.

Looking ahead, when I may not be able or have as much willingness to travel, I believe I will continue volunteering closer to home, doing what I can and creating projects. I have discovered that these endeavors keep my desire to be a doctor alive, even when the routine is challenging, or complicated bureaucratic situations arise. I seek for the opportunity to always encounter patients like her, especially when I have more experience, to better understand how to rewrite their stories, casting stars back into the sea.

Hope this report can offer you a different vision of the world, hopefully I was able to transmit what I felt. Even if I do not get to meet you someday, writing this letter was like a call for myself, a way to keep her memory eternal. Some people do not get to experience consults like this, but I was glad to be the one that lived this with her. Also, I feel thankful to have learned something to take with me within my journey.

Thank you for reading my account, and I hope I have contributed. Thank you for the opportunity.

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Medical School: Pushing Boundaries and Beyond

Dorothée Otte

Introduction: From Nightmare to Dream Career

Bortfeld, the village where I grew up. I switched from the elementary school in the village to the high school in the city next to us. It was the time of friendship books. You were allowed to write what you liked most, what you wanted to become, and what you absolutely could not imagine becoming. I answered the latter with full conviction "doctor" (and misspelled it, because I always got confused with the sequence of letters in my native language German). 16-year-old me on a trip to Minnesota, USA, as part of the CBYX program from the German Bundestag and the American Congress. I was able to visit the Mayo Clinic in Rochester, MN, USA, because an acquaintance of my host family worked there. Insights were gained, fates moved me, dreams were created. Three years later, I found myself studying medicine. After two elective internships in cardiac surgery, one in the ENT department and two internships in general practitioner practices, my path led me to my next internship.

Hospice: The Place of Encounters with Mr. W, Death, and Oneself

It led me into the hospice in my hometown. Without a precise understanding of the significance of this place, I set foot in the majestic building on my very first day. It was the only facility of its kind in the city, with coveted and limited spaces. I was to become a part of it for the next month. At that time, my studies had not explicitly covered palliative medicine. However, I had two points of contact at that time: one of my tutors in my “Professional Development” course had additional training as a palliative care physician and gladly shared his experiences about his work. The acquisition of this additional qualification has been possible in Germany since 2004. While it was founded by a dozen people back then, now several thousand individuals opt for this additional designation as a “palliative care physician”. Thanks to my tutor, we were able to discuss topics such as patient and care directives, power of attorney (POA), and euthanasia. During one of my internships at a general practitioner’s office, my supervising physician was also responsible for the care of palliative patients. His empathy, passion for his work, and approachable nature inspired me. One encounter will always stay with me, when we sat across from a patient who was the same age as my mother. His skin and sclerae had a yellowish hue, he was gaunt, and his eyes lacked their usual sparkle. He had been diagnosed with terminal pancreatic cancer. However, during our conversation, it became clear that he had never been informed of his final diagnosis. When he heard that he might have at best 6 months to live, he wished to have a moment alone. I admired my supervising physician for finding the right balance for this patient, between empathy, professionalism, and focus. So, three months later, I found myself in the hospice; it was to be my third encounter with palliative care – and with Mr. W.

I chose this experience out of my own interest in this field. Not all our patients can be saved, even though our studies mostly focus on how to best treat patients. I was now in a place where patients resided, whose lives were already limited, with an awareness of death, their own death, and a desire for a passing with the highest possible quality of life. While serving meals, I got to know each hospice resident. Each room presented its own challenge: while some felt lonely, others threw food at me, had screaming fits, or did not react to anything said or offered. I did not experience the typical consultation as in a general practitioner’s office, but rather an approach to persons who found themselves in an exceptional situation. Because who thinks, without being confronted with a life-limiting illness, about dying in a hospice, and who knows so far in advance that they will get one of the coveted spots before death removes them from the waiting list? I had never thought about death before. When my grandmother passed away, I was 11 years old. I did not cry. One of the residents was Mr. W. Although it wasn’t a typical consultation, our first encounter began with mutual inspection. A slender, sunken man whose mouth corners were not pulled down by life experience but rather mischievously pushed upwards as he spotted me with the tray. There was an immediate connection and sympathy for each other. He sat on the edge of the bed, his shirt neatly ironed, looking much too big for his delicate body.

Later, I learned that he had been a teacher for most of his life, had lived completely independently until recently, and suddenly faced the separation from everything he knew. Conversing with him was effortless; his charisma and intellect kept the conversation engaging. Day by day, we got to know more about each other. He thanked me every time for my time. On the third day, after reflecting on the experience, I did the same for him. He was the one with limited time and invested so much of this precious commodity in me.

Another patient captivated me with her entire presence. The pillows seemed oversized compared to her delicate body. Even though her makeup was meticulously applied, her face showed no expression. Neither did her body. We never exchanged a dialogue. During a hand massage, I told her about my day. I used hand techniques that I had learned during an employee training at the hospice to help patients feel their own bodily boundaries again, which often blur quickly for patients who have been lying down for a long time. We did not make eye contact, but she was there. In the exchange with Mrs. K, I learned to reflect on my communication on both verbal and non-verbal levels. What do I say to her? How do I say it? And how do I come across to this elderly lady? In those moments, I could apply and question what I had learned in my communication lectures. But what is it like when my counterpart neither responds nor reacts?

After a week, Mr. W, closely followed by Mrs. K, was the room where I spent the most time. We talked about his time as a teacher, a human being, and a world traveler. He mentioned his son. One day, he sat on the edge of his bed looking slightly nervous, trying to fasten the last button of his shirt, which did not seem to want to cooperate. Through our conversations, I knew how much he missed his independence, which had been abruptly taken from him when he moved into the hospice. The button found its way through the right hole, and he thanked me for letting him do it himself. His attentiveness to his surroundings was unique. I felt that this should be reciprocated; it was the least I could do. He told me that his son would come to visit today. He had not seen him in two weeks. He wanted to bring some things over. His eyes sparkled with life in the midday sun shining through the window.

The next day, I encountered a man slumped in a room that, while still clean and tidy, now seemed sterile and empty. Today, the emptiness of the room seemed to swallow up the old man. Where was Mr. W? He wanted to have his meal in his room today, not downstairs at the communal table. His speech was more hesitant than usual, and he seemed withdrawn, thoughtful, almost absent-minded. As I was halfway out of the room, I heard a slightly trembling but composed voice: “He didn’t come.” In that moment, it struck me that I could not begin to understand how Mr. W was feeling; there were far too many missing pieces about him, his person, and his life for me to comprehend fully. Yet I found myself saying something like "I can understand how you feel." During the last three days of my internship, Mr. W stayed in his room. We talked, but he seemed much quieter than usual. He did not receive any visitors. This fact affected me in some way, even though perhaps it should not have. On my last day, I held his hand and told him that I looked forward to experiencing the midday sun with him.

So began the first week after the end of my internship, and the longing for my more human self, drew me back to the hospice. With my backpack filled with sweets and a candle, and a homemade cake in my hand – a mole cake, his favorite. After a warm welcome, a nurse looked into my eyes for a long moment and touched my shoulders: "Mr. W has passed away." I did not drop the cake, nor did I lose my smile. My heart did not drop. So, he had already left us before he could greet the faint spring sun on a walk before he could enjoy his favorite cake one last time.

Shortly after saying my goodbyes, I met a good friend, a trainee at the hospice. I asked her if he had received any visitors since I had been gone. She shook her head. So, he had left before he could see his son again. She hugged me and said, "I was outside with him yesterday; he was incredibly happy." This deeply touched my heart. It is the power, happiness, and joy that we can create through our collaboration.

An Experience of the Extraordinary Kind

This internship not only expanded my horizons in dealing with palliative patients, but it was a journey to myself. It had a lasting influence on my interactions with others. I became more attentive to others. So, a frail grandmother did not get lost in the hustle and bustle of people in front of the bus, but I helped her confidently onto the bus. I actively observed my surroundings instead of letting them passively rush by. I inspected as if on a medical inspection – unbiased, open, and attentive to the "patient". The more I saw, the more I developed a sense for people, I collected knowledge of human nature. It became easier for me to approach the new residents, and I was not surprised by flying food bowls anymore. Either because the residents did not feel forced to such measures due to my adaption process towards my surrounding, or because I was now warned. I dealt with death. It changed my perspective on life and gave me appreciation, gratitude, and vitality. It may sound controversial to some, but this place gave me such strength that after every shift, I went home with a smile on my face and in my heart. I heard that my aura had changed. I noticed this because I found myself engaging in conversations with various people more often during everyday activities, at the supermarket, while exercising, or while taking a walk – and that felt incredibly good.

While I also regularly had conversations with Mr. W, I noticed that no matter how much I learned about him, I knew little about him. Why did the son not visit his dying father? What was his relationship with his wife, were they separated, or had she already passed away? My thoughts about the residents accompanied me on the bus ride home, until I tried to consciously put them aside when passing through my front door. One of the first pieces of advice a doctor gave me. Did that always work out so well? Let's just say I have gotten better at it.

With my decision to study medicine, I did not just choose the path of "wanting to help people", but the path to becoming a medical expert. What is professionalism and what does it mean for us as future doctors? With which of the Can-Meds roles can we most identify individually, and which ones do we consciously strive for? In the context of our seminar "Professional Development", we discussed exactly these questions. Professionalism – some of us agreed – also means maintaining distance alongside empathetic behavior. We take care of the patient, but we draw a line between being professionally involved and being privately involved. When the boundaries blur, then one starts to swim. However, everyone draws this line differently, which is why every doctor handles a specific situation with a patient differently. Reflecting, my naive self was possibly driven by comradely curiosity when it posed these questions to Mr. W in its head, while my medical trained self now realizes that it was possibly my subconscious professionalism that prevented me from asking these questions out loud. I was not a comrade, at best in a supporting role, but I was still in the leading role of a caregiver. How much was I involved then? And how much was I allowed to be? In my opinion, there is no right or wrong, only a spectrum from white to black. The gray area is a popular place. In this gray area, self-reflection on my feelings helped me to get to know myself and my human limits. This reflection had already begun in my medical training as part of our "Communication" classes, but I had not yet attributed importance to it. The focus there is on learning appropriate communication skills for future interactions with patients – from the "simple" consultation to the pre-treatment consultation or patient briefing. With standardized patients, we prepare for our annual final exam, the OSCE. After each conversation, we reflect and receive feedback. The internship also gave me insight here. Because I noticed how much I benefit from reflecting on my self-awareness. And is that not the basis for empathy? The more open I am to my own emotions, the better I can interpret the feelings of others.

When I was confronted with Mr. W's change in behavior due to his lack of visits and other personal factors, I noticed that although I was ready to recognize, understand and empathize with Mr. W's emotions and thoughts, I asserted too early that I could understand him because at that moment I certainly did not. What drove me? Perhaps the need to create closeness and sympathy and build trust, as we had learned in medical school, an emotional foundation for upcoming, professionally focused conversations. It took the rest of the day and the bus ride home until I had organized my thoughts, all information, and impressions until I could really say, yes, I can understand his situation. To truly empathize, I needed additional information because as much as I knew about him, at the same time I did not know enough to be able to put myself completely in his shoes.

Facing Mortality: What It Made Me Do

In my elective internships in cardiac surgery, I learned about maximizing human efficiency. Everything was timed, everything had to work, everyone had to work. Everyone was a cog in the spinning hamster wheel. There was no room for failure. You were needed. This demand had been ingrained in me since the beginning of my studies. I did not want to disappoint. And these experiences further defined and strengthened my own standards. However, when confronted with the death of the frail old lady Mrs. K, which has been so close all along, I ignored that demand. Previously, in my internships, I had experienced composed professionalism. A patient passed away on the operating table, and that was it. It was not indifference, but an unspoken prohibition hung over everyone's heads, prohibiting any emotional, human reaction. It did not require much adjustment from me because it seemed normal to me. This normalcy seemed to be shaken because when Mrs. K died, part of my lightness died with her that day. In the morning, I was surrounded by a feeling that prepared me for the fact that her soul would soon leave us. When she did, we opened a window for her as the candle outside her room danced in the air, just as she would do now. I left the room without saying my goodbyes and asked to go home. My emotions overtook me while my mind went blank for a split-second. Then, my mind raged with chaos, but peace reigned in my heart. I got on the bus, observed those around me and got off again. I walked the last 12 km home. My thoughts were still raging, but my emotions were now rolling down my cheeks in tears.

Since then, in my studies, I have encountered more often the internal drive that compels me to act in a certain way. However, what is important is not what comes out of it, but what it makes us feel. During a submission, I experienced how much my mental health suffered from this additional time-consuming submission between work, study, and family problems. It caused me to collapse internally until it became externally evident to those around me through weight loss, hair loss, and dark circles under my eyes. My surroundings caught me. It took some time for me to minimize this demand to a minimum, and I still struggle with it – some days more than others. But in this hospice internship, without even knowing it, I took a step away from it, a step towards a healthier, more fulfilled version of myself.

When my time at the hospice was coming to an end, the director asked me for a meeting. Her words deeply moved me. Sometimes we forget how powerful our spoken word is and how much we can destroy or build with it. In my case, it was the latter. She said, "To know your limits, to act on them and to gradually push them further, is the key to your future." And she was right. In my studies, I constantly encounter my limits. And while I sometimes push back my boundaries, such as my limits of endurance, there is only growth in my personal development with each step. While Mrs. K's passing threw me out of my emotionally detached normalcy, there was no storm of emotions within me when I learned of Mr. W's death. I walked to his room. In front of it, a candle was burning, just like it had been the case with Mrs. K a few weeks ago. The window was open. I saw Mr. W lying in his bed, wearing an ironed shirt that was much too big for his slim body and the two corners of his mouth that were not pulled down by life experience, but slightly pointed upwards. Perhaps he had found peace within his inner chaos after all. I took his cold and stiffened hand in mine. It was the first time I touched the body of a deceased person whom I knew. In that moment, I devoted all my thoughts to him, thanking him for our encounter. He had made me part of the person I am today. Part of the doctor I aspire to be. I felt a sense of self-blame, mild sorrow, and a sense of peace. It is not always the case that the patient is enriched by us, as we provide them with enlightenment and our attention as a doctor, but Mr. W enriched my life and gave me a part of it that I did not yet know. And so, a part of him will always live on within me.

Lessons Learned: A Time of Realization

When I was 11 years old, death had no significance for me, so it did not trigger any emotional reaction in me. Furthermore, I honestly did not have a strong emotional attachment to my last remaining grandmother; she was nice to me, but so was our neighbor. My encounter and subsequent relationship with Mr. W (and Mrs. K) gave me my emotional depth. And by that, I don't mean that I am now overwhelmed by uncontrollable emotions, but rather that I can allow myself to feel. Previously, this was never something I missed, because as I quickly noticed: feelings were less valued during the daily hospital routine. However, my current self would wish for the transparent veil of emotion prohibition to be lifted. For some, it may work well to consider emotions as private rather than professional, as that is their self-imposed boundary. However, this should not be a standard for everyone, expected from everyone. Because I am convinced that there are indeed some people who deliberately suppress their emotions just to meet this standard – as I would do now. Not only do they suppress their feelings, but occasionally their humanity as well. I stand by my feelings and my humanity because they allow me to act more empathetically and reflect emotions, which can catch patients when they are falling. It is my way of connecting with patients, to create a pleasant atmosphere for the patient, but also for myself.

In doing so, I only must admit to myself: Be aware of promises you cannot keep. It was discussed in medical school, but sometimes good intentions and promises slip out faster than is good for oneself. Not all promises can be kept, and this may leave some people cold, but it gives me inner restlessness. When Mr. W passed away without me being able to take him out with his wheelchair to enjoy the sun, accusations against myself crawled up inside of me like an inner tornado. And here it shows: in a team, you catch each other when one is falling. It makes a good person to feel inner happiness by making others happy. With this stroll, she not only brought happiness to Mr. W, but also to me. My tornado of accusations crumbled into sand and dust. One realization, landing on the ground of hard facts, remained: Do not make any further promises. That is the line I've drawn for myself.

When I decided to pursue this degree, I simultaneously decided against my mother's wishes. She wanted me to pursue a degree with financial support during the training. I then chose a study program that is time-consuming, unpaid, and lengthy. So, I saddled my racehorse and rode off. But what I noticed: my studies are not a racetrack, but an exhibition of things that one should enjoy and let take effect on oneself so that everyone can react adequately to the exhibited objects at their own pace; I realized that it might take me longer to come to a mental decision. And since this internship, I allow myself to take this time as well. Coming from a family with financial instability and emotional strain due to chronic illness, I know how difficult it can be to allow this change in thinking. But there is another way. So now I allow myself voluntary insights into various medical fields that personally advance me and enrich me medically. The medical license is no longer a distant goal that I am working towards. Instead, I dedicate myself to the journey to get there, which one should not lose sight of just as much as oneself along the path.

Do not lose sight of yourself during your studies. It is a journey to yourself, not away from yourself. Two of my friends in medical school are being treated for depression. Various factors and the stress of the first year of study have broken them. I know this abyss because I stood there. It is not a nice place and not one where you want to stand alone. Working in the hospice and the subsequent bus ride home as a contrast program has shown me how little we pay attention to other people in our everyday lives. Everyone is in their own bubble, trapped in their thoughts. Since the pandemic, the seat next to you on the bus is firmly occupied by a shopping bag or any other object of choice. The exchange with each other is successfully blocked. When one eventually manages to push through to the person and the shopping bag could make space, one is faced with the next obstacle: the small white earbuds in the ears of many fellow human beings: the headphones. Everyone can do as they please, but can we not actively engage with our surroundings instead of passively letting it rush by? In our society, there is an urgent need for a shift towards each other, rather than away from each other.

However, my time in the hospice not only revealed my wishes for my future or for society, but also my limits. And just as my two friends with depression would advise me now, this experience advised me: know your limits. Because as Demi Levato sang in 2020: It is “OK to be not OK”. It is okay to not function sometimes. It is okay to need time for yourself. When Mrs. K’s death opened the Pandora’s box of my emotions, I felt my personal limits. And deciding to acknowledge and listen to them allowed me to grow personally. Our individual limits are flexible. With every encounter with “a patient, a person, a human being worthy of respect”, as Jil Keir so beautifully wrote, I adjust these boundaries. Don’t force them to be pushed further too quickly, but here too applies: Enjoy the journey. Know your limits and push them further – all in your own pace.

Medical School as Balancing Act: Navigating the Human and Medical Realms

The knowledge I gained in my studies about diseases, known or unknown to me, brought not only insight but also a certain heaviness into my life. I no longer saw a person directly as such, but rather as a puzzle of their disease. I knew what the prognosis was for a certain diagnosis, I had images in my mind of what the cancerogenic abnormality looked like in the patient's tissue, I knew things that I wished I would not have known during the consultation. I wanted to be a human being, with ease and approachable for my surrounding, not a machine of knowledge. I struggled with parts of the role that my seminars tried to teach me. Self-doubt, fear, identity loss, who am I? I needed time to deal with the impressions, the responsibility, and ultimately the patients, and thus become approachable for them. I realized that I can be both. Human and health advocate. Human and professional. Human and medical expert. A doctor and myself. This inner conflict I could only fight out with the help of patient contact from the beginning of my studies. In lectures such as "Patient Colloquium," students can meet a patient. One gains a sensitivity for conducting conversations during consultations as well as a clinical intuition. It can be overwhelming and enriching at the same time. Such early contact allowed some to realize that the chosen profession is not the right one, or conversely, confirmed their decision.

