Donald E. Nease, Jr.,
Heide Otten, Günther Bergmann (Eds.)

The Student, the Patient and the Illness

Ascona Balint Award Essays 2026

Psychosozial-Verlag

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

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Awarded by the International Foundation Psychosomatic
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Content

Foreword

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Welcome – (again) to all readers of the Ascona students essay book series.

Congratulations to the Ascona Prize winners of 2026, to the Ascona Foundation and to all clinicians working with the relation to their patients and their illness.

Again 2026 has shown a rich harvest of contributions for the Ascona Prize, many were in close competition for the prizes, and I recommend to you to study all these essays in more details. They provide a rich material to be worked on further in the individual authors professional work and in their personal lives as it will be interwoven in their coming practice.

The essays also offer the more experienced Balint Group Leaders new thoughts and a fresh view at well-known experiences. They could be the basis of many discussion groups among professors at the medical faculties around the world.

It's a special honour to me to welcome the winners at the 24th International Balint Conference in Aarhus 'Connected, Committed and Contained' coming in October. I'm sure the presentation of these papers will influence the feeling during the whole conference and that we will share many interesting discussions in the plenary and in the Balint groups.

Tove Mathiesen
President of the International Balint Federation

Introduction

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Dear reader,

it is with pleasure that we present the most outstanding essays from the 2026 Ascona Student Prize competition, including the top three prize winners, which are the first three in the book.

This year we had a total of 56 student entries from 9 different countries, representing approximately 30 medical schools. This greatly exceeded the number of entries from the previous several competitions, and we hope reflects students' renewed spirit of interest in the relational aspects of medical practice.

As medicine itself continues to progress and adopt more technologies including most notably Artificial Intelligence in routine practice, the relational aspects of care take on ever more importance, and this is mirrored in the essays presented here.

Similarly, the impacts of violence from war, climate and relational disruptions are also a theme which is reflected in many of the essays.

As such the students' depictions and reflections offer a unique perspective on not just the medical, but also the current social, climate and political state of our planet.

The voices contained within these essays are to be treasured.

The prizes will be awarded to the three winners at the 24th International Balint Congress in Aarhus, Denmark, in October 2026. The three students are invited to participate in the Congress, take part in the Balint group work and will present their papers there.

You will find the three essays of the winners in Part I of this book. In Part II we present 9 more excellent essays from different countries, which had high rankings.

An international group of reviewers (n = 22) 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 of representatives from the International Foundation Psychosomatic and Social Medicine and the International Balint Federation selected the three 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 by the International Foundation Psychosomatic and Social Medicine, based in Basel (Switzerland) in cooperation with 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 profound need to understand more about the patients and oneself and about the impact of one's own attitudes and beliefs. 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. This book will also be presented in Free Open Access.

The next Ascona Prize will be awarded in 2028. More information will be given on our websites: www.foundation-ps.com and www.balintinternational.com

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Part I

Essays of the Three Winners 2026

Boldog Születésnapot

The Hungarian Phrase For "Happy Birthday"

Jood Ghunaim

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It hasn't been easy acclimating to my environment. I'm sitting in the cardiology Intensive Care Unit of my university's hospital. In small landlocked country in central Europe, Hungary, and South of Budapest, a tiny city called Pécs is where I call home for the next six years. There are not many people here who look like me, and even fewer that speak any of my languages. I like to call myself a linguophile, usually, capable of picking up languages quite easily and holding my trilingual status as a badge of honor. However, the Hungarian language is not one that comes easy to me, in fact, more than a few words and I feel my cheeks get flushed at the visible giggles I get from the native speakers listening to me attempt to speak their language. My accent is not quite right, and no matter how I twist my mouth and how hard I press my throat, the person across from me usually tilts their head to the side and gives me a confused look. After several classes, and several attempts, I decide, there's no need for me to speak, I'll do what I'm meant to do. I mean, that's what matters most, isn't it? Medicine is all about the practical aspects. Fill the syringe, prescribe the medication, and know the steps to perform procedures. So, I simply nod, and smile, and hope this can be the way I am able to communicate. I find comfort in knowing my practical skills will likely be sufficient enough to be my main form of treating patients. I hope that my smile is enough to help the patient across from me feel any type of comfort.

This is my first exposure to the clinical setting as a future physician. I have just finished my first year of medical school; and I'm doing my summer practice. It's a mandatory practice that my university requires students to complete, from year one all the way to year six. This first year's

practice is referred to as "Nursing Skills". As a student, I must practice the basic procedures in the hospital setting. Administration of medication, taking blood pressure, drawings of blood, and of course; care for the patients. This involves making sure they are fed; their gauze is changed should they have any wounds. My course director places me in the ICU of the cardiology unit; quite an intimidating unit for a student with no previous practical experience on real patients.

The ICU is a world of its own. There's a hurried rhythm, beeping monitors, alarms and footsteps I'm trying to keep up with. My first days are spent observing everything. I stay silent but diligently watch the way catheters, syringes and gauze are handled. I watch the small nods and gestures used to communicate without speaking, both nurses and doctors. Each room has its own rhythm. I am an outsider trying to learn. I carry a small notepad with me, writing down steps while watching the nurses perform tasks.

By the end of the first week, I have become flawless at blood withdrawal. I know which medication is for each patient, and I prepare syringes for the nurses in a timely manner. I neatly arrange them on the bedside table for the nurses. I earn a nod of approval and take it as a sign of a job well done. It's hard to communicate well, but I assure myself that if I do things in a procedural manner and if I follow every rule exactly, I will accomplish what I am meant to do. I feel an unspoken pressure to stay out of the way and not make anybody's job harder. So I do just that. I keep myself small and follow instructions without deviation; step by step, and meticulous in my performance.

It is during this first week where I feel my first real sense of accomplishment. I hear my name being called by one of the doctors and quickly make my way into the room. Inside, I find it crowded with nurses and doctors alike. A defibrillator is being set up next to a patient who is on a ventilator. The doctor explains to me that the patient has an abnormal heart rhythm, ventricular fibrillation. A life-threatening abnormal rhythm, he tells me. He dives into the theoretical material I've covered throughout this year. I smile as I recall the pathology unit on ECG's as he explains. As he continues speaking, I notice that that there is a lull in the room as nurses pause and wait for the doctor to finish his explanation and that's when a sudden realization dawns on me: I will be the one performing the defibrillation today.

I feel the blood drain from my face.

I listen intently to the doctor's instructions, while simultaneously trying to recall the safety steps from the first-aid class I took months earlier. No need to panic, I tell myself. Just follow the instructions; it's always just in the instruc-

tions. After a quick debriefing, it's time for me to perform. There is a heavy tension in the room as I walk over to the patient and ready myself. I hold the two paddles in my hand, feeling their weight; both physically and metaphorically. There are two silicone pads on the patient's chest to protect him. I position the paddles over the silicone and take a deep breath.

"Clear."

Everyone takes one step back.

I deliver the shock.

The patient's chest rises, then settles back down. My heart is pounding, yet I do not dare show any emotion. I earn a small round of applause from the attending physician and the nurses in the room. I place the pads back into the machine as another nurse wheels it away. The interaction is precise, and procedural. Everything was done correctly, exactly as I was taught.

Before leaving the room, I glance at the patient's roommate. He is an older man, watching me quietly after what I have just done. He has a tracheostomy tube inserted, and I think he may be my patient next week. In that moment, I still believe the lesson lies in what I have just performed, in the flawless execution of a life-saving procedure. I don't yet know that the deeper lesson will come not from the patient I shocked, but from the one in the bed beside him.

Meeting Laszlo

It's my second week in the ICU. My head nurse, Tunde, walks me into the same room I defibrillated a patient in, last week. She points me in the direction of his roommate. It is here I meet the patient I am responsible for this week. His name is Laszlo. I walk over, and grab his chart and I take an index of him. His file says he is only 65 years old, however he has a tracheostomy tube inserted, and he's unable to stand, walk, or even feed himself. Laszlo has suffered a severe stroke, and has concurrent cardiac events. This has left him unable to feed himself, clothe himself, walk, or communicate. And so, I take my time to familiarize myself with his background. Laszlo was a coal miner on the outskirts of Pécs. Through his job, he was chronically exposed to silica dust, unknowingly, Laszlo had now developed silicosis.

As I finish reading the file, my head nurse walks in. She hands me a orange colored jar with a spoon inside of it. I glance at the label, there's a picture of the baby on the front; pumpkin and carrot flavor. I understand, she wants me to feed him. I nod, knowingly. She smiles at me, and says "Birthday", while

pointing at Laszlo. I glance at the date and compare it to his chart. Laszlo is turning 66 today. Laszlo glances over at me, then at the jar. I watch his eyes peer behind me at the slice of birthday cake the nurses had prepared for him. "Can he have some cake?" I ask. "Little. Small bite," she says to me in broken English. I smile back at her as she turns and leaves the room.

I open the jar, start mixing the baby food, I ready the spoon, and start to feed Laszlo. He doesn't look very happy with me, or maybe it's just the flavor. I hesitate with the spoon in mid-air. I'm suddenly realizing how intimate this task is. Feeding another adult feels entirely different than any other task I've been assigned to do. Drawing blood, changing gauze, all tasks which are procedural, mechanical. Even defibrillation, despite its "violence" felt strangely impersonal. Everything has been rules, commands, adrenaline, noise. But not this. This is quiet. Very quiet. The only sound in the room is the hum of the monitors and the slight hiss or air moving through his tracheostomy tube.

I try to smile at him, unsure if my eyes are reaching him; if he's able to read my emotion. I exaggerate my movements as I move the spoon towards his mouth, hoping each time he understands what I'm doing. He watches me carefully, his gaze alert. There is nothing absent or vacant about him. This is not a man who has disappeared. This is a man trapped.

When he opens his mouth, I miss, just slightly. The puree of pumpkin and carrot lands on his chin. Bright orange. My stomach drops slightly, I feel my cheeks flush.

I rush to wipe it away, apologizing under my breath, embarrassed.

"I'm sorry," I say, reflexively.

He makes a sound, half breath, half frustration, and turns his head ever so slightly away from my direction. I freeze, unsure of whether to persist or retreat. No one has taught me how to read this. Is this refusal? Fatigue? Discomfort? There was no lecture slide explaining this moment.

I wait.

After a few seconds, he turns back towards me. I try again, slower. I take my time. Smaller bites. He swallows with visible effort and I watch his throat move counting seconds, terrified at the chance of aspiration. Only when I watch his breathing steady do I relax.

Slowly, but surely, we find our rhythm. Spoon. Pause. Swallow. Wait.

I watch his eyes glance behind me. I turn and look. White frosting, chocolate shavings, and a single candle. I smile at him.

"Boldog születésnapot" I say quietly. Loud enough for him to hear, but hoping the other nurses can't hear my attempt.

I watch as his eyes widen, for just a fraction. He looks at me- not through me, not past me – at me. He holds my gaze longer this time. Longer than what feels comfortable. Then, knowingly, he blinks twice and gives me a small smile.

Suddenly, it feels like we both understand each other.

For the next week, Laszlo becomes an anchor for me. In a unit where everything feels urgent and overwhelming, his room is the one place where time seems to move differently. I begin to recognize his routines, his preferences, and his dislikes. He prefers a cushion under his knees, his head slightly turned to the left and he relaxes when his blinds are open. I learn these things, not because it is written somewhere in my textbook, but rather because I pay attention. His chart tells one story: age, condition, diagnoses, former occupation.

But the man in front of me tells another story, wordlessly. Through the ways his eyes follow movement, through tension in his jaw when he's uncomfortable, and the rare softness I see in his expression when the nurse adjusts his sheets. Administrating medication became more than following instructions, but rather a chance to connect. It was a chance to speak softly and to reassure him despite the lack of verbal communication. Even when performing blood draws, I realized that explaining the steps, despite his lack of response, was a part of creating trust. Every action, no matter how technical, required attention to his experience.

I start greeting him every morning. At first a nod, accompanied with a smile. Then, I become bolder, speaking some simple words. "Jo reggelt." Good Morning. I practice the pronunciation beforehand, repeating it to myself in the hallway before I come in. Sometimes he gives me a smile, sometimes he doesn't. Sometimes I wonder if I'm doing it more for myself than for him.

Reflection: Experiencing the Relationship

Silence became one of the most unexpected teachers during my time in the ICU. This was a setting dominated by alarms and rapid commands. Silence felt out of place and was deeply uncomfortable. Yet it was within these quiet moments, particularly in Laszlo's room that I learned to listen in a different way. Strangely, I found that this silence was not an absence of communication, rather a form of it. There was a need for patience and attentiveness, and there were no words to guide me. I was being forced to observe closely, to watch carefully; to look for cues. These cues became his

language, and learning to read them felt as important as learning any medical terminology.

With Laszlo, silence carried a different weight. He was unable to speak, and this was not a choice, nor a temporary discomfort. It was imposed on him by his injury. Observing this forced me to confront my own privilege. I could choose when to speak and when to remain quiet; he could not. The asymmetry in our relationship had extended far beyond language. I had mobility, autonomy, and an anticipated future. He existed within constraints, in many aspects. Physical, communicative, temporal, all which shaped every interaction he had. And yet, despite these imbalances, he continued to persevere and take charge of his autonomy. A blink, a turned head, a held gaze. Recognizing and respecting this became one of my most important responsibilities

I am acutely aware of my position in this relationship. I am young, inexperienced and transient. I will only be here for a week. He has been here for months. I have the privilege of leaving at the end of my shift. He does not. As I reflect on this relationship, I recognize how asymmetrical it was. I had access to language, time, choice and mobility, while my patient does not. And yet, despite this, I often felt that he was the one guiding me. The stillness in my patient demanded I be attentive. The silence and knowing looks required interpretation. There was no autopilot in his presence.

It took time for me to realize how patients like Laszlo become absorbed into routine. Tasks are performed correctly, yet often without acknowledgement of the person receiving them. I understand why this happens. The ICU is a place of constant urgency. Efficiency is not a preference but rather a survival mechanism. Still, watching this made me uneasy. I wondered how easily I could slip into a rhythm. How quickly could my attentiveness be replaced by habit? How do I maintain empathy in a setting where speed and precision are prioritized? It is in this moment I recognized that true medical competence is not only procedural; it is just as much relational. It lies in noticing small cues and adjusting care according to individual needs.

Moral Distress and the Pace of the ICU

I became increasingly aware of the unspoken tension between efficiency and attentiveness. This unit functioned on urgency. Lives depended on speed, accuracy, and coordination. In this environment, slowing down felt

as if it was not an option. Spending extra minutes in one room meant less time elsewhere. Presence was a luxury rather than a necessity.

It was an unsettling realization to recognize that I had moments of moral discomfort. I had tense instances where care was technically correct but emotionally incomplete. Patients were repositioned without explanation, procedures were performed without eye contact, and conversations were had over bodies rather than with them. Of course, I understood why this happened. The volume of work was relentless. Emotional distance often served as a protective mechanism, a way to endure repeated exposure to suffering.

As part of the medical team, there is an expectation of being useful, efficient, and sometimes invisible. No one explicitly tells me this, but it is implied in every hurried instruction and every sideways glance when I linger too long in a room. There is always something else to do. Another patient, another task. As a student, I occupied a strange standing amongst colleagues. The hierarchy weighed heavily on me. I was expected to observe, but not interfere, and to care, but just the right amount. It felt as if presence was a misuse of time. I feel guilty for it. As though caring too much is a kind of indulgence. As if emotional engagement is something to be earned later; after I am competent enough, after seniority. These doubts forced me to confront an important truth: emotional awareness is not a luxury or reward to be earned later. Emotional distance was not synonymous with professionalism.

Watching the nurses in the unit reinforced this lesson. I noticed how differently the nurses interact with Laszlo. They spoke to him freely and without hesitation, all while knowing he cannot answer. They adjusted his blankets, they remembered his birthday, it was almost instinctive. Their fluidity showed me a form of competence which combined both skill and presence. This is part of the medical practice that often is unseen, unmeasured and remains unacknowledged; however it shapes the patient experience in a profound manner.

Touch and Intimacy in Clinical Care

Another lesson emerged through touch. Clinical training often frames touch as functional: palpation, auscultation, positioning. It is something done to a body rather than with a person. Feeding Laszlo disrupted this

framework entirely. The act of feeding demanded patience, ease, and cooperation; mutual participation was required. Every movement had to be deliberate. There was no room for rush. The proximity required trust, and trust could not be rushed.

I became acutely aware of how rarely students are prepared for the emotional weight of these moments. No instructions exist for interpreting hesitation, frustration, or eventual consent. No textbook prepares you for the fear of causing harm, embarrassment, or a loss of dignity. Instead, I relied on observation, intuition, and responsiveness. This learning felt fundamentally different from memorization. It was immediate, intimate, and deeply human.

Through this experience, I began to understand how intimacy exists within healthcare, often unspoken and overlooked. Patients repeatedly entrust their bodies, and with them, their autonomy and vulnerability to strangers in the hope of care and healing. Every technical action carries emotional consequences, whether acknowledged or not. The rhythm of feeding, the careful adjustments of posture, the smallest gestures of reassurance all became as essential as any procedure. In these moments, I realized that medicine is not complete without attending to both the body and the person inhabiting it. Touch is never neutral; it communicates attention, respect, and dignity.

Moreover, I began to see touch as a form of communication in its purest sense. When words fail, when a patient cannot speak or express themselves, touch becomes a language of presence. A gentle adjustment of a blanket, the careful support of a limb, even the steadiness of a hand during a procedure, all convey empathy, recognition, and acknowledgment. These moments demand a heightened awareness of timing, intention, and consequence. One misstep can cause pain or discomfort; one careful gesture can convey reassurance that transcends any verbal explanation.

Through feeding Laszlo, I realized that intimacy in medicine is inseparable from responsibility. It is not merely about performing a task correctly; it is about holding the patient's vulnerability with care. This intimacy is a practice of ethics.

Cultural Displacement and Identity Formation

Being an outsider shaped my experience in profound ways. By the age of 19, I had lived in 3 different countries across three different continents. I came into my medical school journey believing I was immune to culture

shock; I had moved, adapted, and thrived before. I never thought that anything could shake me. However, it was not the country itself which challenged me, but rather the hospital setting. Within these walls my sense of displacement intensified. I was navigating not only a new healthcare system but also a new professional identity. As a first-year medical student, I existed on the margins, present but peripheral, eager yet cautious, capable but insecure.

This dual outsider status, both in a cultural and professional aspect, made me acutely sensitive to hierarchy, routine, and expectations. I learned quickly when to speak and when to remain silent, when to step forward and when to recede. Approval came in subtle forms: a nod, a brief acknowledgment, permission to stay. I internalized these cues, measuring my worth through usefulness, my efficacy, and my invisibility. Everyday felt like a balancing act, weighing the desire to contribute against the need to stay small. I became hyperaware of my presence and how it might be perceived by others in this complex environment.

Furthermore, language, or rather the lack of a shared one, had shaped my early days in the hospital. I had prided myself in my English and French skills, sometimes even showing off my Arabic. They were tools I carried with confidence. However, in this environment, there was a strange vulnerability I hadn't experienced before. I struggled with the vulnerability of not being understood. Hungarian had truly resisted me. Its sounds felt unfamiliar in my mouth, its grammar incredibly difficult. Each attempt left me flushed with embarrassment, hyperaware of my accent and the sly but amused smiles of native speakers. Over time, I began to associate my attempts at speaking with exposure, and silence with safety. I convinced myself that competence could substitute communication. My precision and compliance in the practical aspects may compensate for my inability to speak fluently.

Yet, with patients like Laszlo, this assumption was challenged. His silence was not a choice, it was imposed on him. Observing him forced me to confront my own privilege. I could choose when to speak, when to move and when to rest. He could not. His constraints, physical and communicative, shaped his every interaction. This demanded patients. It demanded empathy and presence on my part. This invisible power imbalance between the clinical and patient was becoming more apparent to me. I was becoming more aware of the autonomy I carried versus the limitations my patients endured.

Being an outsider made me aware of these imbalances and the responsibilities they impose. It forced me to realize that communication ultimately transcended language. There is a dialogue in silence and a conversation in touch. My own vulnerability and occasional uncertainty heightened the sensitivity I had to his cues. It helped me recognize that beyond the diagnoses and charts, there was a human being who was constrained.

Navigating this dual identity in being both culturally displaces and professionally marginal also taught me to be resilient. I learned to tolerate uncertainty and to adapt in real time. I had to be effective without imposing. I realized that being an outsider is not a limitation but rather a perspective. It was a lens that allowed me to notice what others might overlook. This dual identity had not hindered my learning, but rather enhanced it. They had made me aware in the inherent privilege in mobility, language and in choice.