In each of my internships so far, it has been the encounters with people that have deeply affected me and moved me on a personal level. To give every medical student, the greatest possible chance for personal development, there needs to be freedom in the curriculum. Optional modules, where students can freely choose their focus areas, would be a way to support the process of self-discovery and promote encounters with diverse individuals. In the preclinical phase, this is exemplarily implemented by being able to choose from numerous research projects and organize one's elective internships according to individual interests. This offers a great deal of autonomy and personal development. However, there is a lack of this same freedom in setting priorities during the clinical phase of studies and in the selection of mandatory clinical internships. At my university, the allocation of internships during our clinical phase is done through a lottery system. The chances of gaining insight into a particular field are therefore in the hands of an algorithm. If one does not get a placement in the chosen discipline, one loses time or is assigned to another specialty. Each specialty offers valuable experiences, but I am convinced that one can benefit even more from unexpected encounters if they lie within fields that interest one from the outset. In the limited time we have in medical school, we should be able to invest time, as the precious commodity it is, as effectively as possible in our future.

Not only can the structure of medical training pave the way for us, but it also provides opportunities for us to not lose sight of our surroundings. During my internship, it became clear to me how quickly and unconsciously this can happen.

And not just there, my fellow students were struggling with certain demons, just as I was, and yet no one knew about it. Organizing workshops that address the importance of key topics such as mental illness, genital mutilation, or chronic pain to facilitate and promote intimate exchanges among students. A diverse range of regular such offerings can only enrich the journey through medical studies, help us grow as individuals, and enable us to actively perceive our environment again. Sometimes, alongside all medical know-how, it is quite beneficial to realize that we are human beings.

Embracing the Journey: Finding Yourself in Medical Studies

I would like to encourage each of my fellow students: Do the voluntary internship. Take the time for your studies that you need. Don't measure yourself against others but get to know your feelings and yourself. Only in this way can we understand our fellow human beings and ultimately our patients. It is okay to need distance from death. But it helps to have dealt with it, because it is a constant companion for some of our patients, a surprise guest, or a frightening construct for others. We can only help if we try to understand, listen, and engage with what is being said. It is an exchange that should not only be based on medical facts, but also gives room for personal growth. This study, this path to becoming a medical expert, this life we have chosen will push us to our limits. Acknowledge them. What do they do to you? How does my body, my soul, my mind react? What is best for me right now? Boundaries are there, but they are flexible. Push them further, feel comfortable, and find yourself. I found my emotional side. I cried for the first time over the loss of a person I had known for 13 days. And it opened a door within me to the vision of the doctor I want to be.

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On the Inconvenience of Empathy

Tuyen Pham

There's a phrase that you may be familiar with if you've ever loitered in a hospital hallway and eavesdropped on the conversations happening between the doctors and the medical students.

"Good signs".

A patient has a "good sign" if they have a clinically discernible finding of their disease that a nervous and inexperienced young student can appreciate. Of course this is quite silly when you think about it because having any signs at all does not bode well for the patients. For medical students, however, "good signs" is music to the ears. You hear a consultant utter the words "bed 24 has good signs" and you're already halfway there, reaching reflexively towards your neck for the stethoscope looped around it. Your fingers are hot and ready on the trigger, eager to plant your stethoscope on that patient's frail chest like it's a flag.

On this particular afternoon I was once again embarking on the eternal hunt for patients with "good signs". I wandered through the maze of hallways like a rudderless boat, each nurse station an island in a sea of floating, faceless patients. They proved as elusive as ever, but as a fresh-faced third-year medical student my search was fuelled by coffee, naivete and an impressive zest for the concrete jungle of hospital life.

Predictably, desperation soon began to erode my enthusiasm. Potential patients turned down my requests for histories one after the other, with many shooting me blank stares or telling me outright that they were sick of students. It was nearing 4 o'clock. The lingering effects of Covid hung over the wards like a muffling blanket, casting weary fatigue into the faces of all the staff members. The next tram home was beckoning me, but I was determined not to leave without having seen a patient.

In a last-ditch effort I decided to finally brave the dementia ward, a floor of the hospital that had felt too intimidating to venture into until now. The first nurse I came across pointed out a cardiac patient nearby with a clear murmur. Jackpot. I set off to find them with a bounce in my step, already thinking through differentials in my head.

I never made it.

Five doors from the patient's room a horrifying, blood-curdling scream stopped me in my tracks. I almost tripped over the carpet in shock. In the room I was passing an elderly woman was stretched out on a mattress, her skeletal hand trembling in the air between us. Pale blue eyes looked straight at me as she cried out.

"Help! Please help!"

I scrambled through the door towards her. My heart was pounding so hard it felt like it would ricochet out of my chest. I was only three weeks into my first ever clinical placement. Was this an emergency? Were there any nurses around? Where was that button?

It didn't take long for me to realise that there was no actual crisis. Not a physiological one, anyway. As I knelt down next to the makeshift bed on the floor and exchanged my first words with the frail woman before me, it became clear that she was only distraught by the staff's ignorance to her cries. She simply wanted someone to acknowledge her for who she was; long-suffering geriatric. Classic dementia case. Dressmaker from Athens. Human crushed alive by the weight of one hundred years.

Woman by the name of Helen.

"What's your name?" she asked, her breath wheezy and shallow.

"My name's Tuyen. It's nice to meet you."

"Tuyen ..."

"That's right."

"I want my daughter." Her hands balled into fists and she slammed them down on the bed with all the force she possessed. "Where is my daughter? She was just here to visit me. I want my daughter back!"

"She'll come to visit you soon. It's okay. She'll be back."

"She will?"

"Yes. She'll be back as soon as she can."

She settled back into her pillow, satisfied for the moment. "Are you a student?"

"Yes. I'm a medical student."

"A medical student." She leaned forward and beckoned me closer. "What's your name?"

"My name?"

"Yes. What's your name?"

"My name's Tuyen."

"Tuyen. That's a nice name," she said. A sudden equanimity passed over her as she looked serenely up at the ceiling. Then she shot upwards.

"I want my daughter!" she screams. "Where is my daughter?"

"She's coming back as soon as she can. She visited you today, didn't she?"

"Yes. She came today. I want her now! Please!"

"I'm sorry, she can't come right now. But she'll be back as soon as she can."

"Alright. Alright. Thank you."

"You're welcome, Helen."

For one hour I sat by her side, holding her veined hands as she oscillated between states of delirium and lucidity. In one breath she would scream out for her daughter; in the next she would cry with gratitude purely because I had taken the time to speak to her. Whenever she slid into that brief penumbra that her condition would occasionally allow her, she would turn to me and ask for my name. Then the pendulum would swing and she would again lapse into confusion. I must have introduced myself a dozen times in that hour.

As I learned how to reassure Helen, I also learned her uncanny quirks. When lucid she was a remarkably funny woman. She hated compliments about how well she looked for her age ("I'm old! I don't want to hear that I'm not old. I don't want the compliment.") and had a great eye for fashion ("This skirt, is it vintage?"). She could name the fabrics my clothes were spun from better than I could.

"Is this silk?" Helen asked me one time, gesturing to my shirt.

I shrugged. "You're the dressmaker. You tell me!"

She rubbed my sleeve between her fingers and wrinkled her nose, almost in disdain at the telltale texture of modern polyester. "It's a blend."

Suddenly Helen lurched upwards with a surprising burst of strength and gripped my wrist. "Be careful of the bad people out there," she told me fiercely. She gestured out the door with a vigorous jerk of her head. Only when I nodded did she settle back into her pillows, a deathly calm settling over her again.

I wondered if she meant to speak of the world in general or if she was referring to those outside her room. From her perspective we were the enemy, faceless strangers who refused to look her way or even acknowledge her existence. But as healthcare workers on the other side of the curtain, we know that there's a different story at play. In an overflowing dementia ward, the clamour of screaming patients was the established hospital soundtrack. The staff were run into the ground, burnt out, stressed and overworked. Every other patient was making unreasonable demands, abusing staff or screaming for attention, and at the end of the day it's simply inconvenient to care. Compassion was a finite resource exhausted eons ago, a fossil fuel deemed unsustainable to keep reaching for.

But as I watched nurses shake their heads and roll their eyes to Helen's face, as they stood outside for twenty minutes with their back to her while she pleaded for them to turn around, it occurred to me how scared these dementia patients must feel. Many like Helen only wanted their existence to be acknowledged. Instead they were met with retreating backs. Helen told me that I was the only person who had responded to her in days. No wonder she'd taken to screaming. I was overcome by sadness not only for the patients, but for these people who had been so worked to the bone that they struggled to acknowledge another person in need.

After over an hour I bid Helen goodbye and told her that I would return to visit her soon. In the hallway I discussed the encounter with one of my superiors. His response surprised me.

"Don't enter the room when patients act out like that."

"What? Why?"

"Don't go into the rooms. There's nothing you can do for them."

But had I not experienced the exact opposite? To this day I wonder if I was making a rookie mistake. These patients were unlikely to survive or even remember me. Many would say that I was setting myself up to be hurt. Perhaps sensitivity was a skin that I would shed as I underwent my metamorphosis into a doctor. Perhaps in years I would look back and smile ruefully at my innocence, glad that I aged out of the blissful ignorance of youth.

But perhaps that's just another spoonful of sugar to help the medicine go down. We see enough of that already. You talk to peers about how you feel and they throw thought-ending cliches at you like it's a defensive play. "It is how it is". "That's just the job, isn't it?". This is the way things roll around here. Studies have shown this and studies have shown that. But have studies shown the smile of a 100-year-old woman as she offers you the flowers in her room? Have studies shown the look on her face when you tell her you'll visit again, even though nobody else will?

What studies have in fact shown is that the more we see, the more our empathy reduces. Maybe once you've exited the revolving hospital doors enough times part of your soul gets snagged on the way out. You grow resistant to it the further into the waters you wade. Pulsus paradoxus, not only in the flesh but in the mind.

Around me it was already happening. I could sense the detachment on the lined faces of the other doctors, the way they walked around looking like a beaten edge. But as a medical student I still inhabited that interstitial space before true responsibility set in where I could spend hours with patients and bask in my own warm-bloodedness. I was determined to remain there for as long as I could.

And so each afternoon I mounted the stairwell to the dementia ward in my best outfit, emotionally bracing for Helen to have forgotten me. To my surprise, although she continued to ask my name, her face would reliably light up in recognition each time I rounded the corner. I would sit cross-legged by her bed as she shared stories, commented on the colour of my earrings and cried for her dead husband. Often we sat in pure silence. In the relentless din of the hospital, we had found a brief window of peace.

Through this I am reminded of the archaic practice of bloodletting; withdrawing blood from our veins in manageable doses for therapeutic benefit. In school we're encouraged to break in our organs. Let them feel something. Haemorrhage those emotions. But medicine dictates that there is a point where the proof of concept intersects with the economics of real life. You see your first few deaths, get a taste of the job and now it's time for the heart to shut up shop. Anything more and it's just an impracticality, an obstacle to vault over by yourself in the shadows of bathroom cubicles and hospital carparks. I'm told it becomes a practised motion after a while.

All this to say, do we really feel as much as we think we do? I watch how humans pass by each other, each of us encased in our own mutinous bag of flesh. So many numbed to the senses, afraid to expose ourselves to the cold bite of life. Conservative management, all the way through. But I scored just past the middle of the bell curve and ended up here by a centenarian's bedside, listening to disjointed tales of Athens and hushing her cries. I'm no medic, but what I know is that people die. They die of disease, of heartache, of pure dumb luck, but also of time. I wonder how long you can lay there on the floor, crying out for the people in front of you to look your way before you start to look away too.

I remember when Helen asked me to meet her daughter, the only child she had not outlived. The next afternoon I slipped away from my ward round early and climbed the stairs to her room, hoping that I'd finally catch her family during visiting hours. Instead of her familiar smile, I was greeted by someone soaping down the blow-up mattress on the floor. The flowers that Helen had offered me were gone from the corner of the room. There was not a trace of her left.

A panicked interrogation of a nearby nurse revealed that she hadn't died but had been discharged early. Although I was grateful for Helen's health, I felt a melancholy pang at having never said goodbye. I wondered if I would ever see her again. If she died, I wondered if I would even know.

Patient death was an idea that I hadn't had to grapple head-on just yet. The closest I'd come was during mandatory dissections in medical school. It was there where I learned the difference between a cadaver and a body donor. A cadaver was a corpse, sourced through various means and not necessarily with the consent of the deceased. A body donor had explicitly and voluntarily donated their body to science. We were told strictly not to refer to the bodies as cadavers. That was not what they were. They were donors who had made a sacrifice to further our learning and they were to be treated as such; with utmost respect.

The cohort was in a buzz before the first dissections began. Many relished the opportunity to prematurely wield scalpels and surgical tools and fulfill their childhood dreams of becoming a surgeon. I, on the other hand, was terrified. I'd never seen a dead body before. I'd never even had somebody close to me pass away. Now not only was I expected to see dozens of dead bodies every other week, I was also expected to cut into one on the first time.

I remember clutching my arms as we walked into that frigid underground laboratory for the first time. Rows of bodies were laid out on their slabs – their beds, as I liked to call them. There was a collective exhale of relief from the group when we realised that the faces of the donors were covered by a sheet. We would be alright today. We'd see their insides, yes. We'd take them apart layer by layer, inspect the texture of their skin, the colour of their blood vessels, but we would not have to look them in the eye. There was a difference there. Interesting how dissecting a body was, well, just that. Looking into someone's face? That was somehow too much. Now there was a curtain to separate us and we basked in the mercy of that detachment.

Starting with the arm, we dissected upwards and moved to the clavicle and the heart. Week by week the sessions slowly evolved from a nerve-wracking, sweat-inducing affair to that other class that we had after lunch on Thursdays. Even I was becoming desensitised to the sight and stench of a dead body in front of me. In my mind the head was not attached to the body. This delusion was what made it achievable.

After a few months the schedules for the upcoming block of dissections were released. We looked through them while we went through handwashing procedures and retrieved our lab coats from the lockers. Lungs next. After that we would move on to the abdomen. That would be unpleasant. Then it was head and neck, and then … wait, head and neck?

Head and neck?

Head?

And neck?

Until now that ghostly veil hanging over the donor's face was the only thing that was keeping me from spiralling. I was treating them as a body instead of a person. But what would happen when I was finally confronted with their ears, their lips, their eyelashes? This was someone's father, someone's son, and now I had to pull apart their face and swallow the fact that they were dead in front of me?

Immediately I started formulating excuses to skip that session, but there ended up being no need to. In the week before it, forearm-deep in the donor's abdomen, a member of my dissection group accidentally nudged the top half of the body. I was resolutely writing dissection lesson objectives on the whiteboard and trying not to look at the spillage of intestines behind me. My back was turned. Then I heard a scream.

"Tuyen, don't look!"

But it was too late. I'd already spun around and my eyes had fallen on the face of the person whose body I had seen turned inside-out over the past few months. The covering had fallen off, now on the floor, and my classmates recoiled at the sight. To this day the image of those pale, cracked lips and lifeless eyes are burned into my mind. Even writing this now goosebumps run up my arms. I didn't know it in the moment, but I'd started to cry. It wouldn't stop. Somewhere inside me something was writhing, turning and screaming and saying get out. Just get it all out!

I dropped my tools and raced out of the lab, wiping furiously at my eyes to stem the flow of tears. Behind the handwashing station and in between the lockers I broke down.

In my arrogance I'd assumed that if I too were cold, I could safely weather the storm of the dissections. I created neat walls of resistance around me, a veil of my own to view the world through. But now the frost was melting away and creating new places for the light to touch. It was my veil that was coming down too. I could never become truly "detached", I realised. The psyche must be heard. It must have an out. And here it was. Here it was all coming out of me, dripping from my eyelashes in one terrifying and torrential onslaught of grief for this man I had both known and never known. There was no use trying to stop the bleeding now.

How strange was it that I knew the size of his heart, the state of his lungs and his kidneys, the layers of his fascia, but didn't know his name?

As much as I wished it, the world didn't stop because I'd had a panic attack in the dissection lab. I spent a week grappling with my emotions and bracing myself for head and neck week. Even that did not prepare me for the sight of a dozen ghostly faces laid out in rows in the lab.

At first I could hardly look. Every time I did my eyes would fill and my breathing would quicken. But as the minutes ticked over, I managed to look for longer snatches of time. The tears dried on my cheeks, leaving behind only a chemical residue. I confronted this man and who he was. I pulled back the layers of skin on his cheek where they were light and paper-thin. I tried to do him honour by knowing him, by not shying away from what was in front of me. I tried to let his body serve me as he wanted it to.

My donor taught me not only the inner workings of the body, but also that everything we witnessed would come back to us eventually. The universe was symmetrical like that. It was only a matter of when. When would it *out* the way it rushed out of me in the lab? If I bottled up everything that I saw, blew it off as the workings of a short-staffed hospital or just another sad case in an endless line of faceless patients, when would I be able to face it? When would it all come to pass?

In my naivety I'd assumed that we pursued medicine so that we could help hurt people and hopefully not end up hurt ourselves. I quickly realised that this was no one's reality. It reminded me of the process of entering medical school. After defeating the multiple grueling examinations and scoring in the top percentile during high school, we all arrived at the final boss; the interview. In a frenzy students would hire tutors and attend interview coaching courses, desperate to learn the secret to the perfect interview answer. Inevitably the age-old medical interview question would come up in our discussions.

"Why do you want to study medicine?"

I remember trawling through an interview coaching website and coming across a "model answer". It went something like this:

"I'm an eager problem solver. Since I was a precocious young child, I've always been fascinated by puzzles and mathematical problems. I wanted to find the x and the y. In pursuit of this I've joined multiple computing, algorithmics and maths clubs, placing nationally in competitions. I love problem-solving and that's essentially what the medical profession boils down to. It's crucial to the discipline. What is the patient's diagnosis? What is their history? What factors do we need to consider in selecting the most appropriate treatment? Everything is a puzzle. This is why I would make a perfect doctor. Medicine appeals to my naturally logical and pragmatic nature."

This person was correct; problem-solving is a central component of medicine. What I learned during this first year in the hospital, however, was that to ignore the humanity underpinning each case was to commit a fatal error. Medicine became not so much the study of the human body as the study of humans themselves. It is not only problem-solving but the art of storytelling, of connecting with a patient on a truly human level, of understanding the underlying psychosocial and economic factors behind someone's presentation. It is the perfect intersection between science, the arts and the humanities.

I was watching a peer of mine take a medical history when this idea of patients as a problem to solve occurred to me again. The patient was presenting with constant chronic diarrhea and admitted to a high alcohol intake and recent unintended weight loss secondary to a dramatic loss of appetite. She possessed almost all the warning signs of cancer. My friend and I exchanged a look of dread before he continued with his line of questioning. Nausea? Constipation? Changes in medications? Any abdominal pain? Where? How long? Any signs of metastasis? Any previous malignancies? He was sorting through the differentials, solving the problem, getting closer and closer to the centre of the maze.

As he progressed through the history I began to notice that the patient displayed an extremely flat affect. Just like signs and symptoms, in medicine we have the mood and its poor substitute for an objective measure of emotion; the affect. It occurred to me as I watched the patient that I had never witnessed a person speak for so long without moving their face. It was as if she were a concrete slab, a blank slate, dutifully opening her mouth to reply but never showing a speck of feeling otherwise.

When we bid her goodbye she watched us leave with those dull, empty eyes, her face again betraying nothing. In the hallway outside we gathered to discuss the case.

"So," the doctor said, "what are our differentials?"

"I'm going to guess a colorectal or a gastric cancer," my friend said.

The doctor turned to me. I shrugged.

"Depression with a side of cancer?"

"Wow," the doctor said, her eyebrows raised. "You actually got it."

"Really?"

"Well, not the cancer bit. That's what we were thinking but thankfully we didn't find any cancer on her. Her diagnosis is depression."

While we were all worried about a malignancy, it turned out that severe depression had caused a lack of appetite, and this paired with her depression-fuelled consumption of two bottles of wine a night was giving her chronic diarrhea.

I learned a fundamental lesson that day. Sometimes you can ask all the right clinical questions and the answer is staring you in the face. Viewing the patient as a puzzle to be solved and fixating on finding a neat biological basis for their symptoms could cause you to forget the fact that they are also a person. We had to look at the crests on the heart rate monitors but also at the bridges between them too. Those spaces between heartbeats were the stretches where humanity bloomed. You could count the peaks and the troughs, but that undertow of emotion was what formed the fabric of the patient's life. I didn't want to forget to inspect it for holes. Just like Helen, the crisis here was cardiac in the metaphorical instead of the biological sense.

Not long after Helen was discharged I found myself on a slow morning on the wards. That quintessential off-putting hospital smell clung to the air. Around the corner visitors were grumbling about having to take the stairs after the lift had broken down again. Codes and MET calls were being announced over the loudspeaker so often it almost sounded rhythmic.

I was restlessly watching my consultant order lab work when a patient began to scream.

"Water! Please, water!"

I jumped out of my skin. The scream was ear-piercing, but here there was a very clear request. Actionable. Instinctively I started towards the room, but I stopped in my tracks when I noticed that nobody on the ward was moving. Nobody had even looked up. It made sense, of course. These were seasoned professionals who worked to this soundtrack every day. They couldn't care less that a patient was shouting. But I was no seasoned professional. I was new to clinical life and each one of these sounds startled and pained me. I was still a stranger to the depths of human suffering.

The bystander effect describes a phenomenon wherein individuals are less likely to help victims when in the presence of others. We've all heard of the bystander effect, but have you ever *felt* the bystander effect? Have you ever felt the muffling, immobilising static that fills up a room and becomes a solid form, taking up space around your ankles like weights to root them to the ground? Have you ever felt your centre of gravity lurch forward and then dip back, retreating into yourself? I was twenty years old and I couldn't move. It didn't feel like my place to.

And so it went on, on and on and on. The woman's screams rose in volume, becoming sharper and more desperate.

"Please! Water! Please!"

The sound gutted me. Still, nobody moved.

A vivid image of Helen's outstretched hands came to mind, the vision so clear that it seemed to spark some sort of kinetic energy within me. The noise was so painful to me that it would have been more painful to continue to listen to it than to do something. I moved towards the sound.

Inside the room an elderly woman was crumpled on a mattress on the floor, the image bearing a surreal similarity to Helen. She held out a shaky hand.

"Water please."

I bent down by her side. "What kind of water would you like?"

"Warm water. Please."

There was already a jug in her room. It was just out of reach on the bedside table and she couldn't move out of the bed to fetch it for herself. I stood up and poured her some water from the jug, making sure that it was warm.

"I've been calling for so long. Nobody hears me …"

"I'm really sorry about that."

I handed her the water and helped her take a sip.

"Can I get you anything else?"

"Can you help me shower?"

"I can't help you with that unfortunately, but I can ask somebody to come and help you shower as soon as they can."

"Alright. Thank you, my angel."

My consultant was waiting for me in the hallway.

"Did you get her water?" he asked. I nodded.

He looked me up and down, his eyebrows lifted in dubious surprise. This made me frown. Was what I had done genuinely so surprising? In that moment I felt that it was what anybody would have done, but when I recounted the scenario to a friend later that night, I was met with a different response.

"Okay, but she was probably screaming the entire time and annoying everybody."

"I suppose it was annoying, but you could tell that she just wanted some water."

"Yeah, but staff are burned out already. They don't want to deal with someone who's screaming at them."

"Of course, but you could tell that she just wanted water. That's all she was saying."

"The workers had probably just had enough of her. I don't think you should do something like that next time. It's like you're encouraging bad behaviour."

I couldn't help feeling slightly annoyed by my friend's reaction. Had it become radical to believe that our compassion was not a design flaw but in fact an asset? Our syringes come pre-loaded with this stuff called empathy. Perhaps we can pick and choose when to use it, and perhaps as a doctor the ratios will shift, but there were so many who didn't want to push the plunger at all. The layers of bureaucracy and emotional taxation had systematically worn them down. If hospitals were more dedicated to implementing effective support programs to preserve the well-being of doctors, to replenish their fuel and to nourish that dormant child within them that dreamed of being a doctor only "to help people", they could make room for empathy instead of siphoning it away. I truly believe that patient-centred care could be achieved if only we allowed it to take up space. Encouraging doctors to spend more time with their patients if appropriate without fearing a heavy loss of wages or shunning from their superiors could unlock more emotionally effective care. Medical students could better preserve their mindfulness by being educated on the dangers of burnout and how to fight off the attitudes of apathy that pervade the profession. In university lecture theatres, in outpatient clinics, in the hallways of hospital wards – there is capacity for it.

I've decided through these experiences that my barometer of success as a doctor would not only be a patient's physical outcome but also how I made them feel. Now I'm no medic, yet. But what I've learned is that love for people is the vital artery that links us, the connective tissue that binds us together at the marrow. And when the chemicals corrode us, when our bodies give way to the elements and the eternal march of time, perhaps we'll realise how hollow our hearts really are, and how the blood pushing through them, that proof of life, is only a composite of every interaction we've shared with another person. After all, we have each other's air in our lungs. All we can do is give mouth-to-mouth and exchange those precious words of comfort and reassurance. Look that person in the eye and truly see them. Ask another what their name is. Have them ask my name too.

I don't know if these words will still be true to me in years to come. Perhaps desensitisation is unavoidable, a dead end that every path in the maze leads to. But I truly believe that all I have to give in life is my own time and understanding. That's the real finite resource. And when my stores are depleted down the line, when I'm scraping at the bottom of the barrel for any dregs of feeling that I have left, I hope I'll search within myself for the pockets of compassion that I've kept hidden away for a rainy day. I pray I'll remember to keep mining for it.

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Virchow's Legacy: Beyond the Science of Medicine

Reflections from a Rural Australian Medical Student

Morgan W. See

Preface

Rudolf Virchow, a German Pathologist from the 1800's, has been a great source of inspiration for me since I began medical studies. Virchow's triad of clot formation is not only a universally accepted cornerstone of medical education, but a foundation principle of most curriculums. *Endothelial dysfunction, hypercoagulability, stasis of blood flow*: this triad epitomises the "science of medicine" and is Virchow's most identifiable legacy.

Yet, Virchow has another significant legacy in medicine, a legacy which was the focus of my coursework in the social determinants of health, which I completed immediately prior to medical school. In all course readings, Rudolf Virchow is referred to as the "Father of Social Medicine".

This identity stems from a time of political turmoil in 1800's Germany when Virchow proclaimed that doctors have a unique role in society to serve as natural attorneys or advocates for their patients. Natural advocacy, according to Virchow, extends beyond the consult room to patients' home lives and the living conditions which are detrimental to their health.

In the days before patient-centred care was placed at the forefront of medical school curriculums, Virchow was a trailblazer in the "art of medicine". This legacy and his legacy of the "science of medicine" have endured for the past 200 years and continue to epitomise the balanced perspective that medical practitioners need when assessing patients.

Like many of my contemporaries in medical studies, I strive to embrace both legacies in clinical placement. I am aware that Virchow intended for the science and art of medicine to be woven equally into the mosaic quilt of a doctor's clinical practice, not for the two domains to be considered dichotomously; yet, my limited experience has highlighted how quickly the balance can tip to favour one domain over the other.

This paper explores my personal experience of the tentative balance between the science and art of medicine which is at the heart of my clinical practice as a medical student. Through an explanation of a clinical encounter with a patient, I will reflect on the insight that I have gained about the importance of embracing both domains when advocating for patients. This balance is what good patient-centred care is all about.

What follows is a detailed explanation of a patient encounter, the context of my approach, my supervisor's feedback and a conclusion which highlights the need for medical students to use Virchow's domains to ensure they advocate for their patients and place them at the centre of all clinical decisions.

Part I: The Science of Medicine

I had just moved from a metropolitan hospital near Sydney to a beautiful rural area of northern New South Wales, where "coast meets country", for a final twelve-month rural placement to round out my medical degree. With pre-clinical years and short-term hospital rotations behind me, this year would be dedicated to understanding the more nuanced approaches to the "undifferentiated patient" in emergency department and primary care settings. It presented a unique environment for me to learn as much as I could about patient-centred care.

Each day, I alternated between a general practice clinic and the local emergency department. The nature of the clinical supervision was referred to as "parallel consulting", which, as I have learned, equates to the privileged position of "junior doctor with training wheels on". The patient was invited to consent to an initial appointment with me as the medical student. Given the shortage of doctors in rural Australia, with sometimes a waiting period of four weeks to see a general practitioner, patients are usually willing to comply with this request for an initial medical assessment. Following the patient's consent, I would undertake a history and examination, then report my findings to my supervisor. Ideally, this would be done in a concise manner and followed up with a proposed diagnostic workup including my differential diagnoses, investigations for consideration and a management plan for the patient.

With every individual patient encounter, I found my supervisor's teaching approach to be both instructional and collaborative. I would explain that "Patient

X has presented with symptoms A, B, C, in the context of D ..." Following each case presentation, my supervisor questioned specific findings in my history and exam and suggested modifications to my proposed management plan. To me, it seemed that the number of follow up questions by my supervisor appeared to inversely correlate with the proficiency of my case presentation.

"Are you happy to see the medical student before you go in and see the doctor?"

Prior to calling in the patient from the waiting room, my approach was to read through the doctor's recent notes and investigations about the patient, along with any hospital discharge summaries which would be flagged through the practice software. Many patients were often long-term patients who needed new prescriptions and were often unaware that I wasn't qualified to prescribe for them just yet. The days were busy at the clinic, and I found myself invested in "patient flow" through the practice to ensure everything was running smoothly and the waiting room wasn't becoming too congested.

Mid-morning on one autumn's day, I was reading through my next allocated patient's notes. Attached was a discharge summary from the small rural hospital's emergency department. As I began to read through the notes, I could hear friendly banter in the waiting room. It was Bob, my next patient, debriefing the waiting room on the weekend's football match. Bob was the maestro, and the rest of the waiting room was his orchestra.

I continued to read Bob's discharge summary from the emergency department. An abbreviated version read as follows:

Bob Jones is a 72-year-old male who presented to the emergency department over the weekend with symptomatic anaemia in the context of two days per-rectal bleeding. Bob's bloods were taken, and his haemoglobin was recorded at 87 g/L, with a microcytic anaemia detected suggesting likely gastrointestinal blood loss given his clinical picture. Bob was treated and stabilised with 2 x units of packed red blood cells and was advised to seek GP advice regarding further investigation.

Before hearing Bob's version of events, I felt I had a grasp of the "science of medicine" in which I was soon to practise. I contemplated the frameworks I would employ once Bob entered the consult room. I would screen systematically for potential sources of gastrointestinal blood loss. My mind bounced around, thinking of questions to elucidate useful information about any colorectal cancer symptoms, other vascular pathologies suggestive of angiodysplasia, any history of haemorrhoids or constipation, or liver disease contributing to possible rectal varices or coagulation disorders. The problem-solving, scientific nature of the medical history and examination was appealing to me; it's in part why I wanted to enter the medical profession in the first place.

Part II: Meeting Bob

"Bob Jones," I called.

Bob approached me as I waited by my consult room door with the adjoining sign "Medical Student".

As Bob approached, I greeted him in the usual way that I greeted all patients.

"Mr Jones, my name is Morgan See. I'm the medical student at the practice. Thanks for your time. Just this way."

I ushered Bob into the room.

Bob was a tall man, with a commanding presence. I could now understand his waiting room enthusiasm about the weekend's game; Bob looked like he might have been a rugby player in his earlier days. He reached out a calloused hand and greeted me with a firm handshake and unwavering eye contact. A typical country greeting. Bob appeared a bit pale in complexion, but that was to be expected given his discharge summary.

It was immediately apparent that Bob truly was a country gentleman with impeccable manners. His description of his time at the emergency department aligned with the discharge summary.

The salient features from my assessment of Bob included:

- 3 weeks of on and off painless PR bleeding, mixed with stool
- Tenesmus for 3 weeks
- Increased frequency of bowel motions in the past 4 weeks
- 5 kg of unintentional weight loss in the past 2 months
- Widespread family history of bowel cancer.

From my examination, the only positive finding was left iliac fossa tenderness on light palpation.

I updated my formulation of Bob's clinical presentation from my assessment; colorectal cancer was my provisional diagnosis at this point.

With Bob still sitting in front of me, internally, I started to consider the implications of such a provisional diagnosis in terms of investigations and management from this rural location. It was at least two hours' drive to the nearest tertiary hospital where a general surgeon remained on call to see emergency cases. With Bob unlikely to qualify as an "emergency case", an additional hour of driving would be needed to reach an outpatient clinic for surgical review, where an appointment may not be available for several months' time. These are the harsh realities of rural medicine in Australia. Irrespective of the challenges of accessibility to specialist medical services, the medical history I ascertained from Bob revealed that the rurality of the health service would only be a minor hurdle to overcome, relative to his daily challenges.

Bob's history of his presenting complaint was interspersed with stories of how these symptoms were affecting his day-to-day life.

Bob continued to run a cattle property just out of town; he was a farmer who "never gets sick". He had been married to his wife for 45 years. Bob's armoured exterior did break momentarily upon me asking about his wife's health. He tearily reported that she had been diagnosed with early-onset Alzheimer's disease 10 years ago and that he was her full-time carer.

In Bob's own words, "I have a full dance card at the moment". This is an old Australian expression, one which my grandmother has often used. It describes the old school hall dances where each attendee was given a "dance card". A maximum number of "dances" with other attendees was permitted, at which point the card would become "full". For Bob to have a full dance card, meant life was very busy.

To share the company of patients like Bob is a real privilege. Along with discussing his symptoms, home life and history living in the region, Bob asked me about my own career thus far and the odds of me returning here one day as the doctor at the practice. Bob was one of those gentlemen who shook hands on arrival and departure. Graciously, he thanked me for my time and I assured him that it was I who owed him the thanks. I left Bob with a parting remark that the doctor would call him in shortly.

After Bob returned to the waiting room, I took a moment to reflect on the encounter. I probably had only five minutes before I was expected to knock on my supervisor's door, thankfully only the next room along, to give my "case presentation".

From a clinical standpoint, grounded in my understanding of the "science of medicine", I felt my clinical assessment had been thorough and suggested an underlying colorectal cancer may have contributed to Bob's symptoms and recent hospital visit.

Considering the "art of medicine" and the extent of my advocacy for Bob, I felt that the interaction itself was patient-centred and that I had understood Bob's "context" or life outside of his immediate symptoms. Even so, I was already wondering about the implications of Bob's health on the care of his wife, the effect on the farm's operation, their geographical isolation and lack of nearby service provision.

With all the complexities of Bob's case in mind, I believed that on this occasion I had utilised both the science and art of medicine, which together supported my satisfaction with a patient-centred interaction with Bob.

It was time for me to present the case to my supervisor.

"Ready for me to discuss Bob?" I asked my supervisor.

"Go for it. Tell me about Bob," my supervisor replied.

After taking in a big breath, I momentarily considered how I wanted to execute this presentation seamlessly.

I began.

"Bob is a 72 year old male who has presented for review following a visit to the emergency department over the weekend for symptomatic microcytic anaemia, with a measured haemoglobin 87 g/L. With no active bleeding found, he was treated with two units of packed red blood cells and discharged with haemoglobin at 107 g/L. This is in the context of 3 weeks intermittent painless PR bleeding mixed in with the stool, increased frequency of bowel motions and tenesmus for the same time. Bob confirms he had 5 kg of unintentional weight loss in the past 2 months. Bob had not experienced anything like this before, with no history of haemorrhoids or history of constipation over the past year. He denies abdominal pain. On examination, Bob is hemodynamically stable but appears grossly pale in appearance. He examined well, with the only salient feature being left iliac fossa tenderness on light palpation. Despite no medical history of his own, nor regular medications or known allergies, Bob has a widespread family history of bowel cancer. He has never undertaken colorectal cancer screening. He is normally very well and lives an active life as a cattle farmer just out of town, and is also a full-time carer to his wife who was diagnosed with early-onset Alzheimer's disease 10 years ago. Bob has never been a smoker and never consumed alcohol. My provisional diagnosis is colorectal cancer. Other differentials include angiodysplasia or haemorrhoids being less likely. I think that whilst Bob's symptoms can continue to be treated with blood transfusions, from my assessment I would recommend Bob to have an urgent gastroenterology referral for colonoscopy to investigate a suspected malignancy for the cause of gastrointestinal blood loss."

I exhaled. The case presentations always are a bit of a mouthful; I glanced intermittently at my supervisor for reassurance that my provisional diagnosis was sound. He remained engaged throughout the presentation, a promising suggestion that I had completed the task at the expected standard.

My supervisor nodded, contemplatively.

He began, *"From what you've told me, it sounds like a scope is on the cards. I'll see him now."*

As I returned to my desk, part of me did feel like I was making a positive contribution to this clinic. I was even bold enough to think that perhaps I had made my supervisor's job easier through Bob's case presentation.

Bob was now seeing my supervisor and I had another patient to see in the interim.

During the next break between patients, my supervisor would call me in to discuss Bob's management plan, including additional factors to be considered from his own clinical assessment.

Part III: Beyond the Science

A knock on the door from my supervisor.

"So I just saw Bob … I don't think we will be referring him for a scope."

I was perplexed. Perhaps, I had missed something quite critical in my clinical assessment of Bob. Was there something in exploring the presenting complaint that I had missed?

Had I not considered other causes of anaemia at play other than the PR bleeding?

Was this more an issue regarding rural referral pathways for colonoscopies?

My supervisor's next statement could not have been more clear and direct.

"Bob said he doesn't want to go looking for a cancer, and that if there is a cancer, he would rather it find him than vice versa".

I was quick to ask my supervisor whether Bob understood the implications of not having a colonoscopy and not "finding" a malignancy to resect or treat with other modalities. Then my mind jumped to Bob's role as carer for his wife, then to the farm itself. Did Bob really have informed consent to make such a decision? And did my supervisor have a duty to convince Bob to have a colonoscopy? My supervisor explained that Bob understood the risks of not looking for this cause of bleeding, along with the implications this may have on prognosis and his ability to care for his wife and the farm.