Progression: Looking Forward

This experience reshaped my understanding of what it truly means to be be a medical student and a future physician. I entered the hospital believing that my value lay primarily in my ability to perform tasks without error, and to follow protocols perfectly as well as remaing unnoticed. I believed that procedural competence was the primary measure of doing well. As a medical student, I find comfort in organization. There is a sense of reassurance and calm that comes from following steps, from knowing there is a correct order to things. Our textbooks reinforce this way of thinking: everything is systematic, everything is ordered. This is science, and by extension, this is medicine. Steps of hematopoiesis. Steps of bile formation. Steps of an appendectomy. Read, understand, memorize, follow the sequence, and do not stray. I believed that if I performed all tasks correctly, I would fulfill my purpose as a student and eventually, as a physician.

It was through reflecting on my experience with Laszlo that a more uncomfortable truth came into focus. There exists another kind of responsibility; One that does not come with protocols, checklists, or assessments. It cannot be memorized nor can it be numbered. This responsibility lies in holding space for emotional care alongside practical care, recognizing that the two must work in tandem. Medicine cannot be separated from its core purpose. At its foundation, the practice of medicine is guided by

the principle of "primum non nocere": first, do no harm. This principle extends beyond the avoidance of physical injury or procedural error. True adherence to this oath requires attending to the emotional, psychological and human needs of the patient alongside the physical interventions we perform. Emotional support is not secondary to the physical care but rather it is a part of the same ethical and professional obligations. To fail to recognize a patient's fear, discomfort or vulnerability is, in its own way a form of harm. Likewise, providing emotional comfort without attending to physical needs is incomplete. These two aspects of care are inseparable.

As I continue to move forward in my training, I hope to carry this awareness with me. I know that the pressures will intensify. Time will become increasingly scarce, expectations will rise, and emotional distance may feel not only tempting but necessary. There will be moments when slowing down feels irresponsible, when efficiency will seem to outweigh attentiveness, and when the demands of the hospital or clinic make it difficult to pause and fully see the patient in front of me. In those moments, I want to remember that medicine is practiced not only through intervention, diagnosis, and treatment but also through recognition. To truly see a patient, to acknowledge their presence, their fear, their dignity, and their humanity, is as vital as any technical skill. I will actively seek ways to connect, whether through language, gesture, patience, or silence. I will remind myself that even small acts, like an extra moment spent adjusting a pillow, a quiet word of reassurance, a nod acknowledging discomfort, can all profoundly affect a patient's experience and honor the oath I have committed to uphold.

I will also challenge the assumption that emotional engagement is a weakness or a liability. Too often, students are taught to maintain distance, to protect themselves from the suffering of others, or to focus solely on measurable, practical tasks. My experience with Laszlo has taught me that emotional engagement is not only a strength but a skill that requires practice, courage, and deep reflection. Being emotionally present does not reduce professionalism; it enhances it. Emotional awareness allows for nuanced care, better patient communication, and a more profound understanding of the complexities of illness and healing.

Furthermore, I believe medical education can and should do more to protect this awareness. Reflection should not be treated as an afterthought, a checkbox to be completed after the clinical day, but rather as an essential component of training. Students should be encouraged to write, to speak openly, to discuss their experiences, and to sit with discomfort. They

should be guided to notice the subtle lessons that emerge from small, often overlooked moments of care: the fleeting glance of recognition in a patient's eyes, the slight tension in a hand as a procedure begins, the way a patient relaxes when someone is truly present. These quiet interactions, which rarely appear in evaluations or assessments, profoundly shape professional identity and inform the kind of physician one becomes.

These small, subtle experiences cultivate empathy, ethical responsibility, and intercultural competence. They teach students how to navigate uncertainty, power imbalance, and vulnerability with humility and respect. They cultivate patience, self-awareness, and the ability to hold space for others' suffering without being overwhelmed by it. I want to advocate for a medical education that creates space for these reflections, one that encourages students to examine emotional encounters, and to learn from moments that are subtle, silent, and unmeasured. Such reflective practices do not diminish scientific rigor; rather, they strengthen it by anchoring clinical knowledge in lived human experience.

Laszlo never said my name. He never thanked me. Yet he taught me one of the most important lessons of my early medical training: care is meaningful even when it is not curative. Healing does not always come in the form of recovery or resolution. Sometimes, dignity is preserved through presence, through respect, and through continued attention. These moments which are quiet, unobserved, and intangible are ones which carry profound significance. They remind me that the essence of medicine lies not only in curing disease but in honoring the humanity of those we serve, a principle that is inseparable from the oath I have committed to uphold.

As I move forward, my approach to each patient will be shaped not only by technical skill and clinical knowledge but by deliberate presence and mindfulness. I will strive to notice the subtle cues of distress or comfort, to prioritize human connection even when efficiency is demanded, and to remember that the smallest acts of attention can resonate deeply.

Ultimately, this experience has taught me that being a physician is not simply about accumulating knowledge or mastering techniques; it is about cultivating the capacity to truly see and respond to the people entrusted to our care. It is about blending skill with presence, knowledge with compassion, and action with reflection. It is about holding space for the person behind the patient, recognizing the full humanity of each individual, and carrying these lessons forward into every interaction, every shift, and every decision in my career. This awareness, rooted in the principle of "do no

harm," will continue to guide my growth, shape my values, and define the kind of physician I aspire to become.

The lesson I learned from Laszlo will carry forward.

A simple phrase carries a heavy significance in my professional career.

Boldog Születésnapot.

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Between the Flood and the Farewell

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The rain had never truly stopped. Even two months after the beginning of the floods that devastated southern Brazil, it lingered in a thin drizzle, as if the sky itself had not yet decided to release what it was holding. When we arrived at the indigenous village of *Tekoa Porã*, the Guarani name resonated with a painful irony. *Tekoa*, the place of being, where life unfolds; *Porã*, good, beautiful, worthy. A "good place to live," they would say. Yet the original land that gave meaning to that name lay submerged somewhere beyond our reach, claimed by waters that had redrawn maps and erased certainties. What remained was a provisional settlement, assembled in haste, where existence itself seemed suspended between what had been lost and what could not yet be rebuilt.

I had come as a medical student and humanitarian coordinator, though neither title felt adequate that morning. Just months earlier, alongside close friends, I had refounded the *Bandeira Científica*, a traditional academic project of the University of São Paulo's Medical School, born in 1957 to bring humanitarian health expeditions to neglected regions of Brazil. Dormant since the pandemic, it had been revived with the conviction, perhaps the naïveté, that medicine could and should respond when institutions falter. In the face of the largest climate disaster ever recorded in southern Brazil, a catastrophe in which floods displaced more than 2.4 million lives and left over 180 people dead, we mobilized ourselves to the Brazilian state of Rio Grande do Sul.

The *Tekoa Porã* community had been forced to move when the floods swallowed their territory. Families now lived beneath blue plastic tarpaulins donated by relief agencies, fragile membranes separating them from the cold. Our improvised clinic was no more than one of those tarps, generously lent by a family who insisted on hosting us. Inside, a small fire burned

continuously, fed by the little dry wood they had managed to save. It was lit, they said, to welcome us properly. The gesture carried a dignity that felt largely undeserved. Outside, the tarp deflected the drizzle; inside, it trapped the smoke, which mingled with the smell of damp earth. Our pharmacy and supplies remained in the open bed of a pickup truck, exposed to the same cold that stiffened our fingers. Winter in the south is unforgiving, and the rain seeped everywhere, silently, persistently.

The settlement itself was an archive of loss that mixed all my senses. Blue tarps stretched across uneven ground; along the road leading there, entire neighborhoods had been reduced to heaps of debris, piled like mute testimonies to lives interrupted. What struck me most, however, was not what I saw but what I did not hear. In Indigenous villages, I am accustomed to the sound of children running, laughing, calling out to one another. Here, there was silence. A dense, reverent quiet that seemed to press against the ears. My senses were overwhelmed in contradictory ways: the smell of mud and wet dust carried by the drizzle; the acrid smoke curling around our faces; the cold rain beading on my hands and cheeks, the only parts of me not shielded by boots, heavy trousers, and a thick coat. And, unbidden, a bitter taste rose in my mouth: a mixture of helplessness and shame at witnessing a suffering so disproportionate, so undeserved.

The community endured. They were still there, physically present, yet an absence lingered in the air, of places, of homes, of familiar paths, and, though I did not yet know it, of bodies that should have been laid to rest. It was in this setting that he appeared.

He was a man in his fifties, tall and broad-shouldered, with a build that spoke of strength shaped by years of physical labor. And yet his posture betrayed him. His shoulders sloped forward, as if bearing a weight invisible to the eye. He approached with measured steps, his gaze steady but guarded, carrying a seriousness that bordered on suspicion. Dark circles framed his eyes, giving his face an exhaustion that felt incongruous with the few signs of age etched into his skin. It was as though the fatigue of recent weeks had eclipsed the vigor that once defined him. The man spoke little. When he sat down across from me, he did not offer his name, nor did he introduce himself in any formal way. Only later would I learn, after discreetly asking a local collaborator, why no one had objected when he moved ahead in the line. He was the indigenous leader, the *cacique*, though he never claimed the title. Authority clung to him not by declaration, but by recognition.

Our exchange began almost awkwardly. He avoided eye contact at first,

then fixed his gaze on a point somewhere beyond my shoulder. When I asked what had brought him to see us, he paused for a long moment, as if weighing the value of words. "My body is tired," he finally said. "But it is not just my body."

There was no mention of pain in the usual sense, no clear symptom to guide a differential diagnosis. Karaí, as I will call him, spoke of weakness, of restless nights, of a heaviness in his chest that came and went without pattern. Yet none of it sounded quite medical. As he spoke, I had the unsettling impression that his complaint exceeded the confines of the clinical vocabulary I had been trained to use. He sat there, contained and composed, yet somehow too complete, too whole, to fit into the narrow boxes of a medical form. I sensed, without being able to name it, that something was profoundly out of place. And in that quiet, smoke-filled space beneath a blue tarp, I realized that whatever had brought him to me would not be resolved by prescriptions or protocols alone.

* * *

The floods that engulfed the Brazilian state of Rio Grande do Sul in the autumn of 2024 were not a single event but a slow, cumulative collapse. Rain fell incessantly for weeks, saturating the soil, swelling rivers beyond their margins, and exposing the fragility of infrastructures that had long been assumed to be stable. Dikes failed, hillsides slid, roads vanished, and entire neighborhoods were rendered uninhabitable. What unfolded was not merely a natural disaster, but a systemic one: water invaded homes and buildings, while the routines that sustain everyday life (transport, sanitation, access to care) were abruptly suspended. The scale was unprecedented, as the waters of Lake Guaíba rose higher than any recorded level in more than eight decades. Nearly four out of five municipalities in the state declared a state of emergency or calamity, and 2.4 million people found their lives abruptly reorganized around loss, displacement, and uncertainty.

Far beyond the capital, rural and peripheral territories suffered silently, often without the visibility that mobilizes rapid response. Indigenous and quilombola communities were among the most affected. Located in low-lying areas or along riverbanks, many saw their lands swallowed entirely, their homes destroyed, and their dead left without proper burial. Health services collapsed at the very moment they were most needed. Clinics were flooded, supplies lost, and professionals themselves became victims, displaced from

their own homes and struggling to maintain care under extreme conditions. It was within this fractured landscape that our presence took shape.

At that time, I was still, above all, a third-year medical student at the University of São Paulo. Yet I also carried the responsibility of coordinating an expedition that had been assembled in urgency. Months earlier, together with colleagues, I had participated in the refounding of the Bandeira Científica, a long-standing academic initiative that promotes humanitarian health expeditions throughout Brazil. Faced with the disaster, and aware of the limitations of institutional responses, we organized an emergency action through its framework and created the Humanitarian Health League to sustain it, relying on partnerships with the Brazilian Air Force, the Brazilian Red Cross and the NGO Xingu+Catu. The decision to prioritize Indigenous and quilombola territories did not stem from idealism, but from recognition: these original and traditional communities had been disproportionately affected and, at the same time, insufficiently reached by the state's response. Our role was not to replace local services, but to support them, to work alongside Indigenous health teams whose capacities had been deeply compromised by the floods.

The days quickly settled into a demanding rhythm. We were housed in the event hall of a sports club, sleeping on the floor in sleeping bags, sharing a locker-room shower where the water temperature mirrored the near-freezing air outside. We returned late each evening from the field, and worked into the night organizing medications and supplies for the following day. Sleep was brief and fragmented; at dawn, we prepared our meals for the day. There was a constant pressure for the operation to function, so we could honor the trust placed in us by our partners and by the university we represented. As the coordinator, many of those responsibilities converged on me, though they were sustained, in practice, by the goodwill, discipline, and commitment of students and volunteer physicians who endured much without complaint.

Still, fatigue was not what weighed on us most. What unsettled us was the daily proximity to communities whose losses far exceeded any discomfort. Each encounter carried the awareness that we were entering lives abruptly interrupted, spaces where grief had not yet found words or rituals. There was an unspoken expectation that we had come to "help," an idea both unavoidable and inadequate. We knew we would not resolve what had been broken, nor restore what had been taken. Our presence was necessarily limited. Yet within those limits, we hoped to offer something modest

but essential: attentive care, careful listening, and a form of support that acknowledged suffering without attempting to simplify it. More than interventions, what we carried with us into the field was the understanding that, in such contexts, medicine begins not with answers, but with the willingness to remain present where certainty has already been washed away.

* * *

We had just arrived at *Tekoa Porã* community and started receiving the patients when that man emerged. I will call him Karaí. The name serves, first, to protect his anonymity, but it also carries a meaning that felt inseparable from his presence. In the Guarani world, *Karaí* (or *Karai*) refers to spiritual leaders and healers, who guide their communities through prayer, chants, and ritual, mediating between the visible and the invisible, between illness and balance, between life as it is lived and life as it should be. In Tekoa Porã, those functions had been exercised for decades by his father, a respected spiritual leader whose voice once organized rituals and collective mourning. Karaí himself did not claim such a role. Yet the silence that surrounded him suggested a lineage of responsibility that had not been extinguished, only interrupted.

He sat down slowly across from me, without urgency or ceremony. His presence was firm, but there was a visible tension in the way he occupied the space, as if his body were both there and elsewhere. When I asked what had brought him to the clinic, he did not respond immediately. His gaze wandered beyond my shoulder, resting for a moment on the smoke rising from the fire beside us, before returning, cautiously, to the narrow circle of our encounter. His complaint, when it came, resisted precision. He spoke of pain that did not settle anywhere in particular, of a tiredness that seemed to inhabit his entire body, of headaches that arrived without warning and receded without explanation. Sleep, he said, had become fragmented: nights passed in brief intervals of rest, interrupted by awakenings that left him more exhausted than before. There was no single symptom to grasp, no narrative of progression that could anchor a diagnosis. Everything felt diffuse, dispersed, almost deliberately evasive.

I examined him carefully, guided by habit and training. His vital signs were stable. Cardiac and pulmonary auscultation revealed nothing remarkable. His neurological examination was normal; muscle strength preserved despite the weakness he described. With the limited resources available

to us, we performed basic assessments that yielded little. If anything, the absence of abnormal findings intensified the discomfort. His body, as medicine measures and names it, appeared intact. I conferred with the physicians working alongside me. We considered dehydration, anemia, infectious processes, depressive syndromes, somatization. We reviewed what little medication he had taken, questioned nutrition, exposure to cold, the physical strain of displacement. Each hypothesis could be entertained, yet none truly held. The reasoning moved forward only to fold back upon itself, tracing a circular path that never quite reached a point of intervention. There was no clear place to begin, nor a convincing justification to proceed.

What unsettled me was not diagnostic uncertainty itself, which is familiar territory in medical training, but the sense that the complaint did not belong entirely to the clinical grammar we were trying to apply. Karaí did not speak of illness as a malfunction of parts. He spoke of exhaustion as a condition of existence, of a body that no longer sustained him in the way it once had. His words carried weight, but little specificity, as though exactness were beside the point. Much of what transpired between us unfolded without words, and silence occupied large portions of the consultation, not as absence, but as presence. However, Karaí did not appear uncomfortable with it; on the contrary, it seemed to be his preferred mode of communication. He would pause, sometimes for long stretches, his eyes fixed on the fire or on the rain pressing softly against the tarp. I felt the harmful impulse to intervene, to redirect, to clarify, and just as consciously resisted it. Something in his stillness demanded restraint.

Despite that, the setting itself seemed to speak where language failed. The smoke, the cold, the improvised walls of plastic separating us from the flooded land outside, all of it framed the encounter in a way that made the usual boundaries of the clinic feel strangely irrelevant. The territory pressed in on the consultation, refusing to remain a backdrop. Karaí's furrowed brow, the heaviness in his posture, the measured cadence of his voice seemed to echo the landscape itself: saturated, displaced, unsettled.

It was within one of these silences that the narrative shifted, almost imperceptibly. Without emphasis, and without inviting response, he mentioned that some had not returned when the waters rose. The river, he said, had taken people quickly. There had been no time to prepare, no warning, no chance to gather what was needed. Bodies were carried away, some found days later in unfamiliar places, others not found at all. There had

been no conditions for farewells, no space for the rituals that usually guide their dead.

He did not name anyone then. He spoke as though recounting a fact rather than a wound. Yet the restraint in his voice felt charged, as if holding something in suspension. I sensed that this fragment, offered almost incidentally, was not peripheral to his complaint but central to it, though neither of us articulated it as such. As the consultation drew to a close, the inadequacy of my tools became increasingly evident. I could offer symptomatic relief, such analgesics and advice on sleep, but each option felt provisional, insufficient, almost evasive. To act decisively felt premature; to do nothing felt negligent. I stood, uncomfortably, between action and listening, uncertain which constituted care in that moment.

Before leaving, Karaí finally spoke more directly. His voice did not break, nor did his posture change, but the words themselves altered the weight of the encounter. He told me that the body of one of his cousins had been recovered. The bodies of his two sons, however, had not. The waters had taken them, and they had not returned.

He added, quietly, that the community had not been able to return to their original land. The territory where their ancestors were buried remained submerged, inaccessible. Without the land, there could be no proper farewell. Without the farewell, something remained unresolved. He rose, nodded slightly, and left the tarp. I remained seated for a moment longer, aware that what had just been revealed did not fit within the confines of the consultation I had been trained to conduct. The complaint had finally found its contours, but not in the way medicine had prepared me to recognize.

What stayed with me was not a diagnosis, nor a plan of care, but the unsettling clarity that Karaí's suffering could not be disentangled from the loss of land, of ritual, and of continuity. The medicine I carried with me did not yet know how to name that pain. And so the encounter ended, not with resolution, but with a question that would follow me far beyond *Tekoa Porã*.

* * *

I carried Karaí's words with me after he left the tarp, like an unresolved echo. I attended other patients that afternoon – children with respiratory infections, elders with poorly controlled hypertension, women asking qui-

etly for sleeping pills – but my attention drifted repeatedly back to that encounter. Each complaint I heard seemed, in some way, to brush against the same question I had avoided answering with him. By the end of the day, the sense of impotence had grown intolerable. It was not merely professional frustration; it was an ethical unease, the feeling of having witnessed something that demanded a response, yet not knowing what form that response could take without doing harm. When the flow of patients slowed, I asked one of the local collaborators where I might find Karaí. He was sitting some distance from the improvised clinic, near the edge of the settlement, looking toward what had once been the path to their original land. I approached slowly, uncertain whether my presence would be welcome. He acknowledged me with a slight nod. There was no urgency in his posture, no sign that he expected anything from me. Still, I sat on the wet ground beside him.

This time, he spoke more freely, as if the initial boundary had already been crossed. He began not with his own pain, but with the night the water came. The rain had been relentless for days, he said, but no one expected the river to rise so fast. It was still dark when the water invaded the houses. People woke to shouting, to the sound of walls giving way, to the confusion of moving through water that climbed quickly from ankle to waist to chest. In the chaos, his sons, one eighteen, the other twenty-three, had gone out to help the elders. They moved from house to house, breaking doors, lifting people onto higher ground. They were strong, he said, and they knew the river. The water, however, was merciless.

He described the moment without drama, without embellishment. A sudden surge, stronger than the others. A loss of footing. Hands that slipped. The current carried them away before anyone could reach them. When morning came, the village was already unrecognizable. One body was found downstream in the days that followed. Others were not. His sons were among those who did not return.

As he spoke, his voice remained steady. There were no tears, no visible tremor. The absence of visible grief did not lessen the weight of his words; if anything, it intensified it. He spoke as someone stating facts that had become irreversible, as though emotion itself had been exhausted by the effort of survival.

They searched for months, he told me. They walked along the riverbanks, questioned neighboring communities, followed every rumor of a body found. Time passed, seasons shifted, but the water kept what it had taken.

Without the bodies, there could be no burial. Without burial, there could be no proper ritual. And without ritual, the dead could not be guided.

Death, for Karaí, was not something that simply ended. It required accompaniment. Their songs, prayers and collective rites would anchor the dead to the land and open the path toward the *Yvy Marã Ey*, the "Land Without Evil". He explained what happens when those gestures cannot be performed. "The dead do not find their path. They remain close.".

After one more long pause, Karaí whispered "The water took the living and the dead". The sentence lingered between us. It named something that exceeded loss as I had been taught to understand it. The floods had not only killed people; they had dismantled the conditions that allow death to be integrated into life. The land where their ancestors were buried, the place that held memory, lineage, and continuity, remained submerged. They could not return to their *Tekoa Porã*, their place of being, their good place to live. Joy, ritual, mourning, and daily life were all tethered to a territory that no longer existed in accessible form. In that context, the notion of an "unburied dead" acquired a density that resisted translation. The spirits, Karaí explained, were unsettled. Without farewell, without proper guidance, they remained close, restless. This unrest was not metaphorical. It was experienced in dreams, in sleeplessness, in the persistent sense that something essential was unfinished. The ancestors themselves, displaced by water and silence, no longer had a place to rest.

Listening to him, I began to understand that his body was not merely expressing psychological distress, nor failing in isolation. It had become a territory in itself, bearing the marks of a broader devastation. His pain, his fatigue, his insomnia were not private symptoms but inscriptions of a collective wound, where individual suffering, communal loss, and territorial destruction collapsed into a single experience. Until then, I had been trained to read the body apart from its surroundings, to isolate symptoms from the world that produces them. Yet before me, the body revealed itself as a continuation of the land: flooded, displaced, deprived of its rituals. Karaí's chest heaviness echoed the weight of unspoken farewells; his sleeplessness mirrored spirits unable to rest; his exhaustion reflected the endless search for what could not be found. His suffering did not belong solely to him. It was shared, distributed, relational. As he spoke, I felt the tension of my own position acutely. I feared interrupting, asking the wrong question, violating something sacred through the clumsiness of clinical curiosity. Each word I considered felt inadequate. There was no prescription for

unburied dead, no guideline for displaced spirits. The silence between us became a form of care in itself, fragile but necessary.

I realized then that my earlier sense of impotence had been misplaced. The problem was not that I could not act, but that I had assumed action must take a familiar form. What Karaí required was not intervention but recognition. Not solutions, but the acknowledgment that his suffering made sense within his world.

As he continued, his composure did not waver. He did not cry. His face remained firm, his gaze steady, as though emotion had condensed into something heavier than tears. I, on the other hand, felt my restraint dissolve. The weight of his words, the clarity of his loss, and the humility with which he shared it broke through my professional defenses. I lowered my head and wept, quietly, without spectacle. It was not an act of empathy I had planned; it emerged despite my efforts to remain composed. Karaí did not react. He did not move any muscle, nor did he seem surprised. He allowed the moment to pass, as one allows the rain. In that asymmetry, his contained grief and my visible emotion, I sensed no embarrassment, only a shared recognition of something irreparable.

When we parted, nothing had been resolved. His sons remained missing. The land remained submerged. The rituals remained suspended. Yet something had shifted in me. I understood that mourning, in that context, was not a process with stages to be completed, but a condition imposed by catastrophe. A mourning that could not be finished because the material and symbolic conditions for its completion had been destroyed. Karaí's grief did not ask to be cured. It asked to be witnessed, as it grasped that care, in such contexts, often begins precisely where medicine no longer fits.

* * *

After that conversation, there was nothing more to do in the sense I had been trained to understand action. No new information demanded clarification, no clinical decision awaited formulation, no protocol could be activated. Yet I was acutely aware that I was still being demanded of. The demand, however, was no longer technical, but ethical.

What Karaí had exposed to me was not a problem awaiting resolution, but a reality asking not to be reduced. My action therefore took shape not through intervention, but through positioning. I chose, deliberately, to remain present within the limits that had become evident. Presence, in that

context, was neither passive nor neutral; it required restraint, vigilance, and sustained attention. Likewise, listening became the primary form of action; not the strategic listening aimed at extracting data, but a patient attentiveness that tolerated pauses, ambiguity, and silence. I resisted the urge to redirect his narrative toward clearer causal chains or more "useful" formulations. I allowed his words to arrive at their own pace and to stop where they stopped. Waiting, rather than questioning, became my way of respecting the internal logic of his grief.

I did not medicalize his suffering. Although insomnia, fatigue, and chest heaviness could easily have been reframed as anxiety, depressive disorder, or somatic symptomatology, such translations would have offered a false sense of mastery while stripping his experience of its meaning. I did not prescribe medication as a way of closing the encounter, nor did I reinterpret his account of unsettled spirits into language more compatible with biomedical discourse. To translate everything would have been to appropriate it, making his loss intelligible only insofar as it conformed to my own epistemology. Still, this refusal was not comfortable. On the contrary, it generated unease. I felt exposed by the absence of a clear role, unsettled by the sense that my usual competencies were not only insufficient but potentially intrusive. Remaining silent demanded constant attention. Silence, in that setting, was not emptiness; it was a charged space in which words could either wound or honor. Each interruption avoided felt like a relinquishment of control, but also like an ethical necessity.

That discomfort did not belong to me alone. It reverberated within the team. When I later shared the encounter with the physicians and students working alongside me, the unease was palpable. Some expressed frustration at the impossibility of doing something; others worried about neglecting care by not intervening more actively. We were accustomed to responding to suffering with action; here, action required stillness.

We spoke cautiously about Karaí, with an implicit understanding that his story could not be handled lightly nor transformed into a teaching case stripped of its singularity. The team's discomfort was not resolved, but acknowledged, and from that shared awareness emerged a small but intentional gesture. No ceremony was planned, no explicit ritual proposed. Instead, we allowed space. When Karaí passed near the clinic, we did not hurry him. When he chose to sit nearby, we sat with him. When he was silent, we remained silent. In a context where words had already failed, that shared silence became a mode of validation, an acknowledgment that his

loss could not be resolved there, that its weight was recognized. It was a conscious choice to align ourselves with his tempo rather than impose ours, ensuring no premature closure would be imposed. His grief was neither minimized nor reinterpreted. It was left intact.

This posture demanded humility. It required accepting that our presence, however well intentioned, could not repair what had been broken. The floods had not only destroyed homes and taken lives; they had disrupted the very frameworks through which loss is made bearable. By remaining present without attempting to solve, we acknowledged the asymmetry of the relationship: we would leave; he would remain. Our responsibility lay not in erasing that asymmetry, but in not exploiting it.

In choosing to remain, to listen, and to refrain from reduction, I came to understand action in a broader sense. Action, here, consisted in sustaining a space where suffering could be expressed without being immediately transformed into a problem to fix. Each silence shared, each question withheld, each impulse restrained constituted a response to the demands placed upon me.

Despite my impotence, my action can be understood not as something done to Karaí, but as the position I chose to sustain with him. I remained where medicine faltered, without forcing it forward or translating his grief into terms that would have been easier to manage but unfaithful. Nothing tangible resulted from this stance; yet something essential was preserved: the integrity of his mourning, the dignity of his loss, and the ethical coherence of our presence in that place. By recognizing the limits of what could be offered, we avoided offering what would have been false, allowing the relationship itself to constitute the action.

* * *

Leaving Karaí that day did not bring relief. On the contrary, the encounter settled within me as an open question, persistent and unresolved. I had not failed in any technical sense, yet I felt wounded in a way that no checklist could capture. What unsettled me was not only the suffering I had witnessed, but the realization that my training had offered me few tools to inhabit it without resistance. I had been taught to approach illness as something to be addressed; however, here, suffering did not present itself as a deviation to be repaired, but as a condition to be endured. And that difference marked me profoundly.

For the first time since entering medical school, I confronted the limits of medicine not as an abstract notion discussed in ethics lectures, but as a lived boundary. Western medicine, with its emphasis on categorization, diagnosis, and intervention, suddenly felt narrow – not wrong, but insufficient. Karaí's grief did not expose a failure of technique; it exposed a mismatch of languages. Faced with unburied dead, displaced land, and interrupted rituals, medicine as I had learned it did not know how to listen without translating, nor diagnose without reducing.

This realization did not come gently. It was accompanied by a contained but intense anger. I felt anger at the catastrophe itself, at the water that erased lives and rituals with the same indifference. I felt anger at the structural neglect that left entire communities unprotected. Yet I also felt anger turned inward, toward my own impotence. I had arrived equipped with instruments and institutional legitimacy, and still I stood there unable to offer what truly mattered. That anger did not erupt; it settled, heavy and silent, amplifying a fatigue that no amount of rest could dissipate.

Alongside anger came fear, not the immediate fear of error, but the deeper fear of being useless. Medicine had always promised purpose, a way of acting meaningfully in the face of suffering. Karaí's story fractured that certainty. I feared that if medicine could not respond here, then its promise was more limited than I had believed. And yet, paradoxically, listening was all that remained.

I also became aware that listening exacts a cost. To listen without redirecting, without simplifying, without retreating into technical distance demands exposure. Karaí's grief did not merely pass through my attention; it lodged itself in my body. I carried it in the tightening of my chest, in restless nights, in the difficulty of returning to the ordinary rhythm of consultations. The encounter did not end when he walked away; it continued within me, silently, insistently.

This experience forced me to rethink my place as a future physician not only at the bedside, but within a broader landscape of health. Karaí's suffering could not be separated from the loss of territory, ritual, and collective continuity. Health, in that context, was inseparable from land and belonging. To ignore this was not neutrality; it was erasure.

I became acutely aware of how medical training privileges action over presence. We are taught to decide, to intervene, to move forward; stillness is rarely recognized as meaningful. Silence is often mistaken for omission. With Karaí, choosing not to act felt almost transgressive. It forced me to

confront the possibility that ethical care does not always align with professional instinct. This dissonance was deeply unsettling. I found myself oscillating between the fear of doing too little and the fear of doing too much, aware that either could constitute harm.

The emotional asymmetry of our interaction also left its mark. Karaí spoke of losing his sons without tears, his grief contained and austere. I, by contrast, could not maintain the composure expected of a clinician. That reversal unsettled me. My tears did not signal loss of control, but an encounter with something that exceeded my defenses. They revealed that vulnerability is not incompatible with care, even if it remains largely unacknowledged in medical spaces.

As part of a team, I was not alone in this experience, yet the transformation it provoked was deeply personal. Sharing the encounter did not dissolve its impact; it clarified the shared fragility beneath our professional roles. We were all circling the same question: what does it mean to care when one cannot cure, explain, or resolve? That question lingered, unanswered, shaping my perception of myself as a student and as a future physician.

What remained most vividly was the sense of being marked. Not transformed into certainty or direction, but altered. Karaí's grief became a formative wound, one that did not close, but reshaped the contours of my understanding. It revealed the cost of listening deeply and the inadequacy of pretending that such listening is neutral. I left without answers, but with questions that now belong to my formation: questions that insist that medicine's ethical depth lies not only in its capacity to act, but in its willingness to remain present where action fails.

* * *

In the weeks that followed *Tekoa Porã*, I often recalled the way Karaí looked toward the path that no longer led anywhere. The encounter did not return to me as a memory to be revisited, but as a tension that persisted. It accompanied me in other consultations, in classrooms, and in moments when clinical reasoning felt suddenly insufficient. What gradually became clear was that the encounter had not altered a technique or a skill, but the axis around which my understanding of medicine had been organized.

My relationship with listening was the first to shift. Until then, listening had been largely instrumental: a means to gather information, identify pat-

terns, and advance toward diagnosis or intervention. After Karaí, I became more attentive to listening as a space in itself, one that does not necessarily aim at extraction or clarification. I learned to tolerate pauses without rushing to fill them, and silences without interpreting them as failure. This did not weaken clinical rigor; it expanded it, allowing attentiveness to include discernment about when not to press further.

This transformation inevitably affected my relationship with diagnosis. Medical training privileges naming: to diagnose is to confer legitimacy, to make suffering actionable. Karaí's story revealed that diagnosis can also function as a form of premature closure, fixing meanings before they are ready to be fixed. Going forward, I understand diagnostic reasoning as an ethical act as much as a technical one, requiring humility to recognize when classification clarifies and when it obscures.

More fundamentally, the encounter reshaped my understanding of health itself. Health ceased to appear as a primarily individual or physiological state and came to be understood as inseparable from territory, ritual, continuity, and belonging. Karaí's suffering could not be detached from flooded land, interrupted burial rites, or the displacement of ancestral grounds. His body articulated what the territory had endured. This realization made visible the limits of models that isolate the individual from their social and territorial context, and the importance of collective, relational, and ecological aspects of health, especially in contexts shaped by structural vulnerability.

It was through this lens that my own professional aspirations took form. The encounter at *Tekoa Porã* sharpened a discernment that had been forming gradually and gave it direction. I came to recognize that the questions that most urgently mobilize me, those of prevention, collective vulnerability, environmental disruption, and structural determinants of illness, find their most coherent articulation within the field of Preventive Medicine and Public Health. The experience did not draw me away from clinical care; rather, it repositioned it within a broader commitment to health as a social and territorial process. In doing so, it crystallized my aspiration to work in this field, both as a researcher and as a future sanitarian.

This perspective also carries implications for medical education. Traditional training, especially in urban academic centers, often remains distant from territories most affected by climate change and social inequity. Yet climate-related catastrophes will increasingly force medicine into settings where infrastructure collapses and where loss exceeds what can be repaired.

In such contexts, technical expertise alone is insufficient. Training must include sustained engagement with affected communities and territories and with forms of knowledge that do not align neatly with biomedical frameworks.

Exposure to vulnerable territories should not be exceptional or peripheral, nor framed as heroism or charity. It should be integral to formation, cultivating ethical sensitivity, cultural humility, and an understanding of medicine's embeddedness in social and environmental realities. Without this, future physicians risk remaining technically competent yet ethically unprepared for the kinds of suffering that climate emergencies increasingly produce.

At a personal level, I also learned to accept that some pains do not ask for solutions. Karaí's grief did not seek resolution; it sought acknowledgment. Learning to tolerate this distinction reshaped my sense of usefulness as a medical student. Care, I came to understand, does not always culminate in improvement or measurable outcomes. Sometimes, it consists precisely in accompanying what cannot be fixed without violating its meaning.

This awareness tempered my expectations of myself as a future physician. Effectiveness, I no longer believe, is measured solely by intervention. What I now seek to cultivate is discernment: the capacity to recognize when action is required and when restraint constitutes the more ethical response. Such discernment does not arise from protocols alone; it emerges from encounters that unsettle, resist resolution, and expose the limits of one's own frameworks.

Thus, what changed after *Tekoa Porã* was not a single belief, but an orientation: toward listening that does not rush, toward diagnosis that does not dominate, toward health that exceeds the individual, and toward a medical formation attentive to the realities of climate-induced suffering. These changes do not offer closure. They impose responsibility, and they continue to shape the physician I am becoming.

* * *

When the time came to leave Tekoa Porã, there was no clear moment that could be named as departure. Nothing in the territory itself signaled closure. The rain persisted, thin and relentless, blurring beginnings and endings alike. Our presence had always been provisional, and our exit would be no different. Still, as the last morning unfolded, I found myself attentive to

details with an almost painful acuity, as if the body sensed that something unresolved was about to be carried away.

We dismantled the clinic quietly, returning the blue tarpaulin to its family. The fire that had burned continuously since our arrival was allowed to die down on its own. Few words were exchanged. The community moved around us with the same restrained rhythm I had come to recognize, gestures measured, voices low. The settlement absorbed our movements without reacting, as if departure were already part of its grammar.

I did not see Karaí to say goodbye. I noticed his absence almost immediately, though I could not have said why I expected him to appear. Perhaps I had imagined, without admitting it, a final exchange: a nod, a word, some gesture that might retroactively confer a sense of completion. Instead, there was nothing.

At first, I felt a flicker of disappointment, quickly followed by relief, and then by understanding. A farewell, I realized, would have been an imposition. It would have suggested symmetry where there was none, closure where none existed. Karaí would remain; we would leave. His sons would remain missing; the land would remain submerged. To expect a parting gesture was to seek comfort for myself, not for him.

As we loaded the truck, I looked once more toward the flooded fields beyond the settlement. The water lay still, deceptively calm, reflecting the overcast sky. It was difficult to reconcile this surface with the violence it had enacted weeks earlier. Yet the consequences remained everywhere: in the tarps, in the silence, in the absence of rituals that had not yet found a place to return.

I thought of Karaí gazing toward a path that no longer led anywhere. I felt again the same heaviness in my chest that had settled there during our silence together. What persisted was not resolution, but interruption. As we drove away, the settlement receded slowly, swallowed by the same gray that had welcomed us. I resisted the urge to look back repeatedly, afraid that doing so would turn the place into memory too quickly, smoothing its edges. I wanted to carry it with its roughness intact. The road was lined with debris, remnants of houses collapsed into indistinct piles. Loss here did not announce itself; it lingered.

I realized then that what made the farewell impossible was not the absence of words, but the absence of conditions. Farewells require a place to stand, a future to imagine. In *Tèkoa Porã*, nothing had ended. The disaster had not concluded; it had merely settled into a quieter phase. Grief, unan-

chored by ritual or land, remained suspended, much like the community itself.

Medicine, too, had remained suspended. There had been no final act to perform, no intervention that could be framed as decisive. What we left behind was not treatment completed, but presence withdrawn. That, perhaps, was the most uncomfortable aspect of departure: recognizing that presence, once offered, cannot be neatly taken back without leaving a trace.

Long after the settlement disappeared from view, I remained aware of that trace within myself. The encounter with Karaí resisted closure. It remained, like the rain, thin but persistent. Therefore, I understood then that I would remember this experience not through an image, but through an absence: the man I did not see again, whose farewell did not take place.

We crossed a bridge where the river ran wide and opaque beneath us. For a moment, the vehicle slowed, and I watched the water slide past, carrying with it reflections of a sky that offered no answers. Somewhere downstream, it had taken lives, names, bodies. Somewhere upstream, it continued to rise and recede without regard for what it disrupted.

I did not cure Karaí. I did not help him bury his dead. I did not offer a farewell. Around me, the water remained. The asymmetry of that encounter endured: my trajectory shifted, while his grief remained.

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Opening the Wounds You Cannot Stay to Tend

Sepanta Sadafi

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It had only been a few hours since I'd nervously walked down the steps of the small plane they'd sent us to Mildura on, a rural Australian town about an eight hour drive from my home city, Melbourne. I had been thrown into the hospital for the first time as a medical student. I was in second-year and this was shaping up to be an arduous three-day rural placement.

Barely a minute into the morning group meeting before my first ever ward round, I felt more obsolete than I ever had before. I stood silently in the corner, after introducing myself politely. I understood that their lack of warmth was likely a consequence of the pressure the doctors were under, so I tried not to take it to heart.

I stood there observing the room, wondering whether I was allowed to sit in the empty chair, take notes from the confidential patient list, or ask what all these new acronyms were. I didn't sit on the chair, or take notes. After deliberating with myself, I found a moment of silence and finally struck up the courage to ask what "NDKA", "CVA" and "PRN" meant against my better judgement. One of the doctors begrudgingly responded.

This was my first ever beat-down in the hospital system. Afterwards, the fifth year student on the team who was "responsible" for me consoled me and justified the doctor's tone as "just part of the journey!" stating it was "part of the med student experience".

Nevertheless, I compartmentalised, and followed behind the team, which comprised five doctors and four students. We struggled to even fit half of us within the thin walls which were no more than dirt stained curtains. Every word we said felt completely intelligible to the patient in the next bed and their family, despite the illusion of privacy the curtains were meant to provide.

I stood outside the room of a thirty-eight year old woman being informed about stage four pancreatic cancer, her children beside her. Amid the sound of sobbing, I wondered if I'd have the opportunity to speak to her, or any patient at all.

I yearned to be of use, if not emotionally, at least logistically.

Would I be this useless for the whole day? All three days of this rural placement? Even worse, would I be this useless for the next three years of medical school?

We maneuvered around the curtains to the next bed. By chance, I was standing far enough away from the first patient that I became the first point of contact with the next one.

I did not notice his gangrene at first, but I did hear his voice. Low, fractured, carrying the exhaustion of trauma, long endured. It rasped through the room like static from an old cassette, each word fraying at its edges. The tone was unmistakable, the eyes of a man who had seen atrocities but had been heard too little.

He lay in a small room at the far end of a rural ward, half in shadow even when the blinds were open. The light seemed to stop at the doorway, as if uncertain about entering. His chart was clipped neatly at the end of the bed, the summary line brisk in its finality, "Diabetic foot ulcer, advancing to gangrene."

I've always felt the language of medicine was too clean for the realities it describes. Beneath those words was something else entirely, a story scribed in scar tissue, a man awaiting witness, not cure.