Bob was only 72.

I still had many questions for my supervisor about why Bob would take this course of action, but they were left unsaid and unanswered. There wasn't time for a thirty minute debrief in this busy country medical practice; however, I couldn't help but take some personal time to contemplate how I had perhaps fallen short of Virchow's patient advocacy that I had always aspired to emulate. When I have reflected upon the weeks preceding my encounter with Bob, I realise I may have been chasing a "diagnostic win", a correct scientific explanation and provisional diagnosis of a patient's presentation, at the time of discussing Bob's story with my supervisor.

An accumulation of external pressures and challenging experiences in the weeks leading up to meeting Bob tipped the scales of my clinical approach and formulation towards the science of medicine. It seemed that Bob had a medical condition that I believed needed treatment, regardless of the complex factors in his life. My learnings, and the reflections that follow, demonstrate the need to always strike a balance right between the science and art of medicine.

Part IV: Chasing "Diagnostic Wins"

For context, I'll describe the weeks leading up to meeting Bob.

I experienced my first cardiac arrest resuscitation on one unusually quiet morning in the emergency department. While examining a nine-year old for a suspected swimmer's ear infection, I received a knock on the consult room door.

The nurse unit manager calmly whispered, "*Morgan, we have a 30-year-old male patient arriving in a minute who will need you on chest compressions.*"

I suppressed an adrenaline surge and nerves I was experiencing, removed the otoscope and with my best composure at that moment, asked the young boy and his mother to excuse me for a moment.

After numerous cycles of advanced life support, the patient did not survive. There was a "hot debrief" immediately following with the eight team members at the resuscitation. While this was helpful, it did not exactly eliminate the harsh reality that no amount of study or simulations can prepare you for the loss of human life. I returned to examining the nine-year old's ear canal, my composure somewhat intact. In reality, my mind was swimming with thoughts of the young man's life that had been lost only moments earlier. I am sure that will always stay with me.

Teaching days also brought their fair share of awakenings, with no way to predict how each day would eventuate. Outside of clinical placement, the year-long rotation included scheduled teaching on a Wednesday. These days generally kicked off with an "academic ward round". This involved a group of medical students closely shadowing a general physician and resident around a medical ward with narrow hallways and tightly packed rooms.

A rural physician, one of the finest I have come across, directed questions to the five of us medical students. Despite endless hours dedicated to study, sometimes I finished a ward round without having the opportunity to provide a single correct answer to the physician's questions. In the weeks prior to my encounter with Bob, I became increasingly eager to demonstrate my clinical knowledge.

Undoubtedly, medicine is a journey of learning from mistakes. When gaps appear in clinical assessment, it makes you study harder to consolidate your knowledge for the future; I find this to be a healthier practice as opposed to feeling deflated by the experience. This is a mindset that is easier to desire than achieve.

Ward rounds, resuscitations and challenging viva voces can make medical students feel uncertain about their progress. My natural response was to attempt to become more competent with each patient experience and to gain some "diagnostic wins" when quizzed during ward rounds or case presentations to my supervisor. I recognise now that the internal pressures that I was placing on myself did not align with the dispositions of self-compassion and acceptance that are required for professional personal growth in a sustainable medical journey.

Like many medical students, I strive for excellence in all that I do, knowing that upon graduation in a year's time, I will be fully relied upon in the ecosystem of a hospital. For now, as a medical student in a rural town with a stretched workforce, there was a practical need for me to already be relied upon, just as I had been in my encounter with Bob.

What did I learn from my encounter with this country gentleman?

Part V: The Art of Medicine

When there were a few spare moments, my supervisor gave me a lesson in clinical assessment that I will never forget. He told me that Bob felt he had already lived a full life. His wife had not known who he was for the past five years due to her Alzheimer's disease. He had no other family and an aged-care bed had been secured for his wife. My supervisor said that the past ten years had clearly been demanding for Bob and considerable time had already been spent in hospitals and doctors' clinics.

Irrespective of my own personal opinion as to what course of action I would take if I were in Bob's position or some of the ethical challenges involved, the clinical encounter with Bob, and resultant discussion with my supervisor, had exposed a far more significant issue for me as a medical student. I had overlooked my role as a patient advocate. I had rushed to the science of medicine, the pathology of likely colorectal cancer, without really checking how Bob felt about the various investigative and treatment modalities at his disposal.

When my supervisor left my consult room to return to his busy schedule he remarked:

"Sometimes, the patient perspective is the most valuable part of any clinical assessment."

The weight of those words will stay with me for a long time, as they should. My empathy was what Bob needed during my consult with him. He needed me to "walk a mile in his shoes" just for that brief moment, so that I could understand his perspective on the potential diagnosis and options for investigation, treatment and prognosis. On that day, my supervisor was the better advocate for Bob, whose values were importantly integrated into my supervisor's diagnostic workup. My supervisor established a special relationship between doctor and patient, one which I have learnt much from and will carry with me. The art of medicine was what my supervisor had so seamlessly integrated into his practice.

Since this encounter many months ago, I have continued to reflect upon my clinical assessment of Bob. It was paramount that I could identify where I had lapsed in understanding the balance between the science and art of medicine.

When I met Bob, I felt that I had built rapport with him. While learning about his symptoms during the medical history and examination, I also learned about Bob's experience of illness in the context of his role as a carer for his wife and helping in her day-to-day life with early-onset Alzheimer's disease. On reflection, I think that sometimes building rapport with patients can lull medical students at my stage into a false understanding that we are acting in a "patient-centred" way; I understand now that empathy and compassion for patients do not necessarily translate into true "advocacy" for their perspective about management decisions. They certainly didn't for me when I met Bob.

In hindsight, there is no doubt that I was chasing a "diagnostic win". I had endured a testing few weeks as a medical student. I wanted to feel more competent and contribute to the practice, particularly in a rural setting where medical student contributions are relied upon. I embraced the clinical encounter, applied my understanding of the signs and symptoms of malignancy and built rapport with Bob; that was easy as he was such an affable man. My shortcoming was that I had not sought Bob's opinion about what he thought was the best way forward for his clinical care. In terms of the science and art of medicine, I had embraced the former at the expense of the latter. The culmination of intrinsic and extrinsic pressures to master the "science of medicine" and appear "competent" perhaps created an environment in which I neglected Virchow's full legacy.

Whilst medical school is full of learning experiences such as these, perhaps medical training could re-frame the way students consider "investigations" of suspected diagnoses to ensure patients remain advocated for and both of Virchow's legacies continue to be preserved. Regardless of what changes may lie ahead in medical training, I am now very invested in finding a way to bring patient values to the forefront of my diagnostic formulation in future clinical encounters. I have certainly learned a very big lesson from meeting Bob and realise now that my parting words to him that I owed him thanks were truer than I realised at the time.

Part VI: A Virchow-inspired Safety Net for Patient Advocacy

There will be many times in a medical student's journey where external pressures lead them towards the science of medicine, but there must be a safety net to ensure that balance is achieved between the science and art of medicine. This notion of balance in patient advocacy is what Virchow has left for us as a beacon for patient-centred medical care.

My own clinical encounter with Bob and its resultant reflections have shifted my behaviour in three major ways, which hopefully will safe-guard against any future imbalance in my patient care.

Firstly, and ironically a consequence of writing this paper, is that regularly engaging in pursuits that facilitate reflective practice will continue to be a cornerstone of my own personal and professional maturation as a medical student. Specifically, the process of writing detailed clinical logs and journaling an analysis of my approach and emotions during clinical placement have helped me understand the context in which certain clinical formulations have been made. In essence, to create a "safety net" for patient advocacy in clinical encounters, I believe clinicians must embrace reflective practice. In terms of my own emotional endurance, reflective writing has clarified the results of patient encounters and my inevitable questions about the rights and wrongs of each experience. It seems that medical school curriculums are encouraging reflective practice more than ever and I appreciate why this shift has occurred. By understanding the context to our clinical encounters and reflecting on them – not in a fleeting way, but through extensive journaling – we can better learn from and shape our behaviours to become the clinicians we aspire to be. At the very least, such a mindset will make us open to change, a pre-requisite to embrace Virchow's sense of patient advocacy.

Secondly, from my experience with Bob, I believe that before proposing any means of investigating a patient's symptoms, with colonoscopies for instance, medical students should be encouraged to ask themselves, "does the patient know why we want to select this investigation?" In other words, encouraging dialogue with patients about investigations and their purpose may create a more precise form of patient advocacy by medical students. This attitudinal and behavioural approach may then evolve into Virchow-inspired clinical practice for medical students as doctors in the future.

Often, the "fork in the road" for patient values to be integrated into their care presents at the time of selecting treatment options. Perhaps encouraging medical students to always discuss "investigation options" with patients would provide a "safety net" for incorporating patient values into any decisions regarding their care. This was particularly relevant in Bob's case given his rurality and the disruption that investigations such as a colonoscopy may have on his daily life.

Regardless of the various external pressures or vulnerable dispositions a medical student may be experiencing, patients should be advocated for from the outset of a diagnostic work up. If this is achieved, medical students would have a better grasp of who their patients really are and what they value, so that in any case presentation, patient values can be made very clear for supervisors.

Since meeting Bob and reflecting on my initial clinical assessment involving his history and examination, I have changed my approach to patient care, so that it includes a deliberate commitment to openly discussing investigation options with patients in emergency and primary care settings. I now do this prior to every case presentation with my supervisor. This change in approach has helped me to understand the relevance of patient values in determining their care. It is one thing to enquire about a patient's "home life" during a medical history, but it is more powerful to take the time to truly understand a patient's perspectives on how they want to manage their diagnosis.

What is important to me now is to gain a fulsome understanding of the context of a patient's symptoms so that I can formulate their clinical assessment to ensure I can better advocate for their wishes. My supervisor was able to do this seamlessly with Bob. No doubt, this comes with experience, but it needs to come much sooner in medical school training. Again, with this practical form of a "safety net" for patient advocacy, I feel I can practise medicine in closer alignment to Virchow's notion of patient-centred care.

The third and final cornerstone of this "safety net" really comes down to the clinician whose legacy is at the forefront of this paper: the late Rudolf Virchow. I think that medical practitioners would benefit from following Virchow's teachings more closely. By extension, their patients would also benefit. In my studies, I have not found a physician in history who truly mastered the science and art of medicine like Virchow. For me personally, his teachings have led to very challenging reflections and honest conversations with myself about how I may have neglected my role as a patient advocate in clinical encounters such as my meeting with Bob. Ultimately, “Virchow’s triad” of clot formation should not be his only legacy for medical students. Virchow’s legacy as the “Father of Social Medicine” and his emphasis on doctors being advocates for their patients need to be central to medical school curriculums if graduating medical students are to provide patient-centred care.

While medical students may always feel under pressure to “earn their stripes” on ward rounds or in clinical placements and embrace the science of medicine or the legacy of “Virchow’s triad”, my reflections reveal that this approach in isolation, stymies patient advocacy. Medical students will undoubtedly continue to grapple with balancing the science and art of medicine. My completion of this paper has afforded me the opportunity to reflect on the importance of Virchow’s teaching for me as a future clinician. Importantly, Bob will also be a personal reminder that both the science and art of medicine should be woven together. If medical students are cognisant of the balance between these two domains, Virchow’s legacy and patient advocacy will be in safe medical hands in the years to come.

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The Guaicurus Street

Sarah Tavares Araújo Santos

One Monday in September, my Primary Health Care teacher proposed to the class that we change our day at the health center to go and help with a project known as "Todos por Elas" (All for Them). We agreed, and before we knew it, we were arriving at a popular market in the city center of Belo Horizonte in Minas Gerais, Brazil. At first, it took me a while to figure out if we were at the right address. Once we were allowed in, I understood that the market was organized in such a way that a specific and separate sector worked as an improvised health center, and was completely focused on promoting the health and well-being of everyone who came there with this need. Although Brazil may have many flaws that can be improved in social, political, and economic matters, if there is one thing that is extremely well structured and works surprisingly well, it is the public health system, which leaves no one without care.

When we entered the place, we were faced with simplicity, but with everything that a person, especially one in a vulnerable situation, might need to take care of their health. During that first moment, when we were organizing the room that had been allocated to us for the project to take place, thoughts kept coming up with new possibilities of what this experience would be like for us, and for me personally. There was a stretcher at each end of the room, in order to create improvised offices with screens forming the walls, each office set up should have all the necessary tools to treat, with all discretion and respect, the main patients we were expecting that day. Our aim was to promote sexual health first and foremost, and so we set up an initial screening section, so that anyone entering the room would first have to identify themselves. Additionally, they would have their vital data checked and, if they wanted to, they could take rapid tests for pregnancy and sexually transmitted infections (STIs).

Afterwards, each patient could either go to the Vaccination Center if they had any missing vaccines, or go to one of the clinics set up there to have a preventive examination. We arrived at the site at around 7.30 a. m. and by 8 a. m. everything was set up and ready to receive the patients. But the minutes went by … and nothing, sometimes one or the other would show up and say "Oh no, I just want to get a vaccine, you don't have to do everything else", and so we did. After the first half an hour, without much adherence to our project, the teacher made a decision: active search, "Go!".

It's worth explaining how Primary Care works in Brazil: there are Health Centers all over the city, with all the structure, staff and supplies provided by SUS, our public health system. The entire population has access to SUS whenever and wherever they want or need it, but each Health Center serves a specific perimeter of the city, so each citizen is linked to a Health Center. Additionally, even though the Health Centers have all the facilities for medical, nursing, vaccination and pharmacy care, they don't always serve all the citizens allocated to them, since there may be factors that prevent a patient from going to the Health Center. This includes anything ranging from mobility difficulties to homelessness.

Thus, each Health Center has a team of "Agentes Comunitários de Saúde" or ACS, who go out into the streets every day to bring access to health care to those who can't get to the Health Center. During our weekly classes at the Health Center as medical students, we were always free to stay and help with consultations, deliver medication and vaccinations, or accompany these agents. I hadn't done this before, so it was a new experience on this day. Some of the students remained on site in case any patients arrived and needed assistance. We then left in pairs: 2 ACS and 2 students. We headed towards our main focus with that project, the vulnerable population in a nearby street, Guaicurus. I had heard about Guaicurus Street, I knew it was famous, having been the setting for a successful Brazilian soap opera, but I still didn't know why. I did research before coming to the project, but I admit I couldn't believe it was real. There, before we left the street, an agent began to explain to us: "Guaicurus is part of the Carlos Chagas Health Center area, and that's why it's up to us to go there, from hotel to hotel, to take care of the girls." Afterwards, I managed to understand that my previous research was true and what we were referring to: sex workers.

Guaicurus Street is known for a famous story on Brazilian television, in which the young socialite Hilda Furacão scandalizes the conservative Minas Gerais society of the 1960s by turning into a prostitute. The most famous bohemian street in Belo Horizonte, Guaicurus, is still marked by the presence of "up and down" hotels, so named because they are all built next to each other, with a wide open door, a security guard at the door and staircases that are always full of men who go up and down stairs into a lapse in reality. I wasn't prepared to see how it is in reality. Remembering it was a regular Monday morning while we were walking to arrive there, I imagined it would be shocking for me, because of the simple fact that it is a situation definitely out of my comfort zone, but the most surprising thing was the number of customers present there when we arrived.

The ACS were already well known in the region and were treated with such respect and kindness. When we arrived at the first hotel, the agents I was accompanying, Maria and Fernando, started chatting and laughing with the man at the door, who I later found out was the owner of the establishment. He spoke so that the other student and I could hear, "These guys are very special, they look after the girls here. You can go upstairs, they'll be happy to see you!". That was the start of my first experience at Guaicurus: my mind was filled with various thoughts, from shock at seeing the place so full on a Monday morning, to fear at being stared at by some customers as if I worked there. However, my biggest and most important thought was not to prejudge the place, the customers, or the girls who worked there.

When I was still at the beginning of medical school, I often found myself in situations where I made opinions or judgments about patients or even colleagues. This, of course, is inherent in human beings, but we have to work to ensure that, as professionals who ensure people's well-being, we don't infer thoughts based on our outlook on life, that could jeopardize the quality of care and attention we give to patients.This was one of the most challenging moments for me, putting myself in the position of someone who was there to bring equal access to health (the principle on which the SUS is based) to the people who need it most, and not to try to understand why each person was there.

Our role there was simple: we accompanied the agents, with bags full of condoms that are given out by the SUS, and with some paper invitations, with the date and times of our project, describing everything they would have access to there. I think it's important to describe what the hotels were like and how I felt: there were 2 or 3 floors, little lighting or ventilation, and long corridors with several rooms. As we passed through these corridors, with several men around, I felt like I was in a supermarket, a butcher's shop: the rooms were kept with the doors open, there was little distance between them, and the girls were either standing at the door – perhaps in a desperate act to be more inviting to customers – or lying on the bed inside the room, just waiting for the next offer. The girls wore lingerie or perhaps nothing at all, and the men went from door to door, analyzing each one down to the smallest detail, asking prices, and acting as if they were choosing the meat they were going to take today.

As we walked, we had to focus on not "getting in the way of business", targeting the girls who weren't trying to win a customer at the moment. I was extremely surprised at how the agents were greeted by them, calling them by name, chatting about other matters, always with a smile. We were instructed to offer the free condoms, with no limit on the quantity, and then to give them the card and invite them to come and take care of themselves at the project. Most of them volunteered to go, saying that they knew it was important, but they kept saying that "one or two hours going there to take care of myself are clients and money I'm not earning". Maria, the agent I accompanied, was ready to schedule a time for the girls to go to the project, writing down the name and time in her notebook so she could go back and pick up the girls, and with this attitude I could see how she really cared. Later that day it came to my knowledge that Maria had once been a worker in those hotels, perhaps that's why she had so much empathy.

At that first hotel we were welcomed with open arms by all the girls, which calmed my anxiety a little about the experience. I admit that, as much as this made me feel a little more comfortable in that situation, I couldn't help but notice the up and down looks on me and the other student who accompanied me, making us extremely uncomfortable and in a way feeling vulnerable. This made me wonder for a while how these sex workers feel in the environment in which they work, do they feel as I did, an object of consumption in the eyes of those men? After going from room to room, three floors full, we left and, curiously, the security guard asked, "Are you of age? You look like an angel, if I'd noticed I wouldn't have let you in," which prompted me to show my ID and smile a little awkwardly. This also made me think: an environment like that, in a way so hostile, with terrible working conditions, girls almost struggling to scrape together enough money to pay the rent for the rooms they use and have some money left over to support themselves, and what mattered to that security guard at that moment was whether I was of legal age or not.

We then headed towards the second hotel, separated from the previous one by the distance of a garage. It was exactly the same environment, the same situation, the same vulnerability. However, this second hotel brought something new that I wouldn't have imagined: diversity. This hotel, which the community worker later explained was one of the oldest in the area, had a huge variety of girls, from girls who looked like they had dropped out of high school, to ladies who could be grandmothers, as well as trans women, black women, and one of them was even pregnant. I had to work hard on my non-judgmental skills at that moment. In a later conversation with the agents, it was possible to understand that, at least in a situation like that, of such vulnerability and need, which the prostitutes found themselves in, our work as health promoters ended up being more corrective than preventive, our role was to try to stop the situation from deteriorating even further.