I had never felt such purpose at the prospect of listening to his story, caught in a wave of curiosity and empathy.

A small flock of students in stiff lanyards, learning to fit questions inside the gaps between obs rounds and discharge summaries. We were taught which boxes to tick, how to phrase "any concerns?" so that it did not invite more than we could afford to hear.

Compassion was encouraged rhetorically, but the day was scheduled in five-minute increments. I absorbed the lesson quickly. Move fast, smile often, do not get stuck.

He was meant to be a quick follow-up. The nurse had already peeled away the outer layers of gauze when we walked in. I remember the way the air thickened, it was instant and heavy, with the metallic sweetness of decay. It was the type of smell that bypasses language and goes straight to the body, lodging somewhere deep in the throat.

I focused on not flinching, acutely aware of my own performance of professionalism. We leaned in as the registrar inspected the wound, narrating the findings in terms of perfusion, tissue viability, surgical options.

Then, almost casually, the man turned his head towards me and said, in that rasping voice, "It smells like war again."

At first I thought I had misheard him. To my teenager brain, war did not belong in the neat clinical column of "diabetic foot ulcer." It belonged in documentaries, history essays, and dusty memorial plaques, not in the humid air of a rural ward. I hesitated, my mind already reaching for differentials.

"Vietnam. Sixty-nine," he continued, eyes fixed on some point above my shoulder. "They sprayed us with Agent Orange. Said it was harmless. Just something to clear the jungle."

He spoke without bitterness. His gaze did not seek pity. He was offering something else, a chance to remain, to see what most prefer to avert. There was an invitation in the way he said it, as if testing whether I would retreat back into the safety of the chart. I didn't say a word. Words, I sensed instinctively, would only diminish the gravity of what he carried.

"They never said we'd cough blood. Or bury our mates every few years. Cancer, lungs, skin, marrow. This leg, of many reminders, seems to be the last reminder."

The registrar shifted his weight, checked the dressing plan, and spoke about vascular reviews and probable amputation. The man nodded, as though discussing weather. I stood at the bedside, stethoscope idle, feeling as if two conversations were unfolding on top of each other. There was the clinical one about muscle and bone, and another, older one, about a war that lived on within him spiritually.

He paused, and the silence that followed was by no means absence, it was arguably more present than any silence 19 year old me had ever heard before. Thick, living, almost unbearable. The nurse reached for fresh gauze. The registrar gave a small, practiced smile and said we would "keep an eye on things."

The patient began to talk to me as we locked eyes one last time, talking me through the death of his wife and the unfortunate suicide of his son. About how he bought the car he always dreamed of but could not enjoy it one bit with the absence of his family. About how he was the injured, chronically ill soldier, and still the last man standing.

It felt to me like a final cry for help.

As he was speaking with profound candour, the registrar insensitively shut the conversation down, and pulled me out of the room.

As we stepped back into the corridor's fluorescent light, an older student beside me murmured, half to himself, "Be careful opening wounds you will not stay to tend."

The phrase lodged deep. It was akin to a splinter.

We moved on. The ward reclaimed me, as if I'd rejoined the pack of sardines. There were other patients, other wounds, other learning objectives. Yet all afternoon, my mind kept circling back to that room and the smell "like war again." I tried to redirect my attention to the tutorial on insulin titration, to the consultant's explanation of HbA1c targets, but his voice kept intruding, low and cracked, dragging the past into the present.

The official rhythm of the day demanded obedience. We had notes to write, checklists to complete. When our group was dismissed for an hour of independent study, most of my classmates vanished into the students' room with textbooks and laptops. I stood in the corridor, halfway between where I was meant to be and where I felt pulled.

The older student's warning replayed itself. "Be careful opening wounds you cannot stay to tend". I told myself that I was not opening anything, merely walking back to someone who had already begun to speak. I told myself it would be brief. I told myself it mattered.

I could not resist.

I returned to his room.

The light had shifted slightly, falling across the bed in a thin rectangle. He was awake, staring at the ceiling. For a moment I hovered by the door, self-conscious. I had no lab result to discuss, no update to deliver, nothing that could be categorised as "educational activity" on my logbook.

"Hi," I said, feeling the inadequacy of the word. "I'm sorry we couldn't finish our conversation this morning, the doctors were quite busy, but if it's okay with you and if it's something you'd like, I could sit here and listen."

He turned his head and regarded me quietly, as if weighing this intrusion, this second arrival of a stranger in scrubs. A tear fell, he smiled subtly and gestured to the chair.

We did not start with Vietnam. He asked my name, how far along in my training I was, whether I was "going to stick with it or run for the hills." I laughed, slightly too loudly, and said I planned to stay. Only later did I realise it was the same question he was asking about himself.

Slowly, without any prompting I could identify, his words shifted. He

spoke of the day they flew home from Saigon, young and sunburnt, expecting parades and finding protest. He spoke of nightmares that never stopped, of waking with the sound of helicopters in his teeth.

Then he spoke about home.

He told me that two weeks earlier, his wife had died. They had spent years talking about a shared dream, saving slowly for a second-hand Mustang and planning to drive it around Australia once "the doctors' appointments settled down." He smiled when he described the car, but that was only a reflex of remembering his soulmate. A small, crooked smile that held both pride and disbelief. "We finally got it," he said. "But now I don't have her, or my son." She saw it, sat in it twice, and then her heart gave out."

In the days after her funeral, he said, their son ended his own life. He told me this without drama, almost as if stating another side effect, another item on a long list of losses. There was no language big enough for the shape of that grief. A wife gone, a son gone, the car they had bought to outrun the years now sitting idle in a shed, keys glinting uselessly on a hook.

He spoke of mates who overdosed and of those who "just faded away." He spoke of the slow erosion of his body and the faster erosion of meaning. The war had followed him home in various uniforms. Cancer, nightmares, funerals, an empty passenger seat where his wife was meant to be.

This conversation was not intended to be history taking practice for me. It felt like being trusted with something that was precious and dangerous. His voice moved between memory and confession, circling what language could not contain. He did not ask to be fixed. Only to be met.

I listened, acutely aware of how little I knew, of how far outside my training this all fell. Every instinct I had been cultivating told me to summarise, to clarify, to reflect back using phrases we practiced in communication skills workshops. None of that felt right here. To package his sentences and pain into neat formulations would have been erasure. This was not a conversation to take notes about.

So I stayed mostly silent. Occasionally I asked a small question, more to show I was still there than to direct him. I felt the weight of his story settling around us, heavy as the smell of antiseptic and decay.

Until then, I had mistaken compassion for its performances: kind phrases, careful tones, a well timed nod. Sitting with him, I realised that compassion is not spoken. It is endured. It demands that we resist the reflex to retreat from what wounds us.

By the time I stood to leave, the light had thinned further. I thanked

him, awkwardly, knowing the word was too slight for what he had laid out between us. He shrugged, as if to say that talking had changed nothing and yet, perhaps, a little.

That evening, guilt and a kind of fierce tenderness twisted together in my chest. I replayed his sentences in my mind, trying to decide whether I had done something good or something foolish. Part of me felt that staying had honoured him. Another part braced for the possibility that I had transgressed some unwritten rule.

The next morning, as the ward round was about to begin, the registrar asked if he could speak with me. His tone was neutral.

"I heard you went back to Mr H's room yesterday afternoon," he said. "On your own."

I nodded, heart quickening. "Yes. We talked for a bit. He wanted to tell me about – "

He held up a hand gently, stopping the sentence before "Vietnam" could land between us.

"I appreciate that you care," he said. "But you cannot just go and have unsupervised in-depth conversations like that. You are a student. There are boundaries. We are already stretched. If every student sat talking for an hour, nothing would get done. You also risk bringing up things you are not trained to manage. Trauma, depression, all of that. You open doors we cannot guarantee we can help them close."

He did not raise his voice. There was no dramatic anger. That almost made it worse. The reprimand was delivered in the same tone as instructions about heparin doses, as if this were just another protocol I had failed to follow.

I felt my face burn. I apologised automatically. I heard myself say that I had not meant to overstep, that it would not happen again. In that moment, the previous afternoon, with all its fragile honesty, shrank into something labelled "inappropriate over-involvement" in my mind.

The sting of being disciplined wasn't just about the embarrassment. It was the sudden suggestion that my attempt to be present had been not only inefficient but potentially harmful. I had walked out of his room feeling that I had honoured a story. Now I was being told that I had mishandled it, that in opening space I could not fill, I may have re-injured a man already flayed by institutions and recent grief.

I thought of the red Mustang in his shed, of the wife who had sat in it twice, of the son who could not imagine a future without her. I thought

of how easily my own departure, abrupt and unexplained, could become another small confirmation that everything and everyone destined to care eventually departed whether by choice or not.

After the round, I sat in the empty tutorial room and stared at the whiteboard. Part of me bristled. Had I really done something so wrong by sitting with a man who had lost his wife, his son, and his leg within weeks of each other, and who wanted to speak? Was the system so fragile that one hour of listening could destabilise it? Unsettlingly, I recognised a kernel of truth in what I had been told.

I remembered the older student's warning in the corridor: "be careful opening wounds you will not stay to tend". Until then, I had heard it as a call to be efficient, a cynical acceptance that we should not "get too involved." After the reprimand, I began to hear a second meaning. To invite a story is to enter into a kind of contract, however implicit. You become, in that moment, part of the architecture holding it. If you vanish abruptly, the structure can collapse, leaving the other person buried under what they have unearthed.

I would only be on that ward for two more days. I could not promise him continuity, only a brief flare of attention in a long corridor of neglect. Did my presence give him something, or did it remind him that people can still leave without warning? Was I a salve or another small laceration in a life already cross-hatched with them?

This question haunted me as his clinical course unfolded.

Within hours, the decision was made to amputate. The leg that "smelled like war" became a surgical specimen. The notes in his file described the procedure with precision. "Below-knee amputation performed. Uneventful peri-operative course." The phrase "uneventful" felt obscene. The nurses managing his post-operative pain did not have capacity to also manage the old pain resurfacing under the morphine. The physiotherapists focused on mobilisation. The endless business of saving bodies continued.

I visited him twice more, each time more aware of my own inconsistency. He was alternately drowsy and sharp, drifting between ward remarks and fragments of memory. Once, in a lucid interval, he looked at me and said, "You're the one who keeps coming back." It was said without accusation, but it landed like one. Keeps coming back, as if my intermittent returns were a pattern he recognised from elsewhere. Things that appear and disappear, promising solidity and dissolving, like the promises made before Agent Orange soaked into his skin and before the Mustang key turned useless in the ignition.

The next morning, it was my final ward round on this placement.

His bed was empty.

The nurse at the desk told me he had gone to high dependency overnight with sepsis. The operation site looked clean, but his blood pressure had collapsed. "These old blokes," she said, half sighing, "one thing knocks them off course and the rest just follows." I nodded, feeling both included and excluded from some adult knowledge about mortality.

I read the note. It was short: "Expired overnight. Sepsis following surgery. Family informed." I wondered who there was left to inform, maybe a brother or sister.

That was all. Clinical, complete, conclusive. Whatever war had been continuing in his dreams ended without ceremony in a three-line entry.

I still think of him, in the smell of iodine mingled with darkness, in the split second of hush before I ask a patient about their past, in the awareness that our pains predate our arrival in any room. Medicine teaches us to take histories, not to bear them. But every story offered in trust becomes a small inheritance of suffering. To witness it without turning away is not ancillary to care. It is care.

After his death, I tried to talk about him with my classmates. I mentioned how he had compared the smell of his wound to the jungle, how he had spoken of Agent Orange and buried friends, and of how in the space of a fortnight he had lost his wife, his son, and now, finally, his leg. They nodded politely, said "that's intense," and then resumed their exam revision. The moment compressed into anecdote, something one might one day use to get a good mark in an OSCE station on "breaking bad news."

Something in me shifted. I felt an odd dislocation, as if I were straddling two realities. In one, he was a case study in complications of diabetes. In the other, he was a man whose life had been shaped by decisions far beyond his control, whose final days were spent in a room that smelled of both rot and disinfectant, whose last significant conversations may have been with a student who had later been reprimanded.

I began to pay more attention to the texture of everyday apathy on the ward.

It was rarely dramatic. No one announced, "I do not care." Instead, it seeped in around the edges. A registrar who once sat at the bedside would now stand at the door. A nurse who used to ask about grandchildren now focused solely on blood pressure. Jokes became sharper, flung into the air as a way to blunt the emotional sting of the work. Phrases like "You cannot

save everyone" and "You get used to it" floated through handovers like protective spells.

Initially, I judged this as moral failure. How could they not care? How could they talk about a man's amputation in the same tone as they discussed the lunch menu? As the days passed, my judgment softened into something closer to understanding.

The ward was understaffed. Nurses were carrying six patients instead of four. The registrar's pager seemed to scream constantly. Rosters were stretched so thin that most people had not had a proper break in weeks. In such an environment, emotional presence becomes a privilege and a luxury rather than a standard. Apathy, I realised, was not always a defect of character. Often, it was an adaptive reflex to scarcity.

When the system is stretched to breaking point, what frays first is not technical skill. It is softness. To feel everything fully, day after day, in a context that offers little space for recovery, would be to risk collapse. So people learn to narrow their emotional aperture, to see wounds primarily as problems to be solved, not as stories to be heard. They cut their empathy to fit the available time. It is therefore unsurprising that my parents, emotionally depleted by the cumulative traumas of immigration, have long been unsupportive of my passion for psychiatry, seeking to shield me from what they perceive as the psychological unravelling inherent in sustained emotional exposure.

In that light, my reprimand took on a different hue. It wasn't simply about me, or about this particular veteran. It was about the system's fear of any interaction it could not sustain. If every student spent an hour with each patient who wanted to talk, the already overburdened staff might be left with a ward full of opened wounds and no capacity to tend to them.

My act of staying was, in one sense, a small rebellion against this pragmatic logic. It was also, potentially, an additional burden placed on a team already at their limit.

This did not absolve the pain of being disciplined for trying my best with a patient.

It did, however, complicate it.

So I find myself caught between two imperatives.

The first is internal and moral, to be the kind of clinician, who does not turn away from suffering, who stays seated when the wounded speak candidly.

The second is external and structural, to become the kind of clinician

the system could accommodate, applauded for efficiency and bounded. After all, most of the metrics we seem to strive for are based on how fast we can successfully discharge patients.

Each time I choose one, I feel as though I'm betraying the other.

I returned back to Melbourne and eventually started metropolitan placements. Some days, exhausted and anxious about assessments, I tried on the detachment I saw around me. I hurried through questions, avoided asking anything that might lead to tears, laughed at jokes that flattened patients into "frequent flyers" and "heartsinks." On those days, I went home with a tightness in my chest, sensing I had rehearsed a version of myself I did not want to grow into.

On other days, I allowed myself to slow down, to linger at the bedside of someone whose eyes followed me as I moved past. Those days carried a different cost. I risked falling behind, risking criticism for inefficiency. I risked, as with the veteran, disciplinary conversations that framed my empathy and presence as a problem.

Somewhere between these extremes lies the practice I hope to cultivate.

Attentive yet boundaried, open yet honest about my limits. To reach it, I will need more than personal resolve. I will need training that acknowledges these tensions instead of punishing their emergence.

Looking back, I can see that my return to that room was less an isolated misjudgment and more a collision between two pedagogies. The formal curriculum taught me to take a history, examine a limb, write a succinct note. The hidden curriculum taught me that spending too long with someone was suspect, that tears were time-consuming, that the safest question was the one that did not invite a complicated answer.

The veteran taught me something else again; that bearing witness is itself a form of treatment.

My grandparents had always called the doctor itself "a drug", teaching me quite young that the clinician's presence, personality, and way of relating can be therapeutic, for better or worse. In that rural ward, I glimpsed this truth. I could not prescribe anything. I could not adjust his insulin. Yet something in our sitting together shifted the distribution of weight in the room. I was, briefly, part of the medicine. The reprimand that followed was, among other things, a reminder that I was not yet authorised to administer this particular drug.

I understand the caution now more clearly. There is risk in inviting someone to unseal old grief if you are unable to offer a reliable container.

To open wounds you cannot stay to tend may re-enact earlier abandonments. If I had stayed away, perhaps his final days would have been more uniformly dull, less fissured by reminders of a war the ward could not acknowledge and a family he had just lost.

And yet, when I imagine the alternative, I feel otherworldly unease. I picture him lying in that dim room, his leg turning black, the smell thickening, his memories pressing against his ribs with nowhere to go. I picture the red Mustang sitting cold in a shed, a monument to a future that never happened. I picture everyone walking past, seeing only an "advancing diabetic foot ulcer." I do not know whether my listening did more good than harm. I do know that to have left his words unspoken would also have been a form of neglect.

I imagine a system where, after such an encounter, I could go to a mentor and say, "He spoke of Vietnam and nightmares and his wife and son, gone within weeks of each other. I feel out of my depth. Can we think together about what I have opened and what can be offered now?" I imagine a ward where there is space to hand over not only blood results but stories, where the psychosocial wound is acknowledged as something the team shares responsibility for, not something smuggled into a spare moment by a student.

Instead, I learned to silence my own unease. I learned that certain kinds of care can attract punishment. I learned that resource-related struggles can harden into apathy that is almost indistinguishable from cruelty, except that it is born of depletion, not malice.

His story continues to shape the doctor I am becoming. When I sit with patients now, I am more deliberate about the questions I ask. Before I invite someone to talk about old losses, I consider what I can realistically offer in return. Continuity? Or maybe a referral and handover that honours what has been said. If my role is transient, I name that openly. I say, "I am here with you today. I may not be the one you see next week, but I want to understand what matters to you so we can pass it on properly." It is not perfect, but it feels more honest than pretending I can stay when I cannot.

He also changed how I think about medical education. We spend countless hours memorising receptor pathways and management algorithms. We are given far fewer structured opportunities to explore what it means to be the person who hears, and sometimes triggers, another human being's deepest pain. When those moments do occur, they are often handled privately, in the spaces between formal teaching sessions, or punished through quiet admonishments to be "more professional."

We need spaces, where students can bring these encounters not as embarrassing missteps to be corrected, but as complex events to be examined. In such groups, my story of the veteran could have been unpacked with nuance. We could have acknowledged the real risk of opening wounds without adequate support. We could also have honoured the value of a young clinician learning to tolerate the smell of war without fleeing. We might have asked what changes at the level of rosters, staffing, and supervision would be needed for such listening to be sustainable.

Most of all, we might have named openly the pain of being disciplined for trying one's best with a patient. That pain, early in one's career, can feel like personal humiliation. It is a micro-trauma to the developing professional identity. Each time a student is told, implicitly or explicitly, "Care less, you are in the way," a small piece of their initial idealism is amputated. Over time, those losses accumulate, producing the very apathy we then lament.

I do not romanticise my own role in his story. I was a brief visitor in a long campaign. His leg would have been amputated whether or not I sat down that day. His nightmares would have continued long after my rotation ended, had he lived. Yet within the narrow band of influence I had, he taught me something I could not have learned from a lecture.

He showed me that the body does not forget what the world refuses to name. He showed me that some wounds smell of jungle and jet fuel even when described as "infected tissue." He showed me that sometimes the most radical act a clinician can perform is to stay seated when silence speaks, while also being humble enough to recognise when you must call others to help bear what has been uncovered.

I still see his room when I close my eyes on certain nights. The dim light, the peeling poster on the wall, the metal frame of the bed. I still hear his voice when I stand at the threshold of difficult questions. When I am tempted to ask about a past that I suspect is littered with landmines, I pause and ask myself: What will I do with the answer? Who will help me carry it? How will I ensure that my curiosity does not become another unkept promise?

I have not resolved these tensions. I suspect I never fully will. Perhaps that is the point. The work of medicine, especially in its relational core, is not about achieving a stable equilibrium between care and distance. I am learning to live honestly in the pull between them, to recognise

when the system's constraints are shaping my choices, and to protect, whenever possible, the small, fragile practice of being present.

He died days after I first met him. In institutional time, he is long gone, his notes archived, his bed occupied by others. In my time as a student becoming a doctor, he is still there, in every decision I make about how long to stay and when to leave. His war continues to echo not only in his scarred lungs and damaged marrow, but in the reconfiguring of one student's understanding of what care demands.

I do not know if he would recognise himself in these pages. I hope, at least, that he would recognise the effort to listen without turning away.

If I have opened his story again here, I do so with immense responsibility, one I am also still learning to inhabit. The responsibility to let his life, and my brief mis-steps within it, shape how I stand in rooms that smell of antiseptic but emanate a life full of battles. I will teach those who come after me not merely to take histories, but to bear their stories.