Additionally, this second hotel had a bigger impact on me. At one point, the community worker I was accompanying started talking to the owner of the establishment, between explaining about the project and asking him to encourage the girls there, to relaxed conversations as if they were old friends. While I was waiting, I heard “Hey girl, do you have any condoms?”. I looked in the direction of the corridor from which the voice had come, and reached into my bag for the packet of free condoms. “Yes, yes, of course, you can take as many as you want” (I had been taught by the agents: sexual protection is a right, if you want to take all the condoms, take them all. We’ll bring more later).

The woman thanked me with a huge smile on her face. She was beautiful, and there was a colleague at the door of the room opposite hers, so you could tell they were friends. Two women in their 40s, with pale skin and long, straight black hair. For one lousy second before I thought about leaving, I remembered one of the principles of primary health care that my teacher ALWAYS encouraged us to practice, at the Health Center or anywhere else, which was proactivity. I admit that I’ve always thought of myself as a very shy and introverted person, and I don’t tend to take the lead in things, but at that moment I saw an opportunity to work on this characteristic that I lack and that I believe is crucial for health professionals.

So I asked for their names – another crucial factor that the teacher always taught about making the doctor-patient relationship as personal as possible – then I took the project leaflets, handed them out and explained how it worked. I wondered if they would take what I was saying so seriously, on their own, or if perhaps the lack of the ACS with me would take away my credibility. Then one of them said, “You study medicine, do you? Wow, because I have a vaccine to take, but I can’t remember what it is. I also had a test, I don’t remember when, and I got a diagnosis of x”. Suddenly, my active search for patients for our free primary care project turned into a consultation for that girl. She told me everything she knew or remembered about the diagnosis she had received, and tried to get me to help her remember which vaccine she hadn’t had. It was the most complicated 30 seconds of the day so far, until the agent arrived, joined the conversation and told her what the vaccine was that the girl was describing, saying that she would be able to get it at the project. From then on, for a long time I kept thinking about how much more I needed to study, how much more I needed to learn and be prepared for the demands of the patients. And that was stimulating, in a way, knowing that I was there, having that opportunity, even though I knew so little, alongside people who knew much more than I did, and that I should feel encouraged to learn as they did.

As we left the second hotel, the third was just a few steps away, but Maria told us, "This is a new one, I haven't talked to it yet to see if we can get in, let's go to the next one". But, surprisingly, the security guard at the door, a huge, bald man in his 40s, asked us what it was all about as we walked straight past the hotel he looked after. The ACS then quickly explained who they were and what we were doing, and the security guard promptly said, "Get up there too, you can go," which made us look at each other with a little sign of enthusiasm. There, in that small gesture, I finally realized that, even in such a simple way, the role of primary health care really did have an effect (perhaps in the long term, but it did). That man, who looked angry and serious, observed what we were doing, going in and out of nearby hotels, and when he found out why, he thought it was valid for us to do the same in his own hotel, guaranteeing the care of the girls who worked there.

This third and new hotel was totally different from the previous ones, an impeccable and extremely new structure, rooms with electronic locks, and not as many girls as in the others – Maria explained that the price of renting one of the rooms there was probably much higher than in the other hotels – so we introduced ourselves to the owners, chatted to the girls and headed for the last hotel on our list.

This last hotel was a little further away, on the next block. As we walked down the street to it, I realized how dirty and perhaps even grotesque the environment seemed to me, one of the countless moments when social inequality in Brazil infuriated me. I didn't understand how a country so rich in nature, people and cultures could have settled for being so unequal, to have people who have enough food to feed 20 people in one meal, while there are people who struggle to get a simple meal every day. In that simple street, I could see garbage thrown on the sidewalk, homeless people in every corner, people with tired looks on their faces. I don't know for sure, but perhaps because of this, perhaps because of the environment and reality that those people live in every day, the lapse of reality that a hotel "up and down" can bring is the only moment of pleasure or happiness in such a tiring day-to-day life.

This last one, apparently the oldest in the whole of Guaicurus, was the most deplorable, passing from room to room I could only imagine how many diseases and infections could be transmitted there, a place that didn't seem to be so clean, with such a large flow of people, no ventilation and dim lights. Perhaps I was already tired, but that last hotel was the one that left me with the greatest feeling of revolt and a desire to do something more, to improve the living conditions of those people, to feel more useful as a medical student in that place for those people.

We then return to the project area. When we arrived, all the improvised offices that we had set up were open. The other student who hadn't gone out to actively look for patients, seeing my surprise, looked at me and said "They came, believe me." At that moment, even if quickly, I realized that perhaps the principle of primary health care is there, doing it little by little, and even if we don't see results immediately, they come.

Even though I was tired, I helped there as much as I could with the screening, routine questions and blood pressure measurement. Afterwards, I was assigned to the vaccination area with another student. Our first patient was Marina, 38 years old, a charming woman. Tall, slender, long straight black hair, full of jewelry, a dress and high heels. The smile between the red lipstick lips only disappeared when the vaccine was administered. While the nurse who would administer the vaccine took care of the bureaucracy, we talked to Marina, who started by asking our names and where we came from. As soon as we talked about where we studied, she began to excitedly talk about how her daughter had done at university, how proud she was and how she worked hard to give her everything she could. The conversation continued the entire time, until she said to us before leaving "It may not be viewed favorably by most people, but it's giving my daughter the opportunity to do better than me, right?" Yes, Marina was a sex worker, and I would never have guessed.

Yes, they were really going to the project, taking care of themselves, even if it meant a momentary loss of customers. I was happy to see it happen, but I wondered how. How were these women really prioritizing health care over financial gain? Perhaps the prejudice rooted in me did not make me see how medical care could be constructed in such diverse ways, and that, in this case, it was constructed based on the respect and trust we gave them when going to their workplace, without offering the judgment that society already offered, but rather to offer support.

We then ended that day of the project like this, receiving them one by one, taking care of their demands, carrying out exams and tests. They all loved being who they were, they were not ashamed, they were proud to go after their money as best they could. Some came from other cities, states, and worked there to be able to send money to their families elsewhere. Without a doubt, this experience impacted me in an extraordinary way, it made me reflect on myself, on patients, on how medicine is experienced in Brazil.

Approximately one month after the project, we were back at the Health Center, assisting with care and other necessary procedures. That day, I watched the bandage change. I felt touched again, like I had never felt before except on the day of the project. That day, 2 bandages were changed, one on José's forearm, and one on Manoel's heel. They chatted outside the room waiting to be called and left the Health Center together. José and Manoel were homeless, each with their own story, both from other states, but somehow life had brought them there. And as we changed the bandages and cleaned the wounds, I couldn't stop thinking about how it showed me what the purpose of becoming a doctor was: to serve. Linked to the fact that I am a Christian, I looked at that moment in front of me, and I remembered the project with the prostitutes, and I felt the extreme certainty that I was doing what I should do in medicine, which is caring.

When we finished the bandages, I still had time, so I decided to go up to the triage and ask if I could follow. Pedro was there, a nurse responsible for the patient's first contact at the Health Center. As soon as I arrived and joined another student, we treated the first patient, Fernando. He claimed to be living in the nearby hostel – which allows homeless people to stay free of charge for 3 months – and that it had been a week since he had not stopped feeling a "stabbing sensation in the chest". Referred to the acute complaints doctor.

The second patient, Ana, a smiling trans woman, arrives complaining of lice in her wig, but "never throw it away, I paid dearly for that hair", referred to another doctor. Until Luzia arrived, a little lady of about 70 years old, 1.50m, simple clothes and talkative. It was clear from the way they talked to Pedro that they had known each other for a long time, he was joking and she was laughing. She had no new complaints, she just said (ashamed of me and the other student) that the dysuria she had complained about in another consultation still persisted. Pedro then told her that she had to take better care of herself, pay attention to her medication, and that it might be necessary to do more tests. That consultation was more like a conversation between friends. Pedro told Luzia that he was going on vacation next week and that she would have to be looked after by someone else. She was unhappy, she just liked him. He asked what day she could bring him some cheese, cheese made at home, by her, just for him, it wasn't to be shared at the Health Center.

After several laughs and catch-up conversations, Luzia went out to the waiting room to wait to be called by the doctor. Before calling the next patient, Pedro looked at us and said "Super nice, right?", we agreed, and he added "She still works there at Guaicurus, can you believe it?".

At that moment, I stopped and reflected for the next few seconds on how that statement had surprised me, and how, in fact, it shouldn't have. The fact that I had gone and met that reality just a few days ago didn't in any way make me deduce where Luzia came from; on the contrary, I was stunned to associate that little old lady with that reality. That thought stayed with me for the rest of the day, as I went back to college and saw other patients at the pediatric clinic in the afternoon. In fact, that "clinical case" I had witnessed and lived through brought up many questions.

I first thought about what my attitude should be towards those patients, who even though they weren't in a doctor's office to be cared for by us, were still my patients. I wondered if I made them feel comfortable and respected, or if my way of speaking or acting could have made them feel judged or less deserving of that care. I tried to understand whether being in that place, living that reality, having that life was really a choice, or a consequence of society; and if it was a choice, was it wrong?

Since I began my path of construction within Medicine, I have found myself in various situations that put me to the test, testing my values, my altruism, my capacity for empathy. And this moment in particular was by far the one that touched me the most. From that day on, after meeting Guaicurus Street, I didn't experience medicine in the same way.

Being a doctor in Brazil is challenging. A country so beautiful but so unequal, so diverse but so prejudiced, so rich but also so poor. And when it comes to health, everything matters: social life, the economy, even the country's political situation influences health. UFMG, the institution to which I am referring, is the largest federal university in the country, and being public, its medical training program is totally linked to the SUS. As such, all the care we students receive at the outpatient clinic is free of charge. It's an annual event, and a date at the beginning of the year is always set as "Forms Release Day". The release of forms for free medical care, for THE WHOLE YEAR, starts at 7 a. m., and the queue has already formed three or four hours earlier. Anguish and despair seize me whenever I imagine this situation, what must be the state of health of someone, without private health insurance, who comes at the beginning of the year to wait in a queue, hoping to get a place for, who knows, some month of the year (maybe September, December? The important thing is to get it, otherwise there's no way).

The weekly appointments, every semester at university, always end up becoming routine and we start to live them on autopilot, sometimes even forgetting to do more than just attend to the patient's main complaint. We forget everything that person has been through to get there. And when, in one of the countless consultations, perhaps in a doctor's clinic or pediatrician's office, the patient sometimes says "Oh, because I spent hours queuing here to get an appointment, it was hard, but I did it.", a flash of reality comes to the surface to remind me of the reason for medicine.

I believe that my career in medicine began long before I was literally in medical school. I feel privileged to come from such a diverse family and with such different realities, being able to experience different ways of seeing life and being. It took me a while to really understand my purpose in choosing to be a doctor. I don't feel good enough at many times and I wonder if I should really be there, seeing and caring for those patients. But in moments like the one I'm describing here, I'm reminded of the purpose of the journey I've chosen, which is to be a better person.

Brazil, with its uniqueness and so many flaws, makes up the best of brazilians, and I believe it has also made me better at always trying to see the good side of situations or looking for the lesser evil. The social inequality that plagues the country ends up dictating how life is lived and how we are formed as people and as professionals.

I believe that medical training in Brazil has this as its strong point, that it allows you to experience the most diverse situations, in which you need to put yourself in the most empathetic way possible, even though you bring with you all your personal baggage. It makes you reflect on your life, on the lives of others, it makes you rethink some preconceptions and ways of acting, it's a constant seeing life with new eyes every day.

As it was shown by those cases I've been able to experience, SUS, Brazil's healthcare system, grapples with lots of challenges and at the same time possesses notable strengths. One of its prominent flaws is the unequal distribution of healthcare resources across regions, leading to disparities in access and quality of care. Furthermore, insufficient funding and overcrowded public hospitals often result in long wait times for medical procedures and consultations, as I was able to see in person during my medical training.

However, it is notable that SUS stands out for its comprehensive coverage, providing free healthcare services to all the population, including medications and surgeries. Its focus on community-based care and public health initiatives, like vaccination campaigns and disease prevention programs, which shows the commitment to addressing broader health concerns. Despite all the problems, SUS remains a crucial lifeline for millions and reflects Brazil's dedication to ensuring healthcare access for its populace, even though in such a poor way sometimes.

Brazil is exactly as it is portrayed, life is not easy, people work hard and are full of character. Some starve, some do okay. We all live under the same problems that plague other nations, class struggle, political rifts, poverty, racism and corruption. The Political instability of Brazil has been its biggest shortcoming, not having an effective central government continuous like other nations has really had some terrible effects on society here. However there is prosperity and growth in many parts of Brazil, its not all Favelas, Crime and poverty. We have farmers markets, we have beach bars, we have national parks, strong social medicine, dedicated teachers even when underfunded, we have skyscrapers and hydro electric dams, and nature conservancies and so much more.

This experience as a whole shaped my perspective as a future health professional so that, in every one of my appointments from that day on, I have tried extremely hard to be there for my patient. Often we are too bogged down in the daily routine, stressed out by other situations or people, and we end up arriving at the office to see patients as if it were just another check on a "To do list". When I arrive at the clinic these days, I always pass the queue of patients outside and try not to be impersonal, I do my best to convey empathy by the way I look at them and the way I act and treat them. It's very common to see groups of medical students, often even myself, entering the hospital outpatient clinic with total randomness, talking about different subjects, with a variety of language and tones of voice, perhaps not even remembering to look at any of the patients waiting outside. For those of us who have worked so hard to get to where we are now, the process of studying medicine in Brazil can be so long and tortuous, that sometimes the monotony of always doing the same thing brings with it the failure to do it well. My approach to patient care has completely transformed. This does not mean that before I did not act with zeal and care with my patients, but today I pay more attention to details: looking them in the eyes, asking their name, even listening to stories that may have nothing related to the complaint, but at that moment, THAT person, THAT patient may need to express themselves, talk to someone, have someone who sees more than just their pain or needs.

Finally, I feel that what changed most in me from this unique case, which I could never have imagined I would experience and that I would benefit so much, was my perception of the doctor-patient relationship. I was always completely sure about its importance, I was outraged when I saw classmates who treated their patients with total coldness and without establishing a real connection with those they were caring for. I always looked at situations like this and thought about how much I wanted to do better, how much I wanted my patients to remember me, maybe not my name or when they met me, but if they crossed paths with me they would know that one day I took care of them.

The health professional's relationship with their patient must be professional but one of complicity. From the lady who wanted to take some cheese to the nurse who always attends to her, to the patient who arrives at the outpatient clinic, waits for hours in line and will have a two-hour appointment because he tells the doctor about his entire family and how this relates to your going to that appointment. I believe we need to stop racing against time and/or treating our patients like products. There are doctors out there who boast about seeing a patient every half hour. Is this serious? What level of importance do we give to those who make us who we are? And when one of those we love becomes the patient? We wouldn't accept a cold, quick consultation without paying attention to the amount of pain we are feeling, would we?

The Guaicurus street changed my medical training life. As I embark on the journey towards becoming a physician, I became more sensitive, more attentive to people and the pain of others. I don't want to become a 30-minute appointment doctor. I'm going to be the doctor my patients remember.

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A Journey into Compassionate Medicine

Taneka Tezak

Waves of tension crashed through my body. She screamed through closed lips trying not to move. I held my breath, my jaw clenched. Despite the general movement and chatter in the theatre, her scream was the only sound I could hear as it echoed through my ears. She squeezed the nurse's arm so tightly her skin went white. It was just a few minutes earlier when I had met this woman and been in awe at the calmness she had radiated. At the time she happily chatted with her husband about her expanding family and laughed about the still unfinished nursery. Now? Now she was kissing her husband before being prepped for general anaesthetic.

In the world of medicine, each encounter with a patient is an opportunity for profound learning and personal growth. The following narrative recounts a transformative experience from an early placement – a journey that unfolded unexpectedly and left an indelible mark on my understanding of the human aspect of medicine. This narrative is not just about a surgical procedure; it's about the complexities of the student-patient relationship and the powerful impact that empathy and compassion can have on both the patient and the aspiring medical practitioner.

It was day one of my women's health placement and as third-year medical student observing caesarean sections I was actively trying to take up as little space as possible in one of the corners. The sterile environment of the operating theatre provided the backdrop for my initiation into the complexities of obstetrics, and women's health more broadly. The woman on the operating table, Poppy, transitioned from that calm expectant mother to a woman writhing in pain and fear. Her scream, an audible manifestation of the emotional turmoil within, served as a catalyst for my own internal conflict – a battle between the professionalism

I sought to project and the overwhelming desire to alleviate her suffering. As I attempted to navigate the unfamiliar territory of obstetrics, the weight of imposter syndrome loomed large. The language of this specialised field felt like a foreign dialect, and I grappled with the fear of inadequacy. However, in the midst of this internal struggle, an instinct emerged – one that transcended the boundaries of medical protocol.

I don't know where I gained the ability to take that first step but one foot in front of the other, I walked over to the top of the bed. Approaching Poppy, I found myself at the intersection of vulnerability and compassion. The communication between us began with a simple question: "Would you like me to sit with you?" I now found myself in the chair her husband should have been sitting on as they welcomed their second baby into the world. The decision to sit by her head, in the absence of her husband, was not a calculated move but a response to an innate understanding of the human connection required in that moment. As I sat by Poppy's side, the weight of imposter syndrome became a tangible force. The medical terminology that surrounded me seemed like an impenetrable language, and the responsibility of being present in such a vulnerable moment brought forth waves of self-doubt and fear. Yet, in that vulnerability, a connection blossomed – an unspoken understanding that transcended the limitations of words.

Sitting with her, the internal tug-of-war continued; the clash between professionalism and empathy was palpable, and the boundaries of my role as a medical student blurred in a way I had not yet experienced. Her whole body was trembling, her teeth chattered and the tears on her face glistened against the harsh white light of the operating theatre. I held her hand and stroked her hair. It was while I held Poppy's hand and offered words of reassurance, that I found myself straddling the line between observer and participant, between the detached student and the empathetic companion.

She was scared. So was I. She asked questions, laden with anxiety, that surpassed the scope of my medical knowledge. However, I persisted in providing answers to the best of my ability, an attempt to create a bridge between the medical jargon of the operating theatre and the human experience. She squeezed my hand tight, a physical reminder of how scared and vulnerable she was. Seeking to relieve some of those feelings I tried to redirect her. We talked about her older daughter and that unfinished nursery. She squeezed my hand so tight; I could feel it going numb, but I did not mind. We talked through her baby name options. Her anxiety grew exponentially as people touched and moved her for the set up. I massaged her temples when she said she was going to throw up.

When she could no longer speak or keep focus, we breathed. I taught her square breathing, my favourite breathing technique. I was well beyond my comfort zone and felt a pressure that I remain unable to put into words. In that moment, those few breaths and the silence were as much for me as they were for her. No medical school class had prepared me for this moment. I had no idea what I was doing or how to help. Instinctively though, I knew I was exactly where I needed to be.