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Part II

Essays 2026

The Fabulous Right-Sided Heart

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The examination room was sterile in the way teaching clinics often are – white walls, fluorescent lighting, two bright red chairs for the patient and his accompanying family member. In the center, a table. Behind it, I sat on an office chair whose gas lift had long given up its original purpose. Every few minutes I felt myself sinking slowly toward the floor, until I had to grip the sides, lift myself, and let the faulty mechanism clatter loudly back into place. To my right, a fellow student perched on a metal two-step ladder, another leaned against a flimsy metal stretcher.

It was an ordinary afternoon in an otherwise unremarkable two weeks of pediatrics rotation. Nearly all our patients had come with learning concerns or controlled asthma – cases that were too neat, too stable, too clean to offer the kind of learning every student secretly hopes for. We yearned for more: a strange rash, an unusual murmur, something we'd only seen in textbooks. That day we were patiently awaiting the attending pediatrician to assign us our first patient. At 08:15 hours, the doctor walked in, handed us the patient chart and informed us that it was another asthma follow-up. The teen wasn't his patient, but the doctor who usually treated him was on vacation, so he took over the case momentarily. He emphasized we should investigate his asthma symptoms carefully but otherwise gave no further instructions.

I read the patient's chart aloud, as I was the one tasked with the anamnesis and my two colleagues would both conduct the physical examination. I read aloud: "Patient M, 17 years old, from the neighboring town of Carapicuíba, located in the state of São Paulo, Brazil, accompanied by his father, Mr. J. Previous medical history includes controlled asthma with bronchodilator applied twice daily, previously treated for tuberculosis in 2022, and Kartagener's Syndrome."

My mind was racing. *Wait, Kartagener's Syndrome? I have heard of this before. Isn't this that rare condition we saw in pneumology class? What was it again? Something that was mentioned in the same class as Cystic Fibrosis. Cystic Fibrosis is screened for in neonatal triage tests, but this isn't. This is rare, but there's also mucous. Why do we insist on learning eponyms? Oh, it has to do with the cilia! That's why mucous accumulates, there's less clearance. What other symptoms were there? The cilia are defective in all cells; they move slowly and ineffectively. Ah, it is Primary Ciliary Dyskinesia! Anyways, the symptoms ... mucous accumulates, so there are recurrent respiratory infections, higher risk of pneumonia. Ah, there's infertility too – but there was more. Patients can also have situs inversus, so the heart can be on the right side! And there was also something about situs inversus totalis, where the abdominal organs are also mirrored. Woah, this is definitely not just another asthma follow-up. This is unbelievable!*

The rarity itself intrigued all of us. A genetic disorder we'd only read about, the kind whose diagrams we memorized for exams, the kind whose clinical findings – like dextrocardia – make students' eyes widen. Even now, I remember the electric shift in the room when this detail surfaced. It was as though the air thickened with anticipation. My colleagues and I exchanged glances, subtle but unmistakable, the kind that says "finally."

We eagerly called the patient into the room. He was a teenager, lanky, his shoulders slightly drawn forward like he was trying to take up less space. Naturally, he was a bit shy upon seeing three female student doctors gazing at him with wonder. When he walked in, he was followed closely by his father, a five-foot two-inch man whose posture, paradoxically, had a kind of dignified erectness. Later, I realized this posture that could be easily mistaken for pride, was in fact vigilance.

I began the anamnesis in my usual pattern: confirming his identification information, establishing rapport with lightheartedness, scanning his demeanor, guiding him gently toward the standardized questions.

There were absolutely no symptoms at presentation. He answered casually, almost dismissively:

No daytime asthma symptoms more than twice a week. No nighttime awakenings. No need for a rescue inhaler. No limitations to daily activities.

His asthma was evidently controlled. I moved onwards to question him about any other symptoms he might be experiencing from head to toe. He promptly denied headaches, difficulties in hearing, sore throat, heartburn, stomach pain, diarrhea or any local pain. Up until this point, this was as

uneventful as any other. Meanwhile, as I continued the anamnesis, my two colleagues away on their phones, absent from the moment. I was relieved they weren't interrupting my flow of questions, since it made it easier for me to organize my thoughts and document everything on his chart.

I then proceeded to inquire about his previous medical history, shifting the anamnesis towards the common ailments associated with Kartagener Syndrome. The atmosphere in the room changed, because we all knew this was where the learning would be. Now everyone was listening attentively, all eyes on him.

He said he sometimes had a cough, but that was mostly it. He didn't seem to be much bothered by his disease, having learned to live with it and normalize any symptoms.

I asked what he knew about his disease; his nonchalant expression turned into mild confusion. He couldn't describe a condition he had lived with his whole life nor what to expect of it. As I explained the dysfunction of his ciliary cells, the tendency toward mucous accumulation, susceptibility to respiratory infections, and possible infertility, he listened with genuine curiosity. That jerked his memory and he mentioned he had multiple ear infections as a kid but denied lingering auditory deficits. He treated tuberculosis in 2022. I questioned if anyone else in the family had had tuberculosis, since people who live in close quarters are susceptible to getting infected.

His father, who had thus far remained silent, interrupted gently to share that his younger daughter had had it as well, but no one else. Suddenly, M and his father's postures stiffened, as if bracing for the sorrowful news that would be shared next.

His father drew a deep breath and my attention shifted to him. He crossed his arms tightly across his chest, holding himself together, a subconscious self-embrace, and uttered: "My daughter, his younger sister, died of pneumonia. Do you think it was because of this syndrome she had, doctor?"

The younger sister had the rare syndrome as well and she died due to pneumonia. These two people in front of me have seen the worst possible outcome of this disease.

I immediately felt a tightening in my chest. *This is heartbreaking.* I simplified the technical terms as much as I could as I elucidated what could've happened to his beloved daughter. "You see, Mr. J, the accumulation of mucous creates a breeding ground for bacteria, which can lead to an infec-

tion, namely pneumonia. The course of pneumonia can be fatal in people with a chronic condition compromising the lungs." I asked if they had any questions about the disease in general. I relied heavily on medical information to comfort his grief.

Mr. J's full head of gray hair had been gelled back with meticulous care, giving him a neatly groomed appearance that contrasted with his large, calloused hands – hands shaped by years of manual labor. He referred to me as "doctor" with a level of respect I felt I hadn't earned, at least not yet. The horizontal lines on his forehead, the deep wrinkles around his eyes, and the sun-tanned skin all hinted at a life lived outdoors, working, enduring, providing. He held his hands together, palms facing each other, the way one might hold them in prayer.

His concern was the thick, heavy kind that fills the room like a second presence. His voice trembled as he asked what he could have done to prevent his daughter's death. He wanted to know whether the fact that his daughter also had tuberculosis could have also worsened her pneumonia. He didn't know how both his kids had tuberculosis. He thought it was a disease long gone. He sought information to justify the unjustifiable. His urgency for information was also prompted by his paternal duty to protect the son sitting beside him.

I felt myself leaning toward him, instinctively trying to meet the vulnerability he had offered. I validated his feelings. I explained the symptoms to be mindful of. I listened and expressed my deepest sympathies for their loss.

After all, the feeling of confusion and desperation about a diagnosis of a loved one were all too familiar to me. Years before considering a career in medicine, my mother, the closest person I have, was rushed to the emergency room with a stabbing pain at the pit of her stomach that she assumed was gastritis. As we were informed days later by a team of stern doctors we had never seen before, she had multiple arterial dissections. They said it was rare, that they themselves had never seen any cases before ...

My reminiscence of old memories was interrupted when the door burst open.

Four giggly students barged in, breathless with excitement. Now I understood what the students in the room with me were doing on their phones: they were texting their friends to come see the teen with dextrocardia. I can still hear the shift in tone, the transformation of the room's atmosphere.

My emotional reaction was immediate, visceral. Disbelief. Incredulity.

A hot outrage that rose from somewhere deep. *What in the world is happening right now?* was the sentence that thundered through me – but only internally. I swallowed it whole. My professionalism suppressed my impulse to reprimand them with vehemence.

Because I looked at the teen, and he was smiling proudly.

These were pretty girls, giddy to auscultate the only right-sided heart they might ever encounter. To him, it felt flattering. At his age, with his vessels pumping with testosterone, attention from four enthusiastic female medical students was likely a welcome distraction. For a second, the condition he's lived with his whole life and that contributed to the death of his sister wasn't a source of suffering. Instead, it made him special, it garnered attention, awe, and admiration. It seemed like a refreshing shift in perspective, even if just for a fleeting moment.

So, I watched, silent, as they crowded around him. The first one to come in asked if they could all auscultate his heart, and he willingly lay back down on the stretcher. She placed her stethoscope tentatively on the right side of his chest. She was delighted to locate his *ictus cordis* on the right side. She exclaimed, "I found it! It's here!", as she pointed to the pulsating area. His body fat percentage was low in that distinct way of adolescents who have been through a growth spurt, so you could easily see his heart in the right fifth intercostal space in the mid-clavicular line. The second student proceeded to auscultate, sharing in the excitement. The third student auscultated the heart, but that wasn't as novel a finding, as the other's had already heard it. She moved on to the abdomen and percussed the left upper right quadrant, hearing an unusual dullness. Then, she percussed the right upper quadrant and heard an unusual tympany. Her furrowed brow accused her confusion. After all, she hadn't read the case, and she didn't really know what Kartagener's Syndrome meant. She barged in to hear a right-sided heart, plain and simple.

Her friend, the one who messaged her to witness this once in a lifetime opportunity, proudly announced, "He has total *situs inversus*." That wasn't enough to soothe her furrowed brow, so her friend explained in full, "All of his organs are switched, so his liver is on the left side, and his gastric bubble is on the right side." This statement cleared up any confusion. The fourth student then auscultated his heart and percussed his abdomen, this time around there was no exclamation of wonder. As abruptly as they barged in, they hurriedly left the room again, thanking the teen for letting them examine him.

The teen appeared relieved to seat back down in his chair. Four consec-

utive auscultations and people drumming on his belly for the purpose of learning probably wasn't what he had expected from the initial flattering attention. There was no meaningful exchange with him, just academic curiosity.

This was a unique learning opportunity, and they took advantage of it. They were learning. They were utterly oblivious to the sorrow in the room before they came in, I'm consciously aware. But inwardly, I was unsettled. It had felt like an invasion of something sacred. I was building a connection with the son and the father, absorbing and processing the tragedy they had recently experienced. Suddenly, my peer's curiosity and excitement assumed the protagonism in the room, while the grieving son before me became an object of wonder and the father became a silent extra.

Somehow, their lack of real interaction with the patient also felt like they were taking advantage of him. They came in to marvel at the anomalies in his physical examination but did not care to stay for the remainder of the anamnesis. They laser-focused on the disease and neglected to see the patient living with the disease. Through my eyes, it was a betrayal of the humanizing principles we are taught. Obviously, the anomalies in his physical examination were interesting, but a doctor must build trust and rapport with the patient to be granted the privilege of examining him. It must be a mutually beneficial interaction: the patient is cared for, while the doctor learns from his case.

I handwrote the remainder of my anamnesis in silence until they left. My thoughts were racing. *I get that this is a cool case, that it's super rare, but I've never seen anyone barging into an exam room like that. This is not a rare dog breed that you find on the street, ask the tutor to pet, and then go about your day as if you had crossed that off your wish list. He is a patient in an exam room, a space that's supposed to be safe, where he shouldn't be made into a spectacle. The door to the exam room didn't say: "Come one, come all! The Fabulous Right-Sided Heart! A show you can't miss!"* That stuffy examination room suddenly felt suffocating. All I could do to divert my attention from my anger was to focus on completing his chart, on moving forward with questions that seemed irrelevant given the severity of the prior conversation in the room.

He ate three meals a day and we went through each one carefully to analyze his nourishment status. For breakfast, he had white bread and butter in the morning, a cup of coffee without milk. He didn't have a morning snack. His next meal was lunch at school, which was a balanced meal con-

sisting of a wide variety of leafy greens and vegetables, some carbohydrates, such as brown rice or pasta, and protein, which the menu alternated between grilled chicken and slow-cooked meat. For dessert, they offered fruit. He skipped the afternoon snack. He arrived very hungry at home every day and ate industrialized snacks. I interjected here and alerted him to the harms of consuming industrialized foods and suggested he eat a snack with yoghurt, fruit and some rolled oats to curb the evening hunger. In the evening, he had basically the same meal he had for lunch.

We asked about his performance at school, and he said his grades were good, his favorite subject was math. His father confirmed that his teachers liked him and he had good relationships with his friends. He played volleyball at school. At this moment, I asked his father to momentarily wait outside the exam room, so we could ask his son more personal questions which could be embarrassing to answer in front his father.

I asked M about his habits and partying. He didn't smoke or drink alcohol or use drugs. He didn't have a girlfriend. He also shared, in an embarrassed tone, that he hadn't had his first sexual experience yet. I asked him if he had any questions he'd like to ask us, assuring him that this was a safe space. He was curious to know why he could be infertile, returning to the beginning of the anamnesis. I explained, "the tubes that carry your reproductive cells from your testicles to your urethra have cells lining them. These lining cells have eye lashes, which are supposed to help guide your reproductive cells onto their path, but since the eye lashes move slower in your case, that might compromise your reproductive cells from getting to their intended destination. Does that help understand it?" He said it was clearer now. Then I emphasized, "you still need to use condoms whenever you engage in sexual activity, alright? There are a lot of sexually transmitted diseases from which wearing a condom protects you." He smirked coyly and shook his head up and down in agreement. With the more private part of the anamnesis over, we called his father back into the room.

Finally, we reached the end of the anamnesis, and the two girls examined him, for the fifth and sixth time. The excitement had worn off from the first physical examination, but this one was more thorough than the initial four auscultations. They examined him from head to toe. His head was free of lice. His ear canal was skin colored with small hairs, a light coating of yellowish-brown earwax, and a light gray eardrum that reflects light. He had pinkish-red mucosa, and a smooth, midline septum, with no discharge in his nose. His oral mucosa was hydrated; there was no evidence of dental

caries. There were no palpable lymph nodes in his neck. The remainder of his physical exam was normal.

He did, however, bring a chest X-ray, where we could visibly see the heart-shaped opacity in his right chest. Faced with the vivid image of his interior organs, the two girls insisted on taking a picture of his x-ray. M asked what for, and they simply answered that they would cut his name out, but that they had never seen anything like it, so you wanted to register it for yourself.

As I wrote down the physical exam findings, I looked down and the student next to me was looking at her phone under the table. I immediately recognized the layout she had open on her screen. She was looking through the list of people who had viewed and reacted to her Instagram stories featuring *The Fabulous Right-Sided Heart. YOU HAVE GOT TO BE KIDDING ME! You said you wanted to take a picture of his x-ray for posterity, as a memento of his rare case. Instead, you blatantly lied to him for your self-promotion online. Is it fulfilling to get a "like" using someone else's pain without their consent? Does it bring you joy to expose a patient like that? Why are you here if you are worried about posting content on social media? You could have become a travel influencer or a food blogger. You know, professions that depend on being relevant online? Hell, if you want to divulge people's tragedies, you could be a wartime journalist!*

In my head, I was screaming. Outwardly, I bit my lower lip to keep my mouth shut. *This is not the moment to say anything. I have patients in the room.* Once again, I felt my blood boiling with anger. Not because of rules or ethics committees or confidentiality guidelines – though those matter. But because posting it felt like the final confirmation that the boy had ceased to be a person in their eyes. He had become a curiosity, an anatomical anomaly, an objectification, a spectacle.

Like my mother once had been. My mind drifted back to my mother in that hospital room years ago. To that sterile room in the most renowned hospital in the country. We had walked in thinking she had gastritis. A simple gastritis. Nothing more. And then, days later, we received her real diagnosis.

I remember sitting beside her in that hospital bed, both of us squeezed together for emotional support. We were surrounded by an impressive medical team composed of a vascular surgeon, a cardiologist, a general surgeon and multiple residents. They didn't know her, they didn't understand her, it was the first time we saw them.

The vascular surgeon, who introduced himself as Dr. K., lead the group.

He stood at the end of the bed in his neatly pressed medical vest and delivered the words I will never forget: "Miss Juliana, you have one large dissection at the celiac trunk and multiple dissections in both renal arteries." We both looked at him with confusion. His words carried no meaning whatsoever, since we didn't know what a dissection was. We had heard of aneurysms and clots, but never dissections. *What even is the celiac trunk? Celiac as in the disease that makes you gassy and bloated and have diarrhea?* He continued, "you had a two percent chance of survival. This is the type of condition I've only seen in autopsies, so we aren't sure what the treatment or prognosis is. Generally, we treat dissections with a stent, but yours is located at the celiac trunk, so we are unable to take the usual surgical approach."

The casualness with which he delivered the news was baffling. With the accumulated knowledge of a vascular surgeon, a cardiologist, a general surgeon and multiple residents who visited her daily, it was surprising that no one bothered to explain the details of her condition to us. But then again, they themselves didn't know much about it. Would a clot form and prevent the blood flow to her internal organs? Would these dissections rupture and she would have internal bleeding? No one dared to infer.

We didn't know how long she would survive. We didn't know if it could happen again in some other artery. We had no clue what could cause such a rare condition. This was a woman with no prior medical history, and in excellent physical health thus far. She didn't smoke, she was fit, she ate an apple a day, or in her case, papaya was more accurate. She owned her own company and that was stressful. Was it stress-induced? Could it be genetic? What was she supposed to do now to prevent any other dissections? How can we prevent it if we can't identify what caused it? We had so many questions and no answers.

Up until her being released from the hospital, doctors and interns visited the "woman who survived multiple dissections." They would come in large groups, look at her in surprise, as if to check that she had lived through another night, and leave. No one asked how she was feeling or if she had questions. No one talked to me at all. It was as if suddenly her humanity, her loud laughter, her adventurous nature, her unwavering work ethic had been reduced to a health condition that inspired awe, but no concrete answers nor treatments. She had defied medical odds and was a wonder to behold, a must-stop on the daily rounds.

And now here I was, witnessing the dehumanization of another patient

with a rare disease. The two patients collapsed into each other: my mother on her hospital bed, and M sitting across from me. Both vulnerable. Both exposed. Both needing humanity more than academic enthusiasm. And internally, something clicked. I recognized that the same thing that unsettled me then – that sense that medicine had turned my mother into "a case" – was what unsettled me now. She had been treated like the *Rare Arterial Dissection*, not like my mother. And M had been treated like *The Fabulous Right-Sided Heart*, not like a teenage boy. It was the same story – just different characters.

Similarly, I identified with the worried family member. I have been in the same position as Mr. J. Granted, I didn't have the paternal responsibilities he had, but I recognized his vulnerability; the feeling of helpless, the incessant worrying, the nagging wondering of what you could've done to prevent this. He needed to protect his son from the tragic fate of his daughter, while I had faced the potential loss of the person who meant the most to me in the world.

The encounter with M and Mr. J. ended with the pediatrician coming in and my going through the full anamnesis, emphasizing that his asthma was controlled. We renewed the prescription for his bronchodilator inhaler. The father looked me in the eyes and thanked me profusely for explaining the disease to him, took my hand into his two rough hands, while the son nodded in agreement next to him, and they left. To them it's possible this was just another examination. To me, this prompted a reflection as to the type of doctor I will strive to become.

The moment the girls barged in prompted a reflection for me. They were bright-eyed, breathless, practically vibrating with the kind of excitement that makes one forget to lower their voice in an exam room. Their giddiness filled the space before they even finished introducing themselves. In another context, maybe their enthusiasm would have been contagious. But here, next to a father and his adolescent son navigating a lifelong, rare disease, it felt jarringly tone-deaf.

And I could recognize myself in them.

I too had been intellectually unstimulated from seeing patients with controlled asthma symptoms for the previous two weeks. I too was excited to finally see a patient living with a rare disease that most doctors only read about in books. I was eager to question his symptoms and to learn about his experience living with disease and to cross-reference it with my notes from class. I was thrilled by the novelty of it, even if I didn't express it in

a giddily tone-deaf manner. I recognized that my own motivations, even when well-intentioned, were not untouched by the thrill of rarity.

When a rare finding appears in front of us, something in our training lights up. It's almost reflexive. A rare disease sharpens our curiosity and crystallizes concepts that otherwise blur together in textbooks. I only remember that epithelial cells hold themselves together through desmosomes – and that desmosomes rely on desmogleins 1 and 3 – because of vulgar pemphigus. In that condition, the immune system attacks those desmogleins, and the patient's skin blisters and peels. Moments like these anchor physiology and pathology to real faces and real stories. They reinforce what is normal, clarify what is abnormal, and keep feeding the endless loop between studying and seeing, memorizing and understanding.

Rare cases also tease something deeper: legacy. Every once in a while, you hear the story of some observant clinician who identified a peculiar triad, or a strange radiological pattern, or an unexpected complication. And suddenly that finding bears their name forever. An eponym is a form of immortality in medicine. It transforms a moment of curiosity into a place in history. Even if we never consciously form the thought as students, the idea hovers underneath our enthusiasm: what if I am the one who notices something new? What if my name survives longer than my own body will?

What's more, a rare disease offers the opportunity to write a case study. You could present at congresses and achieve prestige in the academic community. This could be added to your *curriculum vitae* and it could mean the difference between getting accepted into the residency of your dreams or getting rejected.

This subconscious hunger intertwines with the structure of our education. We are rewarded for spotting abnormalities, for racing toward diagnoses, for catching the one detail that everyone else missed. The more obscure the disease, the more satisfying the chase. And in that chase, the patient can quietly dissolve into the background, overshadowed by the magnificence of their pathology.

It becomes startlingly easy to see a patient as a case rather than a person. This happens out of habit. Out of the way we are trained to survive the avalanche of information we must memorize. Out of the need to organize suffering into categories, patterns, syndromes. We learn to think in terms of findings – crackles, murmurs, hyperresonance, cyanosis – because that is how we are tested, graded, ranked. We become fluent in the language of disease, even as we risk forgetting the language of people.

This is why rare findings feel so electrifying. They give us a break from the monotony of controlled asthma and well-managed hypertension. They validate the years of sacrifice, reminding us that the body is full of mysteries waiting to be decoded. They give meaning to the pages we've underlined and highlighted and annotated until our notebooks look like a rainbow. They feed the loop between theory and practice, between the hundreds of hours spent studying and the fleeting moments in which reality reflects exactly what the textbook promised.

But the danger is that, in these moments of intellectual pleasure, we can drift away from the human being sitting in front of us. The person who has lived with this disease long before we opened the door to the exam room. The person who will continue living with it long after we move on to our next patient, our next rotation, our next thrill.

As much as the theoretical learning is crucial to being a good doctor, understanding the individual patient in front of you – their aspirations, their worries, their beliefs, their doubts – is crucial to being a great doctor. That tailored investment in a patient is what differentiates average medical practitioners from exceptional ones. As Sir William Osler wisely professed, "the good physician treats the disease; the great physician treats the patient who has the disease."

Especially in the case of rare diseases, we often won't be able to treat the condition successfully. Rare diseases impose a heavier burden on patients than more common illnesses. The diagnosis itself brings uncertainty and isolation. At best, we are able to manage symptoms so that patients can pursue their individual goals – their one-of-a-kind dreams. We can work to ease their pain and bring them comfort. We can soothe the worry of their family members. What we are unfortunately unable to do is address the root of the problem altogether. Research funding is scarce, pharmaceutical interest is limited, and our resources are minimal.

To be able to help patients in a truly meaningful way, we need to get to know them – to listen to their concerns and to understand their priorities. In his poignant book *Being Mortal: Medicine and What Matters in the End*, Dr. Atul Gawande sheds light on this issue we face as medical professionals: "We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive." In other words, as important as treating symptoms and searching for a cure may be, our role as doctors is also to ask the ques-

tions that allow patients to voice their wishes and struggles – to name their pain and to share what they hold dear.

We must remind ourselves to listen attentively to their suffering, which naturally also incites pain in us. Perhaps this is precisely what we try to avoid when we focus exclusively on the disease: sharing in the patient's pain. This detachment can be interpreted as a coping mechanism that allows us to keep working despite the many tragedies we witness every day. It can become the crutch we use to remain professional. It hurts to see pain, especially when our treatment options are limited. Yet emotional detachment does not help our patients, and so we must remain vigilant of ourselves.

In this precise case, my tactfulness and empathy in the exam room came from experience – a painful experience that though I do not wish upon my fellow colleagues in that examination room, has certainly set me apart from them. For that, I am relieved.

This is by no means a pat on my back or a scolding of my peers; that would be a wild oversimplification. On the contrary, this reflection serves as a daily mantra. Connecting with M and his father does not mean that I will immediately succeed in demonstrating empathy with every other patient I encounter. This is a continuous, lifelong exercise in recognizing individual suffering. This is me urging myself to remember that any mysterious exam finding, any rare mutation, any complex procedure may impact a patient's life forever. It is a note to self: patients are not a means to learning – they are the end in themselves. A patient is not a dummy in a simulation lab, and he is certainly not material to post on social media.

Until that day, the soft skills necessary to build a good doctor-patient relationship were mostly something I saw in PowerPoint slides: bullet points about attire, punctuality, confidentiality, maintaining eye-contact, building rapport, and speaking in culturally appropriate terms. It felt straightforward, like a checklist we were expected to memorize for OSCEs.

But watching those students rush in – seeing the boy become a spectacle, seeing the father shrink back into a corner after having shared the most devastating part of his life – taught me that building a relationship with a patient goes far beyond an outline. It requires restraint and self-awareness. It means reading the emotional temperature of a room before crossing its threshold. It is knowing when my eagerness to learn must yield to someone else's pain. It is remembering that a body lying on

a stretcher is someone's mother, someone's daughter, someone's brother – someone's whole world. It is ensuring that I don't overvalue my curiosity to the detriment of the patient's privacy.

I want to be a doctor who never treats suffering as an anecdote. Who never lets curiosity eclipse compassion. Who never forgets that a novel right-sided heart is still a heart. I want to be the doctor who closes the door gently behind me – not because of protocol or caution, but because I understand that the space I'm entering is sacred.

A space where someone is scared, or confused, or mourning, or trying their best to make sense of the body that keeps betraying them. A space where every word matters. Where the phrases I utter will echo in my patients' memories. Where my advice will shape life decisions. Where my presence – my demeanor, my restraint, my empathy – can either heal or harm.

I want to be a doctor who remembers that behind every rare anomaly is a real life. Behind every chart is a story. Behind every exam finding is a person. And that the world-famous right-sided heart belonged to M, a boy who lost his sister and was deeply loved by his father. And who deserved better than to be anyone's spectacle.

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Where Knowledge Falls Silent

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Part I: Before the Encounter

Before that man, I believed medicine was, above all, an exercise in control. Control of time, of symptoms, of risks. Control of biological variables which, once organized into protocols, seemed to obey a predictable logic. I did not yet know or perhaps did not want to know that the hospital is the place where control most often fails, and that it is precisely there that medicine reveals its most human face.

The General Hospital of Carapicuíba was the setting for this learning. A public hospital, pulsating, marked by long corridors, harsh lighting, and a constant flow of interrupted stories. There, illness did not arrive as abstraction, but as concrete urgency: injured bodies, disoriented families, decisions made under pressure. The ward was a space where life always seemed provisional.

I was an intern. I carried with me the technical enthusiasm of someone who learns quickly and the silent insecurity of someone who still does not know what to do with what cannot be resolved by knowledge alone. I wore the white coat as if it could protect me not from mistakes, but from the emotional impact of standing daily before human fragility. There were days when I left the hospital convinced that learning medicine meant accumulating answers. Other days, more difficult ones, showed me that learning medicine also meant learning to live with questions that do not cease.

The ward, in particular, unsettled me. Unlike the emergency department, where immediate action creates an illusion of effectiveness, the ward demands permanence. One must return to the same bed, listen to the same complaint, follow the same body that improves slowly or does not improve at all. There, time does not run; it weighs. I walked among the beds observ-

ing patients who no longer expected cure, only care. Some spoke too much, others hardly at all. Many had learned the language of the hospital better than I had: they knew the schedules, the names of exams, the expressions that signaled severity. Illness, there, was also a form of literacy.

I still believed my main task was to understand the body. Subjective suffering seemed important, yes, but secondary. Something to be heard with respect, but not something that substantially altered medical conduct. Clinical practice, I thought, was made of objective data; the rest was context. It was in this state of mind technically attentive, emotionally contained that I arrived at his bedside.

There was also, in my understanding of medicine at that time, a quiet faith in neutrality. I believed it was possible and desirable to remain untouched. To enter rooms, gather information, perform examinations, and leave without carrying anything back with me. I confused professionalism with emotional impermeability, as if to feel less were synonymous with being more competent.

This posture was reinforced daily. We were taught to "stay objective," to avoid "getting involved," to protect ourselves from emotional overload. And indeed, the hospital demands defenses. Without them, one risks being overwhelmed. But I did not yet understand that there is a difference between protection and withdrawal. Between caring for oneself and erasing oneself.

I watched older physicians move through the wards with an efficiency I admired. They spoke little, decided quickly, rarely hesitated. Their authority seemed unquestionable. I assumed that this was the endpoint of formation: certainty replacing doubt, mastery replacing vulnerability. I wanted to arrive there as soon as possible.

And yet, I could not ignore a recurring sensation that accompanied me during long shifts a sense that something essential was being bypassed. I noticed it especially in moments of apparent routine: a patient who asked a question after I had already turned toward the door; a family member who lingered in silence, waiting not for information, but for acknowledgment. I learned to interpret these moments as delays, interruptions, inefficiencies.

Time, in the hospital, is never neutral. It is measured in beds to be freed, exams to be ordered, discharges to be planned. Lingering felt almost transgressive. Still, part of me resisted the constant acceleration. I sensed that haste, while often necessary, also functioned as a defense against what emerges when one stays. I remember standing at the end of the ward on

certain afternoons, watching the light change through the windows, feeling an exhaustion that was not merely physical. It was as if the accumulation of encounters unfinished, unresolved created a residue that no rest could entirely dissipate. I did not yet have the language to describe this sensation. I only knew it existed.

As an intern, my position was paradoxical. I was close enough to patients to hear their stories, but rarely empowered to act decisively. I absorbed narratives, fears, expectations and then passed them along, condensed, translated into medical language. In that translation, something was always lost. I did not yet know what it was, but I sensed its absence. I also began to realize that my own identity was being reshaped by this environment. The white coat did not merely signify learning; it reorganized how others saw me and how I saw myself. Patients trusted me before I felt deserving of that trust. Families listened to my words with an intensity that unsettled me. I became aware that medicine grants authority even to those who are still learning and that this authority carries ethical weight.

There was a growing tension between what I knew and what I felt. Between what I could explain and what I could not resolve. I often returned home mentally reviewing interactions, wondering whether I had said too much or too little, whether silence had been appropriate or cowardly. These reflections rarely found space in formal teaching. They remained private, unshared. I noticed, too, how often suffering was framed as a problem to be solved. Pain, uncertainty, fear everything demanded intervention. And yet, some forms of suffering persisted despite all efforts. They did not diminish with medication or explanation. They lingered, asking for something else. I did not know what that something was.

Before meeting him, I still believed that the limits of medicine were primarily technical. That with more knowledge, better tools, and more experience, uncertainty would recede. I imagined that maturity meant accumulating answers until questions became rare. I did not yet understand that some questions are not provisional that they accompany the practice itself. I also did not yet understand that encounters, not cases, shape physicians.

That certain moments, seemingly ordinary, can quietly dismantle years of assumptions. At that point, however, I still believed formation followed a linear path: study, practice, mastery. The hospital, I thought, was a place where knowledge was applied. I did not yet know it was also a place where identities are undone.

It was from within this framework structured, defended, still intact

that I approached his bed. I did not suspect that what awaited me there would not be a lesson in pathology or prognosis, but an encounter that would fracture the very notion of control I had been relying on.

It was in this state of mind technically attentive, emotionally contained, and quietly resistant to my own uncertainty that I arrived at his bedside.

Part II: The Patient

He did not draw attention at first glance. He was not intubated, did not groan, did not require constant interventions. Sitting in bed, he maintained a calm posture, almost indifferent to the agitation around him. His body bore visible marks of past surgeries scars that seemed already incorporated into his identity. Beside the bed, an open Bible.

It was not uncommon to find religious objects in the ward. Rosaries, images of saints, small prayer books often shared space with charts and IV bottles. Still, in this case, the Bible seemed to occupy a different place. It was not there as an amulet. It was open, used, handled. It was an active presence. He looked at me as I approached. The smile came before speech a calm, sustained smile that asked for neither explanations nor extra care. There was a serenity there that contrasted sharply with the contents of the chart.

I read the clinical history with growing attention. Severe traumatic brain injury. A steel beam had pierced the skull during a workplace accident. The trajectory of the injury included the lateral ventricle, a region whose integrity I had studied with anatomical rigor and functional reverence. The initial predictions had been harsh. The prognosis, guarded. Aphasia. Hemiparesis. Ataxia. Words that, in theory, describe deficits. In practice, they redefine lives.

I closed the chart and looked back at him. He was speaking to me. Slowly, but with enough clarity to make himself understood. He moved with some limitation, but without the rigidity I had expected to find. He was conscious, oriented, present. There was a dissonance that was difficult to ignore. I sat beside him not out of obligation, but out of a curiosity that was beginning to surpass academic interest. I asked how he was feeling. He answered simply:

"I'm alive."

He did not say "well." He did not say "getting better." He said "alive." As if that alone were sufficient.

He spoke slowly, choosing his words carefully. One could perceive the cognitive effort involved in each sentence not as difficulty, but as attentiveness. As if language now demanded respect.

At a certain moment, he mentioned faith. Not as an explanation for the accident, nor as a critique of medicine. He spoke of faith as one speaks of something intimate, almost domestic, something that had accompanied him during the days when he did not know whether he would speak again, walk again, or recognize his own body.

There was an absence of resentment in his speech that unsettled me. No questions of "why." No attempt to assign blame. Only the acknowledgment that he had fallen ill and, somehow, was recovering. I asked perhaps too soon what faith meant to him in that process. He looked at me for a few seconds before answering. The silence was not awkward. It was necessary.

Then, without saying anything, he picked up the Bible.

He leafed through it slowly, with a gesture that seemed familiar, almost ritualistic. He stopped at a marked page and read aloud, softly but firmly:

"There is a time to be ill and a time to be healed."

His eyes filled with tears. He closed the book, holding it against his chest, as if needing to contain something that threatened to overflow. He said that faith had returned to him what medicine could not promise that in the hardest moments, when he could not understand his own body, faith gave him meaning enough to continue.

He cried.

And I, standing beside him, realized that I did not know exactly what to do with that. I knew the mechanisms of neurological recovery. I could speak about brain plasticity, functional reorganization, collateral circulation. I could explain, in technical terms, how an injured brain can find alternative pathways. Still, there was something in that encounter that completely escaped the field of explanation.

His crying was not despair. It was gratitude a gratitude that did not fit into any clinical scale.

At that moment, I sensed something shifting within me still imprecise, still unnamed. I was not merely before a recovering patient. I was before an experience that challenged the way I understood my own role there. And that unsettled me more than any difficult diagnosis.

After that first dialogue, I began to visit him more often than strictly necessary. Not because there were new medical decisions to be made, but because something in that initial encounter remained unresolved. There was a calmness in him that could not be explained by clinical evolution alone, and that incongruity drew me in.

I began to observe him more closely. His movements were economical, almost cautious, as if he were still relearning the limits of his own body. Before lifting a cup to his mouth, there was always a brief moment of calculation imperceptible to a hurried observer, evident to one who had learned to look slowly. Small adjustments revealed the silent effort of an organism forced to rebuild paths that had once been automatic.

I asked, during one of these visits, whether he remembered the first days after the accident. He said he did not. His memory of that period was fragmented, composed more of sensations than images. He spoke of voices without faces, of intense lights, of a persistent feeling of displacement as if he were awake in a place he did not fully recognize.

"It was as if I was here ... but not whole," he said, after a pause.

That sentence followed me for the rest of the day. In medical training, we tend to treat consciousness as a binary datum: present or absent. We rarely speak of these intermediate states, of the experience of existing without being able to fully recognize oneself. He had inhabited that place. And he had returned.

In another conversation, I asked about his family. He spoke of his wife with sobriety, without dramatization. He said she had been present every day, even when he could not recognize her. He told me that in the hardest moments she would sit by the bed in silence, holding his hand, as if believing that the bond could precede understanding.

In that account, I perceived something that had previously escaped me: what sustained him was not only a system of beliefs, but the persistence of someone. The continuity of presence. The refusal to give up when the other was not yet able to respond.

The religious object beside the bed, which I had initially interpreted as an expression of faith, began to seem to me also a marker of time and waiting something that occupied the space while his identity reorganized. What mattered was not so much the content of the book, but the fact that it was there, open, available, accompanying a process that could not be rushed.

I asked whether there had been fear. He thought before answering.

"There was a moment when I thought I wouldn't return to who I was," he said. "Then I realized that maybe I was returning in another way."

There was no bitterness in that statement. Nor euphoria. Only acknowledgment as one who accepts that crossing a rupture necessarily implies change.

One particularly quiet morning in the ward, I sat beside him without opening the chart. We spoke little. At a certain point, he closed his eyes for a few seconds, as if resting from his own presence. Then he opened them again and remarked, almost casually:

"I notice things more now."

I asked what he meant. He pointed toward the window. Light entered irregularly, drawing shadows on the floor of the room.

"Before, I used to rush past this."

In that moment, I understood that his recovery was not limited to the restitution of neurological functions. A deeper reorganization was underway a reconfiguration of his way of being in the world. The injury had interrupted his trajectory, but it had also imposed a pause that made another form of presence possible.

As a physician in training, I found myself before something that did not appear in therapeutic goals, but that might be one of their most significant effects. He had not only survived. He had returned with a different rhythm. I realized then that my own listening was also beginning to change. I was no longer asking questions merely to complete the chart. I was asking in order to accompany to sustain to remain.

There were days when I left that room with the uncomfortable feeling of having received more than I had given. Medical training prepares us to act, decide, intervene. It teaches us little about recognizing when we are affected and transformed by another's experience. He demanded nothing of me. He asked for no explanations, requested no answers. He simply existed before me with an integrity that did not fit into clinical records. And by doing so, he confronted me with the limits of my own way of practicing medicine.

It was in this context made of silent visits, brief conversations, and long pauses that the encounter began to exceed the category of an "interesting clinical case" and become something harder to name. Something that no longer concerned only him, but me.

And perhaps it was precisely there that everything began to change.

Part III: The Central Encounter

The silence that formed after his tears was not empty. It was dense. A silence that did not ask for words, but for presence. I remained beside him, unsure of what gesture was expected of me. There was no intervention to prescribe, no test to order. For the first time since entering medicine, I felt that any attempt to explain would be a form of escape.

The ward continued to move around us. Monitors beeped, professionals spoke in low voices, carts passed through the corridors. And yet, at that bedside, time seemed suspended. The crying subsided slowly. He took a deep breath, wiped his eyes, and looked back at me with the same serene smile as before now more fragile, but also more truthful.

He said only:

"I thought I wasn't going to come back."

He did not ask whether I agreed. He did not seek confirmation. He simply shared an existential fact a boundary crossed. In that instant, I understood something I still lacked the language to fully articulate: I was before a man who had survived not only a brain injury, but the experience of nearly disappearing from himself. What he mourned was not the pain of the accident, but the astonishment of continuing to exist.

I wanted to respond. I wanted to say something that might rise to the height of that moment. I thought of phrases we are trained to use technical words softened by rehearsed empathy. But all of them felt inadequate. I remained silent. And for the first time, silence did not feel like omission.

There, I realized that listening is not merely a clinical skill; it is an ethical position. To listen is to accept that the other exists beyond our explanatory frameworks.

When I stood to leave, he held my hand for a few seconds longer than usual. Not as a gesture of dependence, but of recognition as if to say: you were here. I left the room with a strange sensation not of a task completed, but of having been summoned to something I did not yet fully understand.

The rest of the day passed uneasily. I attended other patients, reviewed charts, answered objective questions. But something had shifted. Complaints that once seemed routine now carried another

density. I could no longer hear only the symptom. There was always something underneath, something that did not present itself directly.

I realized that the encounter had produced a fissure a small but definitive fracture between the physician I believed I was becoming and the physician who was beginning to emerge.

Part IV: Science, Faith, and the Inner Fracture

At the end of the shift, I sought out a neurologist from the service. I needed to reinscribe that encounter within the territory I knew best: scientific explanation. I described the case carefully the extent of the lesion, the initial deficits, the surprising functional recovery. I asked how such an outcome was possible.

He listened attentively and answered without hesitation:

"There was collateral circulation. The brain found alternative pathways."

The answer was correct. Elegant. Reassuring. It placed the event back into a familiar map. Faced with injury, the brain reorganizes itself. It recruits neighboring areas. It creates detours. It adapts. Neuroscience offers solid models for understanding phenomena that, at first glance, seem extraordinary.

I thanked him and walked away holding the explanation. And yet, something remained out of place.

Collateral circulation explained motor recovery. Brain plasticity explained the return of language. But none of these explanations touched the essential core of the experience I had witnessed. None of them reached the tears, the gratitude, the meaning he attributed to his own survival.

I realized then that my discomfort did not arise from the patient's faith it arose from my own limit. I had been trained to believe that to understand is to explain. And now I found myself before something that could be explained, but not exhausted by explanation.