I am not sure I know what I felt in that moment but sitting in that seat holding her hand was the most me I had felt on placement. We continued breathing together right up until they placed the mask on her and she went to sleep with tears still staining her face. Her grip loosened as she drifted with the anaesthetic but I still had to physically remove my hand from hers. These small act of holding her hand, stroking her hair, and engaging in a shared breathing exercise became a testament to the therapeutic power of human connection, something that I did not understand until I had processed and reflected on the experience in the weeks and months that followed. Holding Poppy's hand becomes a symbol of solidarity, a tangible connection that goes beyond the confines of medical protocols. The gentle stroking of her hair, a seemingly simple gesture, become a soothing balm in the midst of chaos. The shared breathing exercise evolves into a metaphor for the synchronisation of two individuals in a shared experience of fear and uncertainty. Each action becoming a musical note in a symphony of the intricacies of nonverbal communication.

Next came the procedure. I do not really remember the details of her caesarean, I mean yes, I could recite the steps of a standard caesarean section and I am sure they were quite similar, but do I remember those few minutes? No. The next memory I have is returning to the corner trying to take up as little room as possible again. It was back in the corner that doubts began to creep in. Had I overstepped my boundaries? Was my presence an intrusion or a source of comfort? Had I done the right thing? What did the consultant think of my actions? These questions representing an attempt to reconcile the professional expectations with the intuitive responses that guided my actions.

Then? Then she was awake and frightened once more. The resident doctor was telling Poppy of the success of the procedure and how perfect her baby girl was. She was still woozy. Poppy's whole body began to tremble again. She was left alone in the centre of the operating theatre as she continued to come out of the fog of anaesthesia. It was like none of the previous caesarean sections earlier on the day where everyone had fussed on the new mum and bub. Poppy, now awake and frightened, faced another moment of profound vulnerability. The contrast between the celebratory atmosphere of new mothers and the isolation she experienced was stark. In this solitude, I found myself drawn to her bedside once again, offering solace in the form of a comforting presence. We exchanged no words. However, the hug that followed became a conduit for emotions that transcended both words and the clinical setting. Tears, whether mine or hers, symbolized the shared vulnerability that defined this unexpected encounter.

As a third year medical student I am on my journey of firsts. Many have occurred and many are still yet to come. The first code I watched while holding my breath. The first time I delivered bad news and felt the weight of that person's world shattering into a million and one tiny pieces with them. The first death I witnessed. There are many moments that I know will stay with me forever, moments that are etched into my memory. Memories that I am reminded of at the times I expect least: in the lyrics of a song, or in the darkness of you're my eyelids as I drift to sleep. These are times I expected to shed a tear, and I did. However, nobody prepared me for the tears that have come in those experiences you least expect.

Poppy and her experience into motherhood for the second time was the first unexpected experience that has stayed with me. It has changed me and how I have since approached my time on placement. After two years of cramming more knowledge about the human body and diseases that I thought was possible, I suddenly found myself in the hospital with a security card that let me into almost all areas of the hospital. The responsibility granted by a hospital security card, had initially led to a loss of self. Up until this point in my rotations, I had worked so hard to present myself as competent.

In that short time with Poppy, I experienced so much. I experienced every emotion I can name; I felt incompetent, and I felt proud, I was commended, and I was disparaged for the very same action. However, in the crucible of Poppy's experience, I rediscovered the essence of my why in medicine. Despite it being the typical answer we give, at the core, it is not helping people that draws and keeps one in medicine. Helping is simply not always enough. For me, it is recognising and responding to the person who presents in front of me.

Now, months later, as the sands of time settle, the impact of Poppy's experience on my personal and professional growth emerges with greater clarity. This journey, initially an intense moment in the chaotic symphony of medicine, has evolved beyond a singular event into a transformative catalyst for a paradigm shift in my approach to the field of medicine. What once seemed like an isolated encounter with Poppy has now become a pivotal touchstone, illuminating the delicate equilibrium between competence and compassion in the realm of medicine.

The months that followed were not a mere passage of time; rather, they unfolded as a period of profound growth. Wrestling with the aftermath of that intense moment, I found myself grappling with questions of vulnerability and authenticity. The threads of complex emotions and insights gained from Poppy's experience wove themselves into the fabric of my evolving identity as a medical professional.

Poppy, lying on the operating table, has transcended the role of a mere patient. Her image has transformed into a reflective mirror, offering a nuanced perspective on the intricate balance between clinical proficiency and heartfelt compassion. The realization dawned that clinical competence, while undoubtedly crucial, stands incomplete without the underpinning of compassion – a realization that unfolded in the sterile corridors of the hospital.

In this environment, the importance of seemingly small gestures emerged as a recurrent theme, extending beyond the boundaries of that singular encounter with Poppy. My experience became a revelation challenging preconceived notions that even I, as a budding medical professional, held before this transformative journey – an acknowledgment that doctors, like myself in the future, are human beings capable of experiencing emotions and displaying compassion.

The narrative of sitting by Poppy's side captures the essence of my evolution that occurred in the subsequent months. Despite the passage of time, thoughts of Poppy linger, a testament to the enduring impact of her journey into motherhood. She became the guiding light that allowed me to navigate the chaotic world of medicine and reassess my values as a medical student and future doctor. Through her experience, I learned the profound lesson that it is acceptable to shed unexpected tears and remain true to myself.

In the haze of imposter syndrome, Poppy became my beacon of clarity, helping me realign my compass to true north. The fog lifted, revealing the profound truth that competence, no matter how extensive, lacks significance without the infusion of compassion and, perhaps more importantly, vulnerability. In this ongoing journey, I have witnessed my own growth in confidence, acknowledging mistakes as stepping stones, and continuously shaping my unique approach to providing comfort.

The reflection on this transformative experience yields a crystallized lesson: there is always time for humanity in the practice of medicine. The small gestures – playing a game of cards, sharing a sandwich, or simply sitting with a person – hold profound significance. Through challenging conversations with myself, I have discovered that all the clinical competence in the world does not hold weight without the compassionate essence and, crucially, the vulnerability that connects us as human beings.

As I continue to traverse the intricate landscape of medicine, Poppy's indelible mark remains etched in my memory. She has become more than a patient; she is a symbol of the profound interconnectedness between competence and compassion, a reminder that, in the world of healing, the human touch is the true heartbeat of medicine.

The journey into women's health, sparked by my immersion and reflection on the experiences with Poppy and others that followed, transcended the confines of a specific medical specialty. What initially began as an exploration of the intricacies within this field transformed into a broader reflection on the implications of medical training as a whole. As I navigated the complexities of patient care, a resounding call for a paradigm shift reverberated – an urgent plea to weave empathy, compassion, and vulnerability into the very fabric of medical education.

This call for change extends far beyond personal growth; it resonates at the core of medical education itself. The lessons learned from my experiences with Poppy and subsequent encounters underscore the pivotal role empathy plays in the world of medicine. Despite the relentless demand for scientific knowledge, it becomes clear that empathy should be elevated to the status of a cornerstone in medical education. Compassion, a genuine concern and care for patients, must be cultivated in tandem with technical proficiency. Vulnerability, often misconstrued as a weakness, emerges as a strength – a bridge connecting healthcare providers with the human stories behind the clinical cases. A comprehensive education, therefore, must not only empower future healthcare providers with diagnostic and treatment skills but also instil the ability to authentically connect with patients on a profoundly human level.

However, the transformative shift needed is not confined simply to the classroom; it extends its tendrils into the very fabric of the healthcare system. Reflecting on my experiences as a clinical year medical student, it becomes evident that there is an urgent need for a cultural shift within hospitals. It is imperative to both recognise and value healthcare professionals who embody empathy, compassion, and vulnerability in their practice and teaching.

In the current landscape, where the focus often leans towards clinical efficiency and technical skill, there is a call for hospitals to acknowledge the intrinsic value of healthcare providers who bring the human touch into their care. The recognition of the significance of empathy and compassion should permeate the institutional culture, steering it away from a purely transactional approach to patient care. Hospitals should become spaces where the embodiment of these virtues is not just appreciated but actively cultivated and celebrated.

The paradigm shift calls for a recalibration of the metrics used to evaluate the success of healthcare providers. It challenges the conventional emphasis on quantitative measures, urging a qualitative assessment that incorporates the nuances of patient-provider relationships. The shift advocates for an environment where healthcare providers are not only acknowledged for their technical proficiency but also for their ability to empathize, communicate, and genuinely connect with the individuals under their care.

As I envision this transformation, it becomes clear that the healthcare system should be a nurturing ground for healthcare providers to evolve into compassionate healers. A system that recognises and supports vulnerability as a conduit for genuine connection, understanding that it is through acknowledging our shared humanity that the most profound healing occurs. This paradigm shift is a call for the healthcare system to be not just a place of medical transactions but a haven where empathy, compassion, and vulnerability are not only valued but integrated into the very essence of patient care.

The lessons I have learned and the experiences I have had as a medical student who has just finished their first clinical year are innumerable and invaluable. The intimate connection I made with Poppy and those who followed have illuminated both a path for myself on the way towards junior doctor and the path I envision for future medical education. Paths that lead to a future where healthcare is not just a science but an art – a collaborative dance between both clinical competence and compassion, guided by the profound understanding of our shared human experience.

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It’s OK, Gary. I’ll Listen to You.

Megan Torpey

It was a freezing evening, wet and more miserable than usual in late June. The day had dragged, and I wanted to go home. But I also wanted to see surgeries, so I stayed despite my empty stomach and the dull ache niggling in my temples. “Just another Friday night!” the registrar responded with a shrug of his broad shoulders, unphased. The shouting increased in volume, then a loud thud. Our team walked, with pace and intention, around the corner. There, was a man.

On the floor, surrounded. Pinned.

The Emergency Department waiting room is never a comfortable place to be. It houses the desperate as they rock prams back and forth, tired and frustrated from the long hours of waiting. It has a certain smell about it, a mix of antiseptic and the unwashed flesh of waiting patients, slumped in cold, hard plastic chairs. “Oh Jesus, It’s Gary again”, the intern doctor mumbled. I slowed my steps in sync with his so that I could discretely whispered: “Who’s Gary?”

Gary was a young man who looked much older than his years. He was local to the area and known throughout the hospital by association to his many family members and their collective complex medical ailments. Gary was a proud Indigenous man, which he would tell anyone who stood still long enough to listen. Though when he did this, it seemed to anger the staff and jolt the security guards into action.

Tonight, Gary swore and begged in frustration, “Test me!”, he yelled. “Go on, just test me. I’m sober! I need a doctor”. Gary didn’t look sober. He was covered in vomit and smelled offensive. The undeniable stench of faeces surrounded him, to which the staff responded by creating barriers between themselves and the polluted man. Disposable, yellow cloaked barriers of personal protective gowns, but barriers non the less. These physical indicators of otherness glared obviously in the stark grey gloom of the Emergency Department corridor where Gary had been ushered, away. The staff chose to unnecessarily wear multiple pairs of plastic blue gloves, one nurse sniggered to another as he "joked", "put on the whole box", which signalled a type of warning to those of us that could feel the separation and sense the imbalance hang in the cold night air. It was a public space by definition and occupation, but the unspoken words of unwelcome repulsion permeated the silence.

And Gary knew this. He knew it to his core.

The scene was one of complete disconnect. A dark-skinned man, in a colourful polyester t-shirt, lay, face down. I remember the recognisable dot print design of his garment and felt my objection to its loudness. Was I experiencing a profound sense of discomfort at the pride in which he proclaimed his identify? Or what I experiencing a sense of disconnection to mine?

I couldn't tell, but it bothered me. It was hard to look at.

Gary's arms were held tightly behind his back, forcibly restrained by the knee of an obese security guard. The staff huddled nearby in discussion, speaking about Gary, but not addressing him directly, which frustrated him further. He raised his head straining, face cocked laterally to gauge his fate. To which he was met with a mean jolt in the back of his lumbar spine. "Stay down, you black bastard", the guard spat. My whole body tightened in disbelief. Staring, shocked by the guard's blatancy, I held his gaze unintentionally. He softened his expression as our eyes met and plainly asked me, "what?" I didn't respond. I couldn't.

Later, for no apparent reason, the two security guards flanked the row of plastic chairs where Gary rested, eyes cast down. My team continued to huddle away behind the glass, separated from Gary, still. His eyes brimmed with tears, he clutched his gut, clearly in agony. I moved closer and bent down to greet him, breathing through my mouth behind my mask I winced at the stench.

"Hi Gary".

"If they've sent ya to send me home. I'm not goin'", he declared firmly but quietly.

"No, it's fine, I'm not sending you home", I said.

I cleared my throat, "My name is Meg, and I'm a Medical Student.

I was wondering what has brought you into hospital this evening?"

"I'm in pain", he groaned, pointing to his stomach.

"Can you tell me some more about this pain? Where it is specifically? Does it move anywhere? Does it come and go? Is it sharp and stabbing or dull and achy?"

He stopped, not quite knowing what to do, wary.

"No one cares, they don't listen" he protested.

I encouraged him gently, "It's OK, Gary, *I'll* listen to you". And with that, Gary told me everything. He'd been in pain for three days and nights. Vomiting, and embarrassed to say that he knew he smelled repulsive. "The vomit is green and brown and smells like …", he trailed off, humiliated. "It's OK, Gary", I laughed a little, meeting his eyes in a moment of human connection, "I can smell what you mean, you don't have to say it". We laughed together and he reached out his hand. I accepted the gesture, momentarily holding his palm in mine. The security guards moved quickly to separate us. "Sorry, I'm so sorry", he offered. Upset with himself for expressing vulnerability. He stiffened his back and readjusted his blanket tightly around his forearms, securing a type of armour.

"Please don't apologise", I said as warmly as I could.

Can I please have a little look at your tummy?" I asked. He replied by lifting his shirt to reveal an enormous, distended abdomen. I thanked him quickly. And left, telling him that I would be back soon. "Don't eat or drink anything", I called back in an afterthought.

I hurried to my team, catching the eye of my intern, I motioned with my head. He stepped back from the inner circle of blue scrubs. "What's up?", he asked quietly.

"Gary's pretty sick", I stated. Which surprised even me. I didn't recognise the boldness I was showing, "he says he's not drunk; he has a three-day history of worsening crampy pain in his lower abdomen associated with multiple bilious vomits. He hasn't opened his bowels in over a week but reports a watery trickle of diarrhoea, he also says that he feels gassy and bloated but can't fart. He has tried to relieve the pain with Paracetamol, to no effect and other than his smoking history has no other salient findings. Gary isn't taking any medications and has no known allergies. Upon examination he has a significantly distended and tender abdomen with no bowl sounds present on auscultation".

Without looking at me, the intern pivoted and stepped back into the navy-blue circle of bodies with one determined stride. "I suggest that we take Gary for a quick scan, he has an acutely distended abdomen with a three-day history of …" he continued confidently, with my summary of findings. I wasn't surprised by this blatant lack of acknowledgement, by now I accepted the hierarchy of information sharing and other hospital-based practices.

"Ok", declared our consultant. "It's not busy. Take him."

"Can I please come?" I piped up, moving forward, making myself known. I was keen that Gary should have an ally. My intern accepted in an unsaid gesture of repayment for my history taking efforts.

* * *

"What's that?", he questioned, as we stood next to the lightbox displaying a black and white image of Gary's gut. "The small bowel" I replied in an upward inflection, ever unsure of myself. "Yes, and what's that?" he probed further. "A massive bowel obstruction", I guessed, worried that my obvious answer would not be correct.

Medical school had taught me bones, vessels and muscles, receptors, binding sites and side effects but it also had slowly dissolved my confidence. I once spoke with purpose, but now I answered silently in my head, despite my correct diagnoses.

"Good get, he's gonna need surgery", he declared. "Can I please observe, I don't mind staying if there's room for a student?" I campaigned. "Go get your sized gloves and a gown. You can scrub if you like. Can you hold a camera?" I'd done it twice, which had slowed the team considerably as I mixed up my left and right, under pressure. "Yes! I can hold a camera", I hoped my enthusiasm would make up for my lack of experience. He laughed. "No, you probably can't, but go on!"

I met Gary again in the anaesthetic bay. He acknowledged my presence with a beautiful wide grin. His perfect white teeth now showed a good-looking young man. He held up his hand. "They attacked me", he joked, demonstrating the many small circular Band-Aids which marked the failed attempts to cannulate his veins. "They don't care", he said dismissively. I stopped what I was doing and reached for the small round black stool. Scooting it over to Gary, I didn't respond. It felt like he had more to say. He breathed out heavily then spoke again, out loud but not really to me. It was more of a monolog. He detailed his own, his family's and his community's many accounts of poor treatment. He discussed the barriers of accessing the hospital, both logistically and culturally. He reeled off sensible suggestions for improvements and well thought out recommendations. He used the words responsibility, advocacy, human rights, culturally appropriate care and connection to Country. He concluded by saying that he'd rather die than come back here. He explained the distrust and public opinion of the hospital from the local Aboriginal Health Service, summarising with a self-depreciating dig at himself, explaining that no sane man waits to seek healthcare for three days covered in vomit and faeces. But he did, because his prior experiences of care here were worse than that. I just listened. And when he was done, he said, "ya know, Sis? And the thing was, I actually did.

As an Indigenous medical student born to an Aboriginal mother, amid the 1950s Australian Government's policies and practices of assimilation, which included the removal of babies by forced and coerced adoption, I live the betwixt experience of intergenerational separation and the trauma that accompanies it.

I innately appreciate that the hospital setting holds much fear and an almost complete sense of mistrust for Indigenous patients. As medical students we are fortunate to have access to patients in a unique setting. Not yet responsible for care, yet participants of care-teams, we are able to engage and interact with patients in the peripheral spaces of their treatment. It is in this space, devoid of time critical emergencies, where we can practice and hone our skills, one more history-taking exercise at a time. But it is also the opportunity to listen to our patient's stories and experiences and to better understand the social determinants of their health. These patient interactions should be reciprocal and if presented, we should act on our responsibility to advocate with kindness. Afterall, the past five years of medical studies has taught me to constantly reflect on my learnings. And every day, in every way I find my place in the healthcare setting as an Indigenous person and student, challenging. Because our mainstream healthcare service is not culturally appropriate.

It is rife with racism.

Since my encounter with Gary, I prioritise the patient experience regardless of what limited participation I might have in my capacity as a medical student. I aim to listen first and advocate always. I plan to carry these priorities into my clinical practice as I transition from a student into a healthcare practitioner, remembering that the currency we are exchanging as doctors is human life. The very stuff that we are working with day in, and day out is someone's loved one. As one laparoscopic cholecystectomy blends into another, I vow to know the story behind the surgical drape and care for each patient as a person, not a set of symptoms.

Some mornings I wake up and tell myself, I don't have to do this anymore if I don't want to. Really, I don't.

I get to do this.

And that is an absolute privilege. One that I will always value and demonstrate by way of support and advocacy for every Indigenous patient, and for every patient of every race that I have the honour to care for.