His faith did not compete with science. It occupied a different register. It did not answer the how, but the what for. It did not deny biology, but traversed it with meaning.

It was there that I understood that the risk of medical training lies not in an excess of science, but in the illusion that it suffices. When technical knowledge becomes a total answer, the human experience we intend

to care for is impoverished. I began mentally revisiting other patients the ones I had labeled "difficult," those who insisted on narratives I considered irrelevant to medical conduct, those who spoke of fear, guilt, hope, belief. I realized that I often listened only until the information was useful for diagnosis. The man with the open book showed me there was something beyond that.

He was not a miracle, nor a statistical anomaly. He was a subject attempting to reinscribe his existence after a radical rupture. For him, faith was not an escape from reality it was a way of reorganizing it. I, on the other hand, was beginning to realize that my own medical identity also required reorganization. To be a physician is not only to intervene in another's body. It is to sustain one's own ignorance in the face of what cannot be fully mastered. It is to accept that there are experiences that do not ask for solutions, but for witnessing.

Since that encounter, I have grown suspicious of explanations that close the conversation. I have learned that, many times, explaining too much is a sophisticated way of not listening.

Science remains my ground. But it is no longer my ceiling.

Part V: After the Encounter

In the days that followed, I realized that the man had not remained merely as a memory. He had infiltrated my way of being in the hospital not in a spectacular way, but subtly, almost imperceptibly, like certain transformations that reveal themselves only once they have become irreversible.

I continued my routine. Shifts followed one another. The wards remained full. New patients occupied the beds. At first glance, nothing had changed. But I had changed, and that altered everything.

I began to enter rooms with less haste not because I had more time, but because I no longer believed speed was always a virtue. I noticed that the way I introduced myself, the tone of my voice, my willingness to listen all of this produced effects that did not appear in exams, but profoundly shaped the experience of illness.

I began to notice something that had previously escaped me: patients do not speak only to inform they speak to exist. Each narrative, no matter how repetitive or disorganized it may seem, carries an attempt to reorganize the

world after the rupture imposed by disease. And often, the physician is the only available interlocutor for that attempt.

I remembered an elderly woman hospitalized for decompensated heart failure. From a clinical standpoint, her course was predictable adjustment of diuretics, monitoring, planned discharge. Still, every day she insisted on telling the same story about her husband's death. Before, I would have listened with polite efficiency. After that encounter, I stayed. I listened. I did not interrupt or redirect. At the end, she said:

"Now I can rest."

There was no change in medical management. But there was a change in experience.

I began to understand that much of the anguish that circulates in hospitals does not ask for technical answers, but for recognition. Suffering intensifies when it finds no language. And the physician, when willing to listen, can offer something no prescription can replace: legitimacy to the other's experience.

The man with the open book taught me this without pedagogical intent. He did not try to convince me of anything. He gave no speeches. He simply existed before me with his history, his beliefs, his gratitude. And that was enough to destabilize my certainties.

I also began to perceive my own emotional limits more clearly. I once believed distance was a condition for effectiveness. I now understood that the true risk lies not in being affected, but in becoming anesthetized. Excessive detachment does not protect it impoverishes.

There were days when I felt more vulnerable. To listen more is to feel more. Some stories stayed with me beyond the end of the shift. Some deaths began to reach me differently not as technical failures, but as real losses. And this demanded a new form of internal support.

It was through this process that I understood the importance of caring for the physician not only as a professional, but as a subject. Medical training teaches us to deal with the pain of others, but offers little preparation for dealing with what that pain awakens in us. The encounter with that patient opened space for questions I did not know I needed to ask.

"Who am I when I cannot cure?"

"What do I offer when science reaches its limit?"

"What is my place when the other finds meaning in something I do not share?"

These questions did not seek definitive answers. They began to accom-

pany me as part of medical practice itself. I learned that sustaining questions is often more honest than offering hurried answers.

His faith did not become my faith. But it transformed the way I respect what gives meaning to another's life. I came to understand that reducing the patient's experience to what I can explain is a form of epistemic violence subtle, but real. It denies the other the right to signify their own existence.

Medicine, I realized, is not merely an applied science. It is a relational practice. And every true relationship requires openness to the unexpected.

I returned to his bedside a few more times. In none of those visits did we repeat the conversation about belief. It was unnecessary. There was between us a silent recognition a tacit agreement that something important had been shared, something that did not need to be constantly named.

When he was discharged, there were no long farewells. Just a handshake. A lingering look. A smile that remained serene, despite everything he had crossed. We exchanged no promises. There were no memorable final phrases. And perhaps that is precisely why the encounter was so definitive.

I never saw him again.

But he continues to accompany me in unexpected ways in every patient who clings to an improbable hope, in every family searching for meaning amid chaos, in every silence that settles when words fail.

He taught me that medicine is not a battle between reason and belief. It is a crossing a continuous attempt to remain human in a territory where dehumanization is always a temptation.

Today, when I enter a hospital, I carry more than technical knowledge. I carry the awareness that every encounter holds the potential to transform us if we are available to it. I no longer seek only to diagnose, treat, and advise. I seek to be present.

I have learned that the most radical medical gesture is sometimes simply to remain

to remain before pain that cannot be resolved, before meaning that cannot be explained, before the other without reducing them to what I know. Because, in the end, perhaps true healing lies not only in the restoration of biological functions, but in the possibility of not crossing illness alone.

And if something of that encounter remains alive in me, it is the certainty that medicine, when practiced with humility, does not eliminate mystery it learns to live alongside it.

It is in this space between knowledge and not-knowing, between what I can do and what I can only witness that I now recognize the deepest meaning of my practice.

Not as mastery.

But as presence.

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Slowing Down Means Care

Jeppesen Iben Armann

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There is no embarrassment now. No nervous smile.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Time.

So I stayed.

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

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

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

But I had stayed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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Remember My Name

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All identifying details have been redacted to safeguard patient confidentiality. I thank all patients, whose courage and lived experiences enable reflection in those of us training to be clinicians; without their real stories, an exploration of this topic would lack the vital human perspective that reminds us why a student–patient relationship truly matters.

Prologue

"One of the essential qualities of the clinician is [their] interest in humanity, for the secret of the care of the patient is in caring for the patient."

Plainly stated yet deeply consequential, American physician Francis W. Peabody's axiom captures an enduring truth at the heart of the student–patient relationship – that care is not only something we *do*, but something we *bring* to the encounter.

I once believed that "caring" in medicine was affirmed through clinical competence: the right question, the right plan, the right words at the right time. As a medical student, I was conditioned early on that the safest way to help was to be efficient – to be useful, demure, and correct.

And yet, we are etymologically reminded of the asymmetry of this encounter. A *student* – from the Latin *studere* – is one who strives, who applies themself toward understanding. A *patient* – from *patiens* – is one who endures, who bears what cannot always be resolved. Between striving and enduring, medicine becomes more than knowledge. It becomes proximity: what we notice, what we avoid, and what we are willing to stay with when there is nothing left to mend.

I am deeply grateful to be the beneficiary of a small chapter of Mona's story – the patient who corrected her name before she trusted me with her story, and in that act, irrevocably reshaped the kind of doctor I am becoming. In anchoring my reflection in her encounter with the healthcare system, I find myself returning to Peabody's work – 'The Care of the Patient' (1927) – using his reflections as a vital guide for how I might listen, linger, and learn from Mona's life beyond what medicine can cure.

Meeting Mona

It was in the quiet corners of the psychiatry inpatient unit that I met "Mona" – a name she chose, distinct from the one printed on her chart. Mona was a Chilean migrant with long-standing diagnoses of Borderline Personality Disorder (BPD) and Functional Neurological Disorder. As the medical team prepared for the morning ward round, her story appeared on freshly printed paper as a clinical précis of survival:

Vee Palavicino. Age 43. Survivor of domestic violence. Familial estrangement. Pending housing assistance follow-up and social worker input from the Hispanic women's shelter.

Before I met Mona, I met her reputation. Her name circulated the ward ahead of her, carried in handover notes and lowered voices: *borderline*, *complex*, *frequent admissions*. Mona lived on the margins of the ward. Her vocal tics – audible reminders of distress rather than defiance – rendered shared living untenable. Complaints slowly accumulated from other inpatients, and with them came an intensifying pressure from staff and hospital administration to – in the consultant's blunt words – "do something with her."

Though the team deemed her "cleared" for discharge and outpatient follow-up, Mona's precarious circumstances conveyed a different story. With eviction from public housing imminent and years spent surviving on a disability pension, there was no safe place for her to return to – no address or stable accommodation that could meaningfully receive her. Together, these factors formed a sobering clinical impasse. Mona remained – caught between patient complaints, institutional limits, and a system unsure how to help her in any way that mattered. And so, each morning, her name

persisted on the ward list–an adjunct to be carried forward until someone could decide where she might be placed, awaiting a solution that lay beyond medicine alone.

As a medical student, I absorbed these fragments more readily than I realised. They settled into me as a quiet vigilance – part apprehension, part self-protection. Before having ever met Mona, I was already rehearsing boundaries I did not yet understand. The uneven clatter of the mobile computer announced our arrival at her room before we did. Her body lay angled away from the doorway, shoulders tense, jaw set – an architecture of defence refined by repetition. The air in the room felt guarded, brittle, as though any misstep might splinter it further. I hovered near the door, clipboard anchored to my chest, alert and careful, hoping – if I was honest – not to be noticed.

"Vee, how's everything?" the doctor asked, already scanning the screen.

"Not Vee," she said, voice rough with something between fatigue and dignity. Her correction was sharp, economical. Not hostile exactly – but closed. "Mona."

There was no invitation in her response – only a subtle, makeshift partition. It was not a physical boundary, but an emotional one, exacted sharply by the gulf between her experience and the clinical system, between Mona and all of us who occupied it. Mona tilted her head, her face pinched with suspicion as she scanned the room, as if weighing whether I belonged to the same system that had institutionalised her. The room did what hospital rooms always do: it absorbed the interruption and carried on. Questions were asked and answers half-offered. The plan advanced with the quiet inevitability of routine.

But something in me stalled.

It struck me then how much effort it must take to remain defended in a place that requires constant exposure. How often Mona's body had likely been examined, discussed, and repositioned – moved through systems where consent can inadvertently become procedural rather than relational. What I had initially read as resistance began to look more like survival: a learned economy of trust.

As the doctor began his physical examination, I stepped closer, no longer lingering at the room's periphery. Mona's feet bore patches of hypopigmented scarring, or what seemed to appear as uneven traces of caustic burns. Her movements were careful, constrained by neurological deficits that rendered even small shifts deliberate and effortful. Her gaze was

steady but distant, holding a stillness that felt less vacant than vigilant. The shadows beneath her eyes spoke not only of fatigue, but of long practice at watching – at staying alert in environments where safety could not be assumed.

I became acutely aware of my own impulse to explain, to organise what I was seeing into something coherent and clinically sound. Instead, I stayed quiet. It occurred to me then that not everything in front of me required interpretation. Some experiences resist being made immediately intelligible. Trauma, I was beginning to understand, does not always ask to be analysed or resolved. Sometimes, it asks simply to be recognised – to be encountered without haste or appropriation.

At that moment, I understood that insisting on "Mona" was not a correction of error, but an assertion of authorship. A reminder that even here – medically cleared, socially stranded, institutionally inconvenient – she retained the right to name herself. And perhaps that was the most intact part of her still standing.

Tending the Embers

"Where there is so much smoke, there is undoubtedly a good deal of fire, and the problem [...] is to consider what [we] can do to extinguish whatever is left of this smoldering distrust."

The weeks blurred into a cacophony of clipped footsteps, handovers, and the ceaseless ebb and flow of patients. As a medical student, my task was to work up cases – summarise, synthesise, and report back. My early encounters with Mona were halting and transactional. I recall asking the kinds of questions that felt safe: timelines, symptom clusters, medication adherence. Each question landed with a dull finality. Her answers were brief, sometimes barbed, often dismissive. I told myself I was being efficient. In truth, I was afraid – afraid of being rejected, afraid of opening something I did not yet know how to contain. When she turned her face away or asked me to leave, I felt a familiar tightening: the quiet relief of retreat disguised as professionalism. It was only later that I recognised how my questions, though clinically appropriate, had failed to meet her where she was. I was gathering data when what she was offering – guardedly – was herself.

On a later morning, I returned without my list.

"Mona, are you there?" Three firm knocks trailed my voice, inflected with a cautious lilt – an unspoken request for entry, not just into the room, but into conversation once more.

"You remember my name."

"Of course. You are Mona. Not Vee."

An exhale escaped her lips. "We don't have to talk about diagnoses today," I continued, surprising both of us. "But I wondered – what has this place been like for you?"

Something shifted then – not dramatically, but unmistakably. A small loosening. A small allowance. She gestured to the chair beside her bed. And I sat. In that chair, I did not offer a solution. I did not have one. I offered my attention. I wanted to ask her what "Mona" meant to her, and what she needed it to protect. It took a crucial moment of reflection for me to see what her name truly represented.

"I changed my name," she said, "because that was what they called me. I have since left her behind."

Once "Vee," I learned that Mona carried the enduring imprint of developmental trauma and family violence. As a child, she had learned that care was conditional and safety could not be relied upon, growing up in an environment where affection was unpredictable and violence was a frequent response from those meant to protect her. Hypervigilance, emotional intensity, and distrust were not pathologies then, but necessary adaptations. Decades had passed since she last saw her daughter – a motherhood not relinquished, but severed by a system that mistook mental illness for an incapacity to love. During a period of acute illness, her child was forcibly removed, the decision framed as safeguarding but experienced by Mona as irreparable loss.

The absence that followed calcified into grief, guilt, and a potent suspicion of systems that claimed to act in her best interests. Their contact thus, had gradually thinned into painful estrangement. Birthdays were marked by unanswered cards and milestones were known only through others. Failures of Mona's care eventually reverberated outward, reinforcing stigma beyond the clinic and into the social fabric that shaped her choices.

For a moment, I was at a loss for words. Not because her story was unfamiliar – I had heard variations of it before – but because this time, it was no longer abstract. It sat between us, fragile and unfinished, and I was acutely aware of how easily language could fracture it. My training urged me toward reassurance, explanation, something *useful*. Instead, I felt the weight of my

role's limits as a medical student. I was not there to undo what had been taken from her, nor to defend the systems that had failed her. All I could offer was acknowledgement.

"I'm sorry this has happened to you." I said quietly – not as an apology that presumed responsibility, but as a recognition of harm endured. I told her I believed her. That what had happened mattered. That it made sense she guarded her name so fiercely. In choosing not to fill the space with interpretation or premature comfort, I learned that empathy does not always announce itself through eloquence. Sometimes it is expressed through restraint: knowing when one's task is not to repair, but to witness; not to explain, but to stay.

I began to understand that Mona's name was not an aesthetic preference. It was a boundary. A survival line. A quiet insistence that she was more than the worst thing that had happened to her – and more than the worst thing she had ever done to survive. A name, after all, is never merely a primordial identifier. It is an assertion of personhood, history, and aspiration. After days of my cautious, incessant questioning, it seemed Mona was now returning the gesture – gently probing into my world, as if to measure whether I too, could be trusted.

"Was it the real name your parents gave you?" Her voice carried a delicate curiosity – a gentle invitation to bridge the space between perception and identity, to understand the story behind the face before her.

"Yes," I replied, a soft smile tugging at my lips. "My mother tampered around with a few alternatives, but she ultimately settled on that."

"Like the flower?"

"Yes. Just like the flower." And, as if drawn by an invisible thread of shared warmth, Mona's unbridled grin mirrored my own, forming lines beneath her eyes not from age alone, but from lived experience – the proof of resilience and hope.

When I left her room and re-entered the ward – still pulsing with clipped conversations and the restless hum of monitors marking time – I carried the weight of that encounter with me. Beyond the diagnoses that chronicled Mona into a "social conundrum," context reframed everything. What appeared as emotional volatility emerged as adaptation. What seemed like resistance became intelligible. In reframing Mona's distress within her personal and social history – asking "What is your story?" and "What has happened to you?" rather than "What is wrong with you?" – allowed her trauma to be recognised, context to be valued, and uncertainty to be tolerated without defaulting to reductive labels. In understanding Mona's symptoms not as deficits,

but as survival responses, I could meet her not as a problem to be solved, but as a person to be known.

In fact, Mona's story did not sit outside the evidence – it illuminated it. A robust body of literature identifies early-life trauma as an implicated antecedent of BPD, particularly among women, where behaviours often represent maladaptive strategies forged in unsafe and invalidating environments. Read through this lens, Mona's distress was no longer paradoxical, nor her behaviour pathological in isolation; it was coherent, contingent, and human.

I thought about how easily a name can be overlooked, and how much is lost when it is. Remembering Mona's name did not alter her diagnosis, her history, or the structural forces that shaped her care. But it altered our relationship. In a system where distrust smoulders quietly between patients and clinicians, that small act of recognition became a way of tending the embers rather than ignoring the smoke.

Lingering in the Grey

On the ward, Mona's clinical complexity was reframed as non-compliance; her isolation, not as a symptom of trauma, but as an administrative inconvenience. They shaped not only how Mona was discussed, but how proximity to her was negotiated – measured, rationed, deferred. I found myself caught between two competing instincts. One was the instinct of the student: to be unobtrusive and do nothing that might slow the machinery of the ward. The other was more unsettling: the pull to linger, to sit longer than was strictly necessary, to attend to what could not be summarised in a progress note or actioned by a plan.

But beneath these instincts lived something less rehearsed: fear. Fear of saying the wrong thing. Fear of not knowing where my role began or ended. Fear of being seen as naïve in front of a team fluent in decisiveness. And perhaps most of all, fear that stepping closer might draw me into an emotional terrain I did not yet know how to hold.

As the weeks continued, I began to notice my internal responses with greater clarity. I felt protective of Mona – and then resentful of that protectiveness, as if caring too much might disqualify me from the role I was training for. When she was spoken about with frustration, I felt defensive. When she was abrupt with me, I felt rejected. Slowly, I recognised how easily these feelings could crystallise into a clinical posture of apathy. The demand Mona

placed on me was not for answers – I had none to offer – but for presence. And this was precisely what unsettled me. Medical training had prepared me to gather data, to formulate, to move things along. However, Mona required something quieter and far less measurable. And so this growing awareness itself became an inflection point. Noticing my impulse to withdraw gave me a choice.

I began to act differently. I lingered. I sat down. I let silences stand without rushing to fill them. I returned even when I suspected she might turn me away. These were not grand interventions. They were small, purposeful acts of resistance against my own training reflexes. In choosing presence over performance, I learned that professionalism need not require emotional erasure – that boundaries can exist without indifference, and care without retreat.

At the end of rounds, I would sometimes unclasp my badge and weigh it in my palm, briefly revelling in anonymity. It felt like a talisman – the symbol of the distillation of years spent in study, of quiet sacrifice, a silent currency of pride in households like mine, and of a future not yet fully formed. Its glassy sheen seemed to mirror my own uncertainty: the tension between who I was expected to become and who I was, in fact, becoming. I trailed behind the team, a medical student learning the choreography of the ward, searching for where – and how – I might belong. I began to understand that formation is not always additive. Sometimes, it requires unlearning.

Amid the flurry of diagnoses, decisions, and daily momentum, a question began to surface with increasing insistence: was I disappearing beneath the role I was learning to perform – or was this very discomfort shaping me into the kind of clinician I hoped to become? Mona did not resolve that question for me. But she taught me how to stay with it. In doing so, she reframed my understanding of action – not as intervention alone, but as the courage to remain present when understanding falters, and to resist converting helplessness into distance.

The Patient as a Canvas

"What is spoken of as a 'clinical picture' is not just a photograph of a [patient] sick in bed; it is an impressionistic painting of the patient surrounded by [their] home, [their] work, [their] relations, [their] friends, [their] joys, sorrows, hopes and fears."

A week later, I accompanied Mona to a meeting with the hospital housing liaison – a setting far removed from ward rounds or observation charts, yet no less clinical in its consequences. If the bedside revealed the body, this room revealed the systems that encircle it. The meeting took place in a windowless office, the air thick with procedural finality. Mona had been on the housing waitlist for years. Each review had promised progress, yet, each ended in deferral. Mona sat beside me, hands folded tightly in her lap. The organiser spoke carefully, professionally – policies, risk assessments, capacity concerns.

"Given her history," she said, without meeting Mona's eyes, "we don't think this is an appropriate placement at this time."

Mona nodded, as though she had anticipated this outcome all along. Later, she told me it was easier that way – expectation softened disappointment. What resonated with me was not the refusal itself, but how easily her past eclipsed her present. Trauma was treated as a static liability rather than a lived context; complexity as a reason to withdraw rather than to persist. In Peabody's terms, her *history* had replaced her *painting*. The surrounding details of her life were no longer context – they had become a verdict.