Upon reflection of these sets of events, I have had had the opportunity to form perceptions of or query the responsibilities and perhaps demands that I felt exposed to. Initially in the acute aftermath of witnessing these acts of racism and racial stereotyping I catapulted into action or what one might call "damage control". I researched the Hospital's policies on discrimination, intent on advocating for patient rights through the Hospital's Reconciliation Action Plan, engaging with the local Aboriginal Community Controlled Health Service in our region as well as the Rural Clinical School teaching campus. I felt compelled to champion some type of change to right the wrongs that I had witnessed. I spent long nights discussing why these sets of events happened and at what point, in my capacity as a medical student and a soon to be Junior Medical Officer could I have intervened better to provide safer care. Care aligned to Gary's cultural beliefs and customs, care that empowered and educated him. Care that provided him with the universal respect that he and every other human should receive as their birthright. Care that promoted access and trus, and care that prevented less critical health outcomes.

Witnessing Gary's lack of all these types of care had ignited in me a guttural drive. This time is difficult for me to reflect on, as well as challenging to describe in words. It was and still is a sheer pulling of my heart so strong that I write this with a lump in my throat and the sting of emotion in my eyes. The immediate weeks following my interactions with Gary exposed me to the realities of the limitations of healthcare for First Nations people in Australia. What followed, I can only describe as a personal call to action.

As an Indigenous medical student, I know the importance of providing culturally appropriate care for our Indigenous community members and patients. As the following weeks continued to pass, my perceptions adapted into a smaller, micro-effort, whereby I settled into the opinion and hope that all medical students and staff training and working at the Albury Wodonga Health service should all hold adequate cultural knowledge and training to be able to offer culturally safe medical care; and that this commitment should be mandated by the employing hospital for all staff and students who will interact with any patients (and therefore any Indigenous patients). This opinion, was formed in the wake of the response to The Voice, No Vote, knowing that our Australian national narrative was one of little support of Indigenous autonomy or self-determination.

As such, I spoke at length with Indigenous Elders residing in the local area who were employed as Cultural Educators at our local Aboriginal Health Service. After much consultation, an opportunity emerged.

I was asked to support a conversation of reconciliation between the Director of Medical Education at the Albury Rural Clinical School and the local Aboriginal community. It was my honour to connect Uncle Sam Jupurrurla Wickman with my Medical Director, who approached the Rural Clinical School with his own ceremonial artwork, which on the back of the artwork, Uncle wrote his offer of reconciliation to the Clinical School and traced his handprint and signed his name. The Medical Director, Doctor Norden returned this gesture of reconciliation and through his own agreement with Uncle, he too put down his hand, made his mark and signed his name in commitment to reconciliation and partnership of Indigenous training and cultural education. Through this artwork, a cultural partnership was formed whereby both leaders committed to a relationship with the intention to improve the learning opportunities of medical students training at the Albury Rural Clinical School.

It was exciting for me to learn that from this interaction, new cultural emersion projects will be available for commencing students to learn from Indigenous staff as well as engage in further online cultural education modules in the medical curriculum. This new partnership excites me, not just because of the positive impact that it will bring locally to Indigenous patients receiving care through Albury Wodonga Health, but because it demonstrates real progressive change that will improve Indigenous health outcomes. Small progressive change but change non the less. Even more uplifting is the fact that this change is occurring at a time where it feels like the nation has revealed its standpoint on Indigenous affairs, which I personally believe has left many of us feeling demoralised, even further marginalised and unsupported.

Therefore, my personal future practice will be guided by the lessons from these atrocities. I will draw on these acts of racism with further tenacity to advocate for all patients. I will speak up; I will speak up loudly, but with the respect that my Elders have taught me. Because speaking up in partnership promotes change.

I believe that the foundations of our medical training as Australian Medical students should be guided by the articles set out in The Universal Declaration of Human rights adopted by the United Nations in 1948. Which declared that the promotion of universal respect for and observance of human rights was essential, and that all human being are born free and equal in dignity and rights. Such rights are given without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, (Rights, U. N. H. (1961). Universal declaration of human rights., Article 2). The purpose of this declaration was that the power of ideas would change the world. I propose that we put these ideas into action through partnership with other supporting individuals and agencies to form robust collaborations. Because together we can create positive change as demonstrated by the small efforts of a few committed individuals in Albury, New South Wales.

These actions illustrate positive and practical reform. Reform that is necessary in our Australian medical sector if we are to provide appropriate cultural and medical care. As well as reform in our medical education training for Australian medical students. It is my hope that small micro efforts such as the one that I instigated will continue to expand in collective participation until it is common practice that all hospitals and health services provide appropriate cultural health care, through committed cultural education and training practices for Australian medical students.

I know that we can do this, because we have already started.

The only way that this reform will not work; the only way that this type of improvement will not continue is if we cease our efforts, if we stop and do nothing; And I am proud to say that I will never stop and I am confident to say that I am well supported. Together, through cultural education we can improve the medical health outcomes for our patients, like Gary. All it takes is to listen and to act.

* * *

In conclusion, of this reflective essay, some further details of the partnership between Albury Wodonga Aboriginal Health Service (AWAHS) and The Albury Rural Clinical School (UNSW) have been included for context.

UNSW and ACCHO strengthen relationship

On National Close the Gap Day this year (16 March), the University of NSW's (UNSW) Rural Clinical Campus in Albury conducted a Reconciliation and Relationship event with Albury Wodonga Aboriginal Health Service (AWAHS), recognising the importance of their partnership. AWAHS is a non-profit organisation that was developed to cater for the primary health care needs for Aboriginal and Torres Strait Islander people and their families. UNSW and AWAHS have been partnering to enable student cultural education and build clinical expertise when caring for and treating Aboriginal and Torres Strait Islander patients. This type of training for doctors and health workers is critical to addressing systemic health inequity.

Looking forward, UNSW is looking to integrate more opportunities for students to learn about Aboriginal and Torres Strait Islander culture and health care. With the support of AWAHS, UNSW is expanding its teaching program at the Rural Clinical Campus to include a 2-day cultural education workshop and are also identifying opportunities to increase the frequency of medical student placements with AWAHS.

In the near future, a pilot longitudinal placement program for Year 3 medical students will commence at AWAHS, providing students the opportunity to engage in longer term care. It is anticipated the student experience and learning within this program will encourage more medical students to consider a career as a rural doctor whilst also graduating with a deeper knowledge of Aboriginal and Torres Strait Islander health care.

To view the *UNSW Sydney* article *Reconciliation & Relationship: strengthening UNSW's partnership with Albury Wodonga Aboriginal Health Service* in full: https://www.unsw.edu.au/news/2023/04/reconciliation-relationship-strengthening-unsw-partnership-albury-wodonga-health-service

* * *

Below, I have included the typewriter print on my mother's birth certificate which states the words *unmarried, woman of colour** which details the reason and circumstance pertaining to her adoption in 1952, at The Royal Women's Hospital on Grattan Street, Carlton, Melbourne; where Aboriginal babies were forcibly removed under the 1915 amendments to the *Aborigines Protection Act 1909* which gave the New South Wales (NSW) Aborigines Protection Board the power to remove any Indigenous child at any time and for any reason. The phrasing of one amendment was so broad as to enable any interpretation by the Board's inspectors and led to thousands of Indigenous children being taken from their parents on the basis of race alone. This government-sanctioned practice was widespread across Australia, and created tens of thousands of Aboriginal and Torres Strait Islander members of what are now known as the Stolen Generations. (The Museum of Australia, 2023, cited https://www.nma.gov.au/defining-moments/resources/aborigines-protection-act).

Section 13A, Aborigines Protection Amending Act, No. 2 of 1915:
The Board may assume full control and custody of the child of any aborigine, if after due inquiry it is satisfied that such a course is in the interest of the moral and physical welfare of such child. The Board may thereupon remove such child to such control and care as it thinks best.

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The Two Sides of the Same Hospital Bed

Ramila Tostes

The act of becoming a doctor requires, first of all, recognizing yourself as a human being. We see ourselves as human beings, however, based on experiences capable of awakening us to feelings specific to our species, such as the feeling of loss, for example, one of the feelings most presented by patients in a medical consultation. Contrary to this logic, medical education seems to demand from us, students and also trained doctors, a succession of constant victories: we need to beat our competitors in the entrance exam to get into a good university, we need to stand out at university to get good projects, we need to have grades high and we cannot, under any circumstances, make mistakes. Failure or loss does not seem to be part of a good doctor's career. Therefore, the difficulty in getting closer to our patients is often the inability to consider ourselves as people who also lose or suffer. We are taught to always be on the victorious side, ignoring any feeling that could bring us closer to a figure exposed to weaknesses, or, in other words, to extremely human manifestations, such as suffering.

8 a. m., November 2012. Together, there are 12 students from the last periods of the medical course, 5 resident doctors, 3 head doctors of the sector, a total of 20 people. The students prepared to visit the 13 hospital beds, accompanied by resident doctors. Soon after, they would present the cases to the heads of the sector. Anamnesis, physical examination, quick, today students need to return home early to study for the upcoming medical residency exams. Quickly, the head of the sector wants some more time with his family who arrived from the north of the country. Quickly, a patient will be admitted to bed 13. Not that. More work.

8 a. m., November 2012. She won't stop vomiting, she's 91 years old and will be hospitalized. The doctors will take care of it. There are 5 brothers, children of the patient, all employed workers, need to be accountable to their employers. Is

there no one who can accompany you? The brothers look at each other, scared, worried, on the verge of starting another fight over who would stay with their mother in the hospital. Nobody wants to miss a day of work. Everyone has their own justification and the possibility of agreement seems distant.

The patient vomited once again, the case does not seem simple, she lost 8 kg in 1 month. One of the students writes the clinical case on the computer in the study room, while another person does the physical examination, to speed up the work. Bed 13, occupied. A large number of laboratory tests were requested. We don't know the patient's religion, her hobby, how she feels about hospitals, what she likes to eat, nor what she did in the other 90 years she wasn't hospitalized there. Time to go. End of the work.

The discussion intensifies on the other side. The brothers face a hospital and a big city for the first time. They don't remember where they entered and how they now get out of that huge space. The city of the hospital is 2 hours away from where they live, they need a car to get around. It's a big city, they need to learn a way to stay there. It was decided who would stay that day. The companion would be Lívia, 59 years old, illiterate, hypertensive, diabetic, suffering from generalized anxiety disorder and depression.

The next morning, 20 people in white coats decide to visit together. There are 13 beds, the objective is to teach and learn. Maria, what are the risk factors for bowel cancer? João, how does oncological surgery work? They are in bed 13. Maria says she doesn't know how to answer, she feels sad, today will be a difficult day for her, she will question whether she still wants to be a doctor. João responded appropriately, today will be a happy day for him, he feels he is on the right path. The other students assess the situation and are grateful for not having been questioned about anything. They all leave with the promise to study bowel cancer protocols this afternoon.

That same morning, Lívia was waiting for a doctor to come to talk about her mother's situation. She had missed a day of work as a cleaner, which meant it would be harder to pay her electricity bill that month. She didn't sleep all night, she was anxious and had forgotten some of her medicine at home. The mother was not reacting well to the treatment and she felt scared. 20 people in white coats arrived. Lívia was unable to introduce herself, they were talking loudly, they seemed very busy. 3 people said good morning to Lívia. 15 people touched his mother's belly. 12 people heard their mother's heart. 1 person said things about cancer, 1 person responded, 1 person said they didn't know, 17 people just looked at the situation. Lívia was afraid of cancer, but no one asked her about it. 20 people came out of the bedroom door. Lívia called her brothers. Something about cancer was said, but no more was understood than that word. The 5 brothers cried that day.

Another day began at the public university hospital's study center. A week has passed since bed 13 remains occupied by that same lady. What's her name? Don't remember. It's the one of the children who doesn't understand anything – a student says. Another person says: I don't have the patience to explain the same thing so many times, why do have a different person to accompany you every day? Why not leave just one? By chance, have you ever had a Deep Venous Puncture procedure, Heitor? Would you like to try it on the patient in bed 13? – said one of the resident doctors to a student. That would be a lucky day for Heitor. Colleagues envied him.

Today Luiza was her mother's companion. Luiza was the youngest of 5 siblings, illiterate, worked washing clothes, her work was late and she would have to explain to her bosses that her mother was sick. When asked what her mother had, Luísa would just say that it was age problems. She didn't know more than that. The brothers seemed to understand less than she did, the doctors spoke difficult words, evidently always very busy and with little time to talk. Luiza simply accepted and went to accompany her mother to the hospital every Thursday. She felt scared, but didn't say much about it, as she wanted to reassure the other 4 brothers who were living in an atmosphere of hostility. Luiza knew that her mother was not well, she seemed not to respond to the treatment the doctors gave her. Luiza didn't know what the treatment was, nor what was being treated, nor why her mother now had some devices invading her body.

20 people in white coats entered the room with bed 13. 5 people wished Luiza good morning. 16 people touched his mother's belly. Luiza asked one of these people: after all, what is wrong with my mother? The answer was straightforward: I don't know either, I'm just a student and my work for the day is already done. The deep vein puncture procedure would begin. 19 people would watch, 1 person would act. 1 person would have their body invaded without knowing why. And Luiza would need to share the news that her mother had received another device that she didn't understand how it worked.

Heitor tried Deep Venous Puncture 4 times, without success. The student Marina was called, who tried 3 times, without success. A resident doctor tried twice and succeeded. The students left frustrated. The resident doctor felt like a savior. The patient suffered the 9 attempts in silence. Sector bosses questioned how good those students who were unable to perform the procedure would be. 20 people in white coats came out of the room, each with their own questions. Luiza and her mother were left with no answers, just the difficult words they heard during the 2 hours in which the doctors tried to perform that procedure for which they didn't know the reason.

Another group started in the hospital internship. Those 12 people from the last three weeks were now another 12 people, new students. The clinical cases of the 13 beds were presented. One of the students became interested in the case of bed 13 and asked the resident doctors and department heads for the patient's name, but no one registered. It was just a lady, she seemed to be sick with bowel cancer, with children who didn't understand anything because they were illiterate and looked sad. They were considering performing a colonoscopy on the patient. One of the resident doctors expressed his desire to carry out the exam and some students would like to follow him. Another great learning opportunity for those academics.

That same day in the morning, Leonardo arrived at the hospital to accompany his mother. He worked as a bricklayer, was in debt and had just been fired for not showing up to work for 5 days since his mother fell ill. Leonardo tried to explain the need to follow this difficult time for him and his brothers. The boss only asked for the work to be finished, and found someone else to take Leonardo's place the previous afternoon. Leonardo was enraged, sad, without hope. He would like to help the hospitalized mother, but he feels weak. 20 people entered the room. When a sixth person was about to touch his mother's belly, Leonardo lost his patience and asked why so many people needed to do this. He said that his mother was suffering, that she was in pain, that she was vomiting, that so many people there were performing the same exam, it was uncomfortable for his mother and for him, who just watched without understanding. One of the heads of the sector stated that Leonardo was not a doctor, that he could not know what was good or not for a patient. Leonardo said that he didn't really know about one patient, but about his mother's suffering he could understand. Leonardo cried that night. The 20 people in white coats left the room and returned to their homes with a day's work completed.

In the conversation that took place at the study center, the son of the patient in bed 13 was just ignorant. They will proceed with a colonoscopy on the patient, without further information for the family, as communication was considered difficult. Students are asked not to speak to that family again, as this could cause further problems. Resident doctors are instructed to prepare the patient for the colonoscopy procedure. The frightened students understand part of the situation as a difficulty in the doctor-patient relationship, but they feel that they cannot do much to help. Resident doctors obey the rules, they do not question what their superiors ask, they just learn how that structure works. The sector's chief doctors have the mission to teach what they learned more than 50 years ago, they fight to ensure that nothing changes, because that is how it has always been done.

On the day of the colonoscopy, the person accompanying his mother was Pedro, a 48-year-old man, who worked as a waiter and did not go to hospitals, saying that the environment was difficult for him. With great difficulty, Pedro tried to overcome his fear and accompanied his mother, to share the work with his brothers. When he received the 20 people in white coats, Pedro's heart accelerated, he felt like he was going to faint, all he wanted was for them to leave. But on that particular day, they didn't just come from the room. The doctors informed Pedro that his mother would be taken for a medical procedure called a colonoscopy and that he could accompany them to the room where they would perform the exam. Pedro felt deep anguish, but knew he needed to stay strong for his mother.

A great learning opportunity was in front of the academics and resident doctors. Performing that colonoscopy procedure would be very important for them to say that they were good professionals, that they had already participated in something so interesting. Resident doctor Luís was chosen to conduct the exam, and that would be a big day for him. Luís studied all the techniques the night before, read several articles, talked to great professionals about how to proceed in the exam. He was prepared. The resident doctor was already prepared. Luís was seen as the best among the resident doctors, the most dedicated, the one who studied all the time. Luís tried 3 times, but was unsuccessful. The examination did not produce conclusive results. He would need to repeat the process.

Pedro asked his brothers not to let him experience another day of that exam, as his mother was weakened during the preparation, he felt unable to help her and, for him, there was no greater suffering than knowing that his mother would go through everything again. The brothers, as they did not witness that moment, considered that Pedro was just expressing his fear of hospitals and doctors. So, a few days later, Lúcia was at the hospital to attend her mother's second colonoscopy attempt. He no longer recognized her, due to the profound weight loss, the sadness on her face, the desire she felt to get out of there. Lúcia tried to talk to her mother about the importance of the exam, but her mother disbelieved her, saying that greater suffering than that could not exist. The mother didn't want it. Lucia didn't understand her. The doctors just followed a protocol.

As he was considered the best among the residents, Luís was once again chosen to perform the colonoscopy exam on the mother of 5 children, the grandmother of 8 grandchildren, the great-grandmother of 2 great-grandchildren, the aunt of 32 nephews, the sister of 6 other women [...] No, Luís was chosen to perform a colonoscopy on a patient in bed 13 with suspected bowel cancer. Luís was chosen to find signs of cancer. And it was like that. The resident doctor tried countless times, but once again he was unsuccessful. The 12 academics watched, some felt bad, others wanted to leave the room, but couldn't, they would be considered weak. That day, Luís felt deeply frustrated. 2 academics doubted whether they would like to continue studying medicine. 3 academics discovered exactly what they didn't want to do in the future. 1 academic cried desperately in the hospital bathroom. The 20 people in white coats went to break the news to the family: they would need to repeat the exam. For the third time.

The family hoped that this time things would go as they should. Some of the brothers believed that this exam was the cure for their mother's illness. Some didn't know how to pronounce the name of the exam, but they were confident that it was the best thing to do. Leonardo would return to the hospital to accompany his mother for her colonoscopy. The preparation had already been done once again. Leonardo's mother was nothing but tears and suffering, she had already lost a lot more weight, she couldn't eat and wanted to go home. But a third attempt was necessary, as the doctors informed. Leonardo lamented the fact that his mother's wishes were not being heard, felt that she was close to death and did not believe that his mother's care depended solely on this examination.

That morning, the medical team was ready to receive the patient from bed 13 again. The examination would be carried out by one of the sector's chief doctors, a reference in colonoscopy. It would be a great learning opportunity. More academics were even called. After all, it would be a unique moment for them to learn how to do a colonoscopy. In the auditorium, where they watched the exam, around 30 people were able to learn about an exam technique, they learned how to do a colonoscopy, perhaps. The exam was a success. The patient from bed 13 suffered cardiorespiratory arrest 30 minutes later. It's time to learn how to fill out a death certificate. Another great learning opportunity at this university hospital. One of the students was invited to train his ability to communicate bad news and talk to the patient's family from bed 13.

The brothers were informed of their mother's death on the afternoon of that day. A very young doctor, whom none of the brothers had met during the days of hospitalization, came to give some news. It was student training. The grandmother of 8 grandchildren, great-grandmother of 2 great-grandchildren, aunt of 32 nephews, sister of 6 other women, her death was announced by a tenth period academic who did not even know the reason for her death. He had recently arrived at that hospital. The important thing was to complete the task, even if I wasn't prepared for it, even if I didn't know how to do it. The family didn't understand. The academic tells this story and is amused by his audacity. Bed 13 is empty, there will be less work the next morning.

I come from a poor family, from the interior of Brazil, who depends on the public health system in my country. Therefore, when my grandmother fell ill, her care was provided at a public university hospital. The presentation of the story I told is based on the real experience that my family lived during my grandmother's hospital stay. The facts and names were purposely modified and interpreted under my eyes at this time, therefore, they are not extremely truthful to reality.

I am one of the granddaughters of the patient in bed 13, who remained for around 45 days without a clear diagnosis, without an explanatory conversation with her family, without the necessary reception and died after insisting on a medical procedure that would not change her prognosis in any way. Today, as a medical student, I know how to write this way. At that time, just a high school student, I couldn't say what had happened to my grandmother. When I began my medical studies and spent years at a university hospital, I began to understand what actually happens behind the scenes of care. All the time my mind works to discover why they treat patients in such an impersonal and distant way, often contributing to the anguish of family members and the patient himself.

I believe that my experience of loss alerted me to the context of my patients' suffering. Every family that finds itself without answers reminds me of mine. Every elderly person who is hospitalized and is about to die reminds me of my grandmother. Every time my fellow students are interested in carrying out unnecessary procedures on patients, just for their own benefit, I am reminded of the fact that complications from a procedure can often contribute to a person's death. Each of my experiences with patients is marked by the feeling of loss I carry. But not only that. I understood that knowing the story of the person I care for is an important step in getting closer to the reasons for the suffering of that patient and the family members who accompany them. Often, pain or illness is just part of something much larger, which is the result of a lifetime. Each person's experience with their illness is unique and reflects their choices, their place of birth, their profession, their family and their way of looking at life.

The current medical structure works with the disease as the protagonist of care and fights it as if it were more important. The absurd amount of classifications, protocols, names of medications and pathologies challenges us to memorize each piece of information as if becoming a doctor were directly related to our ability to memorize. We are questioned for not remembering a subject taught in the first period of college, for example, when we get closer to graduation. But we are almost never encouraged to reflect on the factors that involve the health-disease process, such as lack of money, a precarious family context, the difficulty of active listening at home, loneliness, the challenges of a society immersed in a model of production exacerbated, among others [...]

My choice to approach this story, despite having lived it on the other side, that is, as a member of the patient's family, is precisely the fact that having lived this experience has brought me closer to my patients during my graduation, in a way completely different and unique in my trajectory. The student-patient relationship I try to build is based on what I wish had happened to my grandmother and my family when they were in that situation. Therefore, my incessant attempt is to work on a student-patient relationship based on listening, the exchange of reliable and explanatory information, the understanding of both sides and the exercise of empathy.

"We don't know the patient's religion, her hobby, how she feels about hospitals, what she likes to eat, nor what she did in the other 90 years she wasn't hospitalized there."
Firstly, I would like to highlight the importance of truly knowing the case of our patients. We must question, for example, how that disease is seen by the patient and their support network. As students, we can truly listen to what ails that family unit, trying to understand how our presence can be useful for them and what we have to contribute or reduce this suffering. More than learning what is written in books and articles, the presence of human beings around us awakens us to feelings that can only be experienced through the practice of empathy, for example. If we are not interested in listening and understanding the context of this problem and how it has affected people's lives, we will not be able to offer true comfort to our patients. We will continue to apply protocols without patients participating in their own care, making these human beings invisible and depriving them of being active in their healing process.

"...the doctors spoke difficult words, evidently always very busy and with little time to talk."
A second point to be addressed, seen in a more practical way, is the use of inaccessible language when dealing with patients. It is widely known that medical school is full of specific medical terms and not everyone will know them. Therefore, explaining to the patient and their companions clearly and objectively what is happening is an important part of building the student-patient relationship and, in the future, the doctor-patient relationship. At the end of all the explanations, it is important to listen to any possible doubts that may arise. Making everything clear, making clear the reasons why certain procedures will be carried

out or medications used is part of the success of the treatment, as they reinforce the confidence of both the patient and their caregivers. The art of conversation should be part of the medical curriculum in a more emphatic and necessary way.

"20 people in white coats arrived. Lívia was unable to introduce herself, they were talking loudly, they seemed very busy. 3 people said good morning to Lívia. 15 people touched his mother's belly. 12 people heard their mother's heart. 1 person said things about cancer, 1 person responded, 1 person said they didn't know, 17 people just looked at the situation"

Based on the story presented, one of the biggest questions that haunts me is the medical learning model in the hospital environment. The different people who accompany the same patient, all arranged around the bed, without many functions, just observing and, in accordance with medical education guidelines, learning. However, I believe that there may be more effective ways of learning about a clinical case, which generate less discomfort for the patient and their companion. The fact that there are many people during the medical consultation can even make communication between the caregiver and the person being cared for difficult. In addition to generating a certain insecurity, as it is not known for sure who the person is responsible for everyone else. Without explaining the reason to everyone present, the feeling of invasion becomes even more aroused, after all, the patient is in a situation of vulnerability and suffering, and there are still several people just watching him. The moment of observation already generates great discomfort, but things can get even worse when several people are willing to perform the physical examination on the same patient. At that moment, several hands will touch the same body, giving the sensation that that body is no longer something belonging only to the patient, but rather to several people who will touch it. Therefore, despite it being extremely difficult, in my practice, I use words of comfort to my patients when I examine them, demanding permission to touch their bodies, if I deem such an action extremely necessary or useful for my understanding of the case. The act of being in large groups at patients' beds must be continually guided by the medical education model we have built, and must be questioned whenever possible.

"Heitor tried Deep Venous Puncture 4 times, without success. The student Marina was called, who tried 3 times, without success. A resident doctor tried twice and succeeded. The students left frustrated. The resident doctor felt like a savior. The patient suffered the 9 attempts in silence."

During my medical degree, I was confronted several times with performing invasive procedures on patients. It is a fact that learning and knowing how to perform basic procedures on a patient is part of medical training. However, the discomfort on my part was a little greater. Whenever a patient was about to go through something like this, I questioned myself about a real need. Sometimes there is fear of possible complications arising in the patient who had been trusting me. Carrying out procedures just to learn does not seem like a good justification to me, I always want to know why, the real benefits and to what extent I am really prepared to carry out that intervention. I believe that a single attempt is important in certain situations, as constant repetition by the student, still in the learning process, can generate psychological stress in the patient. Therefore, my experience on the other side, as shown in the story presented, also awakened me to the understanding that I can be more cautious when performing invasive procedures on patients. One way to deal with situations like this is to ask for help and sometimes ask someone with more experience to lead the action.

"In the conversation that took place at the study center, the son of the patient in bed 13 was just ignorant. They will proceed with a colonoscopy on the patient, without further information for the family, as communication was considered difficult."
One of the characteristics that bother me most during hospital projects are the judgments made about patients and the people who care for them. Often, having someone admitted to a hospital means a break in the structure of a family. There are factors such as the displacement of family members, the need for a person to take time off work, the financial expense of medication, the fear of losing a loved one, insecurity about the future of that family, traumas that may have already occurred for the loss of other people [...]. Anyway, there are many issues that can cross situations like this, causing people to behave in ways that are not always nice towards medical teams. However, what is often observed is the lack of acceptance of this suffering on the part of the team, making invisible the fact that that individual is going through an extremely delicate moment. Judgment behind the scenes of medical teaching ends up transferring a growing intolerance towards medical practice for people who are already exposed to other types of difficult feelings. Therefore, once again, active listening is able to avoid problems like this, understanding the moment that the patient and their support network are experiencing.

"Students are asked not to speak to that family again, as this could cause further problems."
Doctors are often placed in an inaccessible social position, as if their knowledge cannot be shared. Or, in some cases, questioned. We are inserted in a structure

that strengthens the perception that we cannot make mistakes. When a patient questions any of our conduct, practice tells us right away that that patient is difficult or could cause us problems. However, we forget that we are treating the conditions that this person suffers from. We, as students and doctors, are the party trying to understand specific problems and not the party suffering from a problem. In this way, listening to patients' questions, valuing their complaints and understanding them in a non-hierarchical way brings us closer to a more effective medical practice for the patient and for ourselves, avoiding wear and tear. One way to promote this type of space is to allow the patient to access the professional doctor in a truly human way, recognizing that the doctor is just like him, who also makes mistakes and may not be right all the time, but who is willing to help you with your complaints.

"The important thing was to complete the task, even if I wasn't prepared for it, even if I didn't know how to do it. The family didn't understand."

It takes courage to face our own limitations. During graduation, and even during preparation for the university entrance exam, we are invited to forget our weaknesses and wish we were capable of anything. This feeling of self-sufficiency and shame of admitting that we are unable to carry out certain activities accompanies us throughout the medical training process. It is necessary, therefore, to break this cycle that limits us and contributes to us becoming intolerant towards our patients. We are taught not to recognize our own difficulties. Therefore, we face big questions when we refuse to carry out any medical action because we need to learn and study a little more. This is not always seen in the good eyes of teachers or our colleagues. We appear fearful or unprepared. However, recognizing that our lack of skill can harm a patient is an important part of exercising empathy, as we do not want to be in that other position, that of someone receiving work that could be improved.

The big reason I brought up this story, experienced as a patient-student, is because it became a constant in my medical degree. I realized that what my family was experiencing was just an example of how things worked. One of the ways I found to avoid being contaminated by this structure was to follow the opposite path. With those patients who passed by me, I tried to understand the entire context that led them to the moment of illness. I understand that this exercise is not part of what the university requires, but I felt the need to do it, given the history I have. I was questioned several times about this stance, faced judgment and was told things like "medicine isn't done like that", "you don't need to spend so much time listening to these stories", "your job is just to write this recipe" [...]. I feel like I experience medical school from two different angles. Now I experience the student-patient relationship through the position of student, preparing to train as a doctor. However, everything that is present in my practice comes from my patient-student relationship, when I experienced the other side and knew exactly what I wouldn't want to do and what I could do.

Dissatisfaction with the medical structure made me question what I was taught and I used this in parallel in my training. I was, for example, involved in building student collectives and associations that seek to improve medical teaching and listen to users of the healthcare system. I believe that it will only be possible to advance in this educational process when patients and their companions are truly heard. We cannot know what is best for a person without listening to them or trying to understand them. While we are building a process of training doctors for doctors, we will be far from those truly interested in improving the care that medicine offers, our patients.

Based on all the questions I decided to address, I think there is obviously no way all students can experience loss, grief, or even be patient. However, medical schools need to offer tools for these students to reflect on their own training process, questioning what they receive. For centuries, medicine was built based on a centralizing and oppressive structure, and only the movement of those who are occupying universities now may be able to change this logic. Promoting acceptance with words of support among your own colleagues can reduce, for example, the need to always be right. Practicing listening in group work can help when patients question some of our behaviors. Recognizing in a classmate a person who is suffering and facing problems is also training to understand the pain of others and exercise empathy. Learning medicine at universities, in a multidisciplinary way and with groups of diverse people, contains powerful tools to create students and doctors who are more welcoming, tolerant and attentive to their own suffering and that of others.

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History of the International Foundation Psychosomatic and Social Medicine

Since 1968 general practitioners, clinic doctors, university staff and medical students have met for International Seminars at the historical "Monte Verità" (the mountain of truth) in Ascona/Switzerland. These seminars were intended to enrich medical training and consisted mainly of Balint work, a reflection on the doctor-patient-relationship in a group setting. Students became part of the team and university lecturers also participated.

Today the "Monte Verità" is a conference centre for advanced education, which is a part of the famous ETH University of Zurich.

Boris Luban-Plozza (1923–2002) was a Swiss family doctor in the region of Tessin/Switzerland. In 1961 he invited Michael Balint (1896–1970) to Grono/Switzerland for a lecture. Before he had read Balint's book *The Doctor, his Patient and the Illness* (translated into German and published 1957 by Ernst Klett Verlag, Stuttgart). Luban-Plozza describes his meeting with Balint's ideas and with him personally as a turning point in his life and medical career. "All real life is encounter."

And it was Boris Luban-Plozza, who in 1968 started the Balint meetings of Ascona. He was the inaugurator of the "Ascona-Model", which had a big influence on the young generation of doctors and students and is well known in Europe. The "Ascona-Model" supported the principles of a relationship-oriented education in how to be a doctor. It is a teaching and a learning model for students and it demonstrates how to understand the doctor-patient relationship in an empathetic narrative- and process-based mode and as well how to understand evidence-based medicine.

The Balint Award for students of medicine is part of this concept. The Award was founded in 1976 in honor of Michael Balint (1896–1970).

The Award was given to medical students every year at the Ascona meeting with one exception: at Balint's 100th birthday in 1996 the conference and ceremony was held in Budapest, the city where Michael Balint was born.

In 1995 a sponsor gave a splendid sum of money for the Ascona Model and the "Fondazione Medicina Psicosomatica e Sociale – Stiftung Psychosomatik und Sozialmedizin" (Foundation of Psychosomatic and Social Medicine) was founded and supports the Ascona Award for students since then. The board members of the foundation take care of the goals.

After Boris Luban-Plozza's passing in 2002 the Foundation and the International Balint Federation (IBF) decided to dedicate the Ascona Award together.

The International Balint Federation (IBF) consists of 26 national Balint Societies today. The organization has the goal to spread Balint's ideas of improving the relationship between doctor and patient by group work, where professionals sit together and try to understand their influence on diagnoses and treatment and the emotional input of doctor and patient.

The IBF organizes an International Balint Congress every second year. In 2003 at the International Congress in Berlin/Germany, the Ascona Student Prize winners where invited for the first time to take part in the groups and lectures and to present their papers in front of the participants. It was a great success. The Student Prize winners have been invited to the International Balint Congresses since.

The Foundation for Psychosomatic and Social Medicine and the International Balint Federation continue to hold the Balint-Award-Ascona competition for essays by students in which they report and reflect on their personal experience of encounters and relationships with patients. Sometimes these encounters date from the very beginning of their medical studies. They are asked to include a detailed description of the first meeting with the patient. This is to be followed by a theoretical analysis and a personal reflection on what it meant for the writer. Some students have also included the presentation of their work in Balint groups, in which they discuss the student-patient-relationship with their peers.

The papers of the students from all over the world are extraordinary essays and illustrations of their progress in becoming a "good enough doctor" (D.W. Winnicott: "the good enough mother")[1].

In his lecture at the last Balint Award Ceremony June 15th, 2002 in Ascona (*Balint-Journal*, 2003, 4[4], 19–20) Arthur Trenkel, the president of the jury at

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[1] Winnicott, D.W. (1953). Transitional objects and transitional phenomena. *International Journal of Psychoanalysis, 34*, 89–97.

that time, summarized what was important for him and his fellow jurors: "In an overall view the papers reflect a kind of painting of the spirit of the age from the students' perspective. This year a strong accent seems to lay on the critical view of the increasing common instrumentalization of human beings caused by reduction to simple roles or functions. In the hospitals especially the patients and doctors are affected by this collusion of anonymity. The students while practicing in the hospital stay so to say 'between the chairs' which grant them welcome opportunities for independent perceptions on another level."

The criteria by which the papers will be judged are as follows:

1. Exposition: The paper should include a presentation of a truly personal experience of a student-patient relationship. (Manuscripts of former medical theses or diplomas cannot be accepted.)
2. Reflection: A description of how the student experienced this relationship, either individually or as part of the medical team.
3. Action: The student's own perception of the demands to which s/he felt exposed and an illustration of how s/he responded.
4. Progression: A discussion of both ways in which the student's own approach might change in the future, and also possible ways in which future medical training might enhance the state of awareness for individual students.

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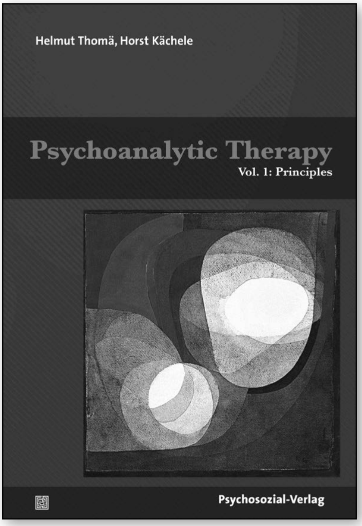
Vol. 1: Principles



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»[T]his is one of my favourite psychoanalytic texts, the one to which I would turn for reference but also the one I would turn to because it is written with a clarity, simplicity, and eschewing of ambiguity that is sadly unusual in psychoanalytic writing. […] Reading this text is indeed taking a voyage around the psychoanalytic century.«

Peter Fonagy

The principles underlying psychoanalytic technique and their impact on practice are the main objects of this comprehensive and systematic study, which is based on research in psychoanalysis. By taking the differences between psychoanalytic schools and the finding of related disciplines into account, the authors describe new perspectives. After descriptions of the development of psychoanalysis, chapters are devoted to comprehensive accounts of the key concepts of the psychoanalytic therapy – transference, countertransference, and resistance – as well as to the initiation and conduct of treatment, to the role of models, and to the scientific status of psychoanalytic theory. Psychoanalysis, understood in such terms, can be applied to a broad spectrum of mental disorders and psychosomatic illnesses.

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The essays for the Ascona Balint Award give a deep impression of the students' experiences, reflections and conclusions. And they show an insight into medical education in different countries.

"As a medical student, I was confronted with the importance of understanding and respecting the diversity of patients' life experiences, recognizing that individual choices and beliefs can significantly influence health care decisions. The ethical dilemma that Eliza faced in relation to her faith and her health condition highlighted the complexities that healthcare professionals can encounter when dealing with religious issues. Throughout our conversation, I realized that Eliza was looking not just for a listener, but for someone who understood the multiplicity of challenges she faced."

Mateus Menezes dos Santos

"Based on the realization of the great potential that can be found in involving oneself with one's feelings in a treatment relationship and the awareness of having to meet the requirements of both a problem solver and an accompanying insight helper, I believe that new spaces for this emotional reflection are needed in everyday clinical practice. Just as a physical and psychopathological examination of the patient is part of the standard toolkit, a kind of mini-emotional status of the practitioner seems to me to be an enrichment in order to professionalize a more empathic attitude in the treatment relationship."

Julian Neugebauer

"That day, Edna recounted a vibrant timeline of her life's events. From college, to family, love, parenthood, illness and age, I learnt many things about the magnificent tapestry that had been her life; the rich and royal hue with which her 87 years had been woven. The lucidity of her recollections served as a poignant reminder that patients at the end of life are still living. Whilst a component of their individuality becomes lost the minute we exchange their clothes for a hospital gown, and their name for a room number; they are still individuals with stories, identities and emotions."

Dikshya Parajuli

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