In that room, I felt the familiar pull to disappear into my role – to observe without disturbing. I bore witness to the quiet humiliation of being deemed too difficult to house. A thick silence swelled between us – an auroral stillness where *being* became more vital than doing. Our consultant, new to the team, had listened without interruption. I noticed how different this felt from previous ward rounds – where Mona's name was often followed by a sigh, her diagnosis used as shorthand for anticipated difficulty. This consultant did not rush to reassure or retreat into protocol. She simply said, "We are here with you. That doesn't change." It was not reassurance disguised as certainty, but presence without conditions – the kind I had seldom seen modelled so clearly, and the kind I aspire to carry forward in my own practice.

The room, once edged with clinical coldness, softened as the entourage quietly withdrew, leaving Mona in stillness. Seated alone, Mona leaned forward slightly and, almost to herself, whispered with quiet resolve, "I just want to hold my baby. Even if only for a moment."

To some, Mona was an ethical dilemma. To me, she was a mother articulating a truth no law could measure: that meaning, love, and dignity do not reside in prognosis alone. The reflex to reassure rose quickly in me, as

did the urge to align myself with authority, to say the *right* thing. Instead, I paused.

"Your daughter sounds very special," I said. "Please tell me more about her."

Mona's shoulders softened. Her story began to surface – not as a case or clinical vignette, but as a life. She was twenty-seven when she last saw Olivia. Olivia, she told me, had her father's curls – tight, dark ringlets that never stayed neat. She loved purple shoes, insisted on wearing mismatched socks, and laughed hardest when being chased around the living room before bedtime. Mona remembered the way Olivia pressed her forehead against the window to watch buses pass, announcing their colours with solemn importance. She spoke of tiny hands wrapped around her finger, of singing the same song every night because Olivia refused to sleep without it – a children's song from Chile. Mona could not remember all the words anymore – only the feeling of it. Something about a caterpillar turning into a butterfly. About wanting to fly. About leaving with small wings. She hummed a few bars under her breath, then stopped, embarrassed, brushing it off with a small shake of her head.

"La cuncuna amarilla," she sang softly, as if testing whether the name itself was still safe to say. She told me Olivia used to stretch her arms wide at the end, insisting on being lifted from the mattress – *con mis alitas yo me voy* – leaving, she said, with her little wings. As she spoke, her voice steadied. These were not the fragments of a delusion or the distortions of illness. They were the ordinary, sacred details of motherhood. Olivia was not only a loss; she was an anchor. Mona told me that imagining her daughter somewhere in the world – growing, laughing, becoming – was what kept her tethered on days when everything else felt stripped away. The hope of seeing her again, even briefly, was not a belief in need of correction. It was a way of enduring. Like the song itself, it held the possibility of transformation – not escape from suffering, but movement through it.

* * *

Peabody's insistence that the clinical picture must include a patient's "joys, sorrows, hopes and fears" had once struck me as aspirational, even idealistic. Yet in my encounters with Mona, I saw how easily that wider picture can still be obscured – by time pressure, by institutional fatigue, by our own discomfort with uncertainty. Peabody's painting, I

realised, does not emerge through interpretation alone. Sometimes it appears simply because someone is willing to stand still long enough to see it. Here, in that quiet office, the colours of Olivia began to emerge on Mona's canvas – small strokes of laughter, touch, and memory; while fleeting in nature, were vivid reminders that even amid loss and bureaucracy, her story remained richly, irreducibly alive.

Amid my perceived inadequacies as a medical student, I understood something fundamental about my role. I could not reunite Mona with her daughter. I could not secure her housing or undo the systems that had failed her. But I could listen without an agenda. Listening, I soon learned, is not adjunctive but a therapeutic intervention that strengthens the doctor–patient alliance and supports shared decision-making. While Mona did not teach me a new diagnosis, she taught me a different kind of attention. What Mona asked of me was not mastery of her story, but humility in its presence. She wanted to be seen as a mother, not a risk profile–whether it be those sixteen years ago or in the present.

I am further reminded of the reflections of Sayantani DasGupta, a contemporary American physician and writer, who describes *narrative humility* as the recognition that patients' stories are "not objects that we necessarily comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction." DasGupta communicates that every story contains elements that remain unfamiliar – "cultural, socioeconomic, sexual, religious, or idiosyncratically personal" – and that assuming our interpretation is definitive risks closing us off to its most valuable nuances.

Regrettably, I recognised myself uncomfortably in this warning in my earliest interactions with Mona. In this way, DasGupta's modern articulation feels less like a departure from Peabody than a continuation of his unfinished work. Where Peabody urges physicians to see beyond the photograph of disease, DasGupta asks us to resist the temptation to frame the painting too quickly – to tolerate ambiguity, to interrogate our own expectations, and to remain alert to our role in shaping the story we believe we are hearing. Mona taught me that narrative humility is not a passive virtue. Rather, it is an active discipline: to listen without prematurely concluding, to remain present without the reassurance of resolution, and to allow a patient's story to change how we understand not only them, but ourselves. As a medical student, I learned that the work is

not only to categorise and contain distress, but to bear witness to it – to remember names, stories, and selves that insist on being seen.

Because sometimes, that is where care still begins.

The Mirror in Medicine

Modern medicine is increasingly and epistemically limited by its focus on the individual in isolation. Illness is never singular–it unfolds within relationships, histories, and systems of meaning. To fixate on Mona's psychiatric diagnoses alone is to crop Peabody's painting down to a single brushstroke, or in other words, to overlook the family and community standing in its shadow. Fractured motherhood, trauma, and trust sit just outside the frame – yet determine whether treatment can take root at all, because healing falters when care ignores the relational terrain in which illness is lived. Symptoms may belong to one body, but suffering is often shared.

Mona's reluctance to comply with medication changes or discharge plans was initially framed – by others and, at times, by myself – as resistance. With time, however, I began to understand this not as an irrational rejection of care, but as an assertion of agency shaped by prior losses. Her choices reflected a careful calculus of meaning and survival, informed by experiences of coercion and institutional harm. What I had first experienced as clinical inertia revealed itself as a protective stance – one that demanded a different kind of engagement from me.

Rather than asking how to persuade Mona toward a predefined "reasonable" outcome, I began to ask what kind of collaboration was possible within the limits of my role. The work became less about compliance and more about negotiation: how to hold concern for her safety without erasing her autonomy; how to support her psychological stability while acknowledging that housing insecurity and relational loss were not ancillary issues, but central determinants of her distress. What this encounter clarified for me was how easily the ethical reflexes of medicine – our impulse to protect, to prevent harm, to control risk – sometimes comes at the cost of silencing the very person we seek to care for. Medical knowledge, for all its esoteric power, is not the sole arbiter of a "good" outcome; without reflection, it risks hardening into paternalism. Our duty is not to steer patients toward our version of logic, but to support their version of meaning.

I became grossly aware of my own susceptibility to anchoring bias: how initial diagnostic labels subtly shaped not only my clinical reasoning, but my expectations of Mona and my emotional responses to her. Recognising this did not eliminate risk or uncertainty, but it allowed me to engage with her more openly, without reducing her to a forecast of adverse outcomes. I observed how changes in tone and openness – both mine and the team's – altered the texture of our interactions. When Mona felt less scrutinised, she spoke more freely. When she felt less judged, she stayed. Mona taught me how quickly patients can be rendered voiceless when trust is absent, and how much responsibility clinicians carry – not only for decisions made, but for the relational climate in which those decisions unfold.

Moving forward, I endeavour to cultivate a different reflex: to approach complexity with curiosity rather than defensiveness; to listen for what is being protected, not only what is being presented; to speak names with intention, recognising them as acts of recognition rather than labels; and to treat a patient's identity and relational context as clinically relevant – not emotionally optional. Good care is not only about preventing harm but also about preserving dignity, even – and especially – when outcomes remain uncertain.

I vow to be more honest with myself about the emotional labour of care. Not to pathologise it. Not to romanticise it. Simply to notice it, early, before it hardens into cynicism. Mona taught me that my reactions – fear, protectiveness, frustration – were not failures of professionalism, but sources of information. When acknowledged, my emotional responses became signals – guiding me toward what the relationship was asking of me. When ignored, the same responses threatened to solidify into distance, mislabelled as neutrality or professional objectivity.

Presence Beyond Recognition

"Medicine is not a trade to be learned but a profession to be entered [...] All that the medical school can hope to do is to supply the foundations on which to build."

Despite careful planning and multidisciplinary discussions, Mona's condition began to evolve in ways that defied straightforward clinical explanation. Her deterioration was attributed not to a single pathology, but to an accumulation of: prolonged dissociative episodes, fractured sleep, escalat-

ing psychosocial stressors, and a suspected episode of delirium precipitated by dehydration and polypharmacy. Her functional neurological symptoms intensified under such strain, blurring the boundaries between psychiatric illness and organic vulnerability.

What remained most striking was not the aetiology itself, but the way her sense of self – so carefully defended – began to fragment under its weight. Mona's severe cognitive decline arrived not as a crisis, but as a quiet, relentless tide leaving only fragility in its wake. She lost track of the day. Then the thread of conversations. She repeated questions she had asked moments earlier. At times she spoke fluently, almost brightly; at others, she seemed to drift somewhere beyond reach, her attention loosening its hold on the room. The Mona I knew, who had insisted on her name, who guarded authorship over her story with such precision, now struggled to remain anchored within it.

Her mind seemed to loosen its hold on her body in a way that felt both medical and existential – familiar in psychiatry, yet still profoundly unsettling. Her room felt altered – not louder, but emptier. The treating team spoke in hushed voices beneath the harsh lights, negotiating plans above her bed as though proximity alone could substitute for presence. When I stood beside her, she seemed untethered – hovering somewhere between past and present, intermittently lucid, increasingly unreachable. The doctors called her name, but it no longer seemed to belong to her in the way it once had. Her gaze drifted past us, resting on nothing in particular, neither fully awake nor fully at rest.

It was at that moment that I felt something I had not expected: not only sadness, but guilt. Grief, because I was losing her as I had come to know her. Guilt, because a part of me wanted to retreat into the refuge of clinical finality – to tell myself that *there was nothing more to be done*, and in doing so, to spare myself the discomfort of staying.

"Mona," I said quietly. "Can you tell me where we are?"

There was no response.

And then – almost childishly, almost selfishly – I asked the question that revealed more about me than about her.

"Do you remember my name?"

She looked through me, not at me. There was no recognition, no confusion – just absence. The name I had carried so carefully for her no longer reached her. However, in that silence, something clarified with unexpected force. I realised that I had misunderstood what it meant to be remembered.

Medicine trains us to value reciprocity: the nod of understanding, the returned trust, the sense that something has landed. Yet here was the uncomfortable truth – sometimes the patient cannot hold you in their mind at all.

But that does not absolve you of holding them in yours.

Peabody's "clinical picture," I understood then, does not disappear when cognition fades. It becomes harder to see, easier to abandon – but no less real. Mona was still surrounded by her history, her relationships, her losses, her meanings – even if she could no longer articulate them. The danger, in moments like this, is not diagnostic uncertainty, but moral erosion: the quiet temptation to reduce the person to a body, a risk, a failing brain. What Mona required of me in that moment was continuity – someone willing to remember her when she could not remember herself.

* * *

As I cycled toward my next rotation, I carried the unfinishedness of Mona's story with me. I am not privy to whether her cognition recovered, whether she found stable accommodation, or whether her distress settled into something more livable. Like so many encounters in medicine, the relationship ended without resolution. Despite this, I have come to understand that not all endings require closure to be meaningful.

Mona did not place a diagnostic demand on me; she placed a relational one. She required that I decide whether she would remain a case discussed at arm's length, or a person acknowledged up close. She did not ask me to solve her illness. She asked – implicitly, insistently – whether I would remain present when certainty fell away. Mona has also taught me something quieter than bravery. In the slow work of building trust, I began to see how courage can exist even in its apparent absence – especially within institutions where patients must navigate diminished agency and constrained privacy. As I came to know her, I realised that Mona's courage was not performative or defiant. It did not announce itself. Like a lighthouse, its presence was felt only once I recognised how disoriented I had been – guided less by curiosity than by caution, less by relationship than by fear.

As trust formed, my apprehension softened, and in its place emerged a different kind of steadiness. In learning to meet Mona without retreat or preconception, I discovered that courage in medicine is not only something we witness in our patients, but something we are quietly asked to develop ourselves. The true paradox of medicine lies in the assumption that

wisdom is imparted solely by physicians when, in truth, our greatest teachers are the patients who entrust us with their stories, their suffering, their hope. The medical student–patient relationship is not transactional, nor is it unidimensional. It is reciprocal, formative, and ethically demanding. Patients do not simply receive care; they shape the clinician who offers it. In entrusting us with their stories, they return our gaze – revealing who we are becoming, even as we seek to understand who they are.

Much of medicine can feel like an unfinished book. Yet encounters like this have taught me that while we cannot control outcomes, we are always responsible for how we emerge within them. To lead with compassion, honesty, and a gentle humility is not to abandon rigour, but to recognise the delicate equilibrium that underlies all clinical work: that presence gives meaning to care, that endings render moments precious, and that our formation as doctors is inseparable from our willingness to be changed by those we serve. These encounters have shaped not only how I hope to practise medicine, but how I understand humanity.

Lessons From Mona

If Mona taught me anything about awareness, it was that it does not emerge spontaneously from good intentions. Awareness requires scaffolding, guidance, and deliberate cultivation. Without these, it is eroded – not by neglect, but by momentum. Medical students are immersed early in environments where efficiency is rewarded, ambiguity is uncomfortable, and emotional responses are privately managed, if at all. In such conditions, self-protection can easily masquerade as competence or composure. These experiences have also revealed how easily students can disappear within clinical teams – present, but unformed. We are taught how to present histories, but not always how to *carry* them. We learn to identify risk, but not how to sit with the fear it evokes. Without structured reflection, these experiences accumulate silently, shaping practice in ways we may not recognise until much later.

Medical training must therefore protect both students and patients by making reflective practice routine rather than remedial. Balint groups, longitudinal supervision, and facilitated discussion of countertransference should be embedded not as optional enrichment, but as core curriculum, treating students' internal responses as legitimate clinical data rather than

private liabilities. These forums offer students a protected setting to examine moments like the ones Mona provoked in me: the instinct to retreat, the discomfort of not knowing, the quiet relief of emotional distance. Naming reactions – fear, aversion, protectiveness, tenderness – does not weaken professionalism; it strengthens it. When these experiences remain unspoken, they are more likely to be enacted as avoidance, judgement, or premature certainty.

Equally important is role clarity education – explicit teaching about what students are *not* responsible for. Much of my early avoidance with Mona stemmed from a blurred sense of obligation: the belief that if I stayed, I must also fix. Training that openly addresses role limitation – what it means to accompany rather than resolve – can liberate students from the false binary of omnipotence or withdrawal. Awareness grows when students are taught that remaining engaged does not require always having the answers.

In tandem with this is increasing the integration of patient-educators into training. By dismantling the hierarchy in which the student is the "knower" and the patient the "known," these encounters with educators–who have had prolonged navigation of the healthcare system–highlight the reciprocity and unpredictability inherent in learning from human experience. These patient-educators can offer insight into subtle relational dynamics, institutional power imbalances, and the human costs of clinical decisions – teaching students to notice, pause, and reflect before acting. Strengthening this approach embeds *narrative humility* in the curriculum: students do not simply acquire knowledge about illness; they learn to witness suffering, recognise resilience, and tolerate uncertainty without attempting immediate resolution.

Medical education may also benefit from making *narrative continuity* a formal responsibility. Students frequently rotate away from patients without acknowledgment of loss, leaving stories unfinished and relational bonds unmarked. Structured opportunities to reflect on these endings – through brief written closures, facilitated debriefs, and supervised handovers – enable students to recognise that not all care reaches resolution, and to understand that this "incompleteness" is intrinsic to clinical work, rather than a marker of failure. Mona's story, unresolved as it remained, shaped me profoundly. Recognising this in training legitimises the emotional and relational dimensions of medicine rather than relegating them to the margins of personal reflection.

Finally, awareness, as I learned, is not taught solely through curriculum, but absorbed through the conduct of those who lead clinical care. Awareness gains its authority when it is visibly practised by senior clinicians. What struck me most in Mona's care was not only what she taught me, but what one consultant quietly demonstrated: the power of staying without spectacle, of refusing to reduce complexity into shorthand. Faculty development that values and rewards this modelling – particularly in high-pressure settings – signals to students that awareness is not a soft skill, but a clinical discipline. When awareness is left to chance, it becomes uneven and fragile. If it is cultivated intentionally – through reflection, mentorship, patient-educator engagement, and structured modelling – it becomes durable, capable of withstanding the ambiguity, complexity, and emotional demands of clinical practice. Students entering medicine with this scaffolding are not only more competent – they are more conscious, ethically attuned, and capable of forming meaningful relationships with patients who, like Mona, demand to be known beyond their diagnosis.

Epilogue

"The good physician knows [their] patient through and through, and [their] knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed."

What Peabody described nearly a century ago has not diminished in relevance, nor has it been displaced by a new paradigm; it has simply become harder to sustain. In an era of accelerating diagnostics and growing taxonomies, the labour of knowing another person risks being compressed, deferred, or quietly abandoned. In coming to know Mona, I learned that this labour cannot be expedited or outsourced: it is forged slowly, through presence, patience, and the courage to stay with another's story. This labour remains central – not because it is sentimental, but because it is formative and a manifestation of clinical fidelity. In bearing witness with curiosity, humility, and compassion, we do not abandon science – we complete it.

Mona may not remember my name, our conversations, or the moments in which her story reshaped my understanding of care. Nevertheless, I find solace in believing that she will remember the moments we shared in quiet

understanding, mutual trust, and unspoken solidarity. Above all, Mona taught me how to remain human within the limits of care.

And that, I have come to believe, is where good doctoring begins.

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The silent patient

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Permission to Tremble

Amit Manor

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All identifying details have been altered to protect patient privacy.

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

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

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

Exposition

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

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

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

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

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

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

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

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

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

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

He nods and offers his hand.

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

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

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

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

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

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

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

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

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

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

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

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

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

I want to try a third time.

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

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

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

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

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

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

He is comforting *me*.

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

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

Reflection

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Action

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

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

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

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

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

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

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

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

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

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

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

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

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

He nods.

I enter.

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

Then, the dark red bloom appears.

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

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

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

"We did," he replies.

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

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

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

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

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

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

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

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

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

Progression

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

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

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

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

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

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

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

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

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

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

I tell them to let go.

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

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

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

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

Coda

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

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

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

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Patient M

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Part I: Exposition

The Circadian Rhythm of Trauma

The hospital at 23:30 possesses a distinct, almost tangible acoustic quality. It is a binary existence, split sharply between the frenetic cacophony of the trauma bay-where life is measured in seconds, and the heavy, sterile silence of the peripheral corridors. Technically, my shift as a physician assistant in the Orthopedic Emergency Room had concluded thirty minutes prior. By all logic, and certainly by the dictates of my own exhaustion, I should have been in my car. I should have been navigating the empty highways, allowing the hum of the radio to drown out the lingering noise of the shift, transitioning back to my primary identity as a medical student preparing for a full day of didactic lectures that would begin in less than eight hours.

But the department was collapsing under the weight of a chaotic night. It was one of those shifts where the laws of probability seemed to suspend themselves, resulting in a deluge of injuries. The tracking board was a sea of red lines indicating "stat" admissions, and the unspoken code of the medical fraternity, A complex mixture of camaraderie, shared suffering, and professional duty kept me anchored to the floor. I stayed to help clear the backlog, working alongside the on-call residents who were visibly fraying at the edges.

The environment itself felt hostile to rest. The air smelled of a specific, institutional cocktail: isopropyl alcohol, drying old blood, and the metallic scent of exhaustion that seems to emanate from overworked bodies. I had spent the last hour assisting in the reducing of a Colles' fracture on an elderly woman, my mind oscillating between the mechanical tasks of

the ER and the abstract pharmacological pathways I needed to memorize for my upcoming psychiatry exam.

It was in this moment of systemic fatigue, when my defenses were lowest and my cynicism highest, that Patient M arrived.

She did not walk in; she was wheeled in by her parents, a tableau of quiet devastation that seemed jarringly out of place amidst the aggressive, kinetic energy of the orthopedic wing. She was slumped in a standard-issue hospital wheelchair, her frame appearing startlingly thin, almost fragile, under the harsh, unforgiving glare of the fluorescent lights. She wore thick-rimmed glasses that kept sliding slightly down her nose, but she made no move to push them back. They acted less as an aid to vision and more as a barrier, a glass wall between her and eyes the reality she had chosen to check out of.

She was draped in a heavy blanket, pulled tight up to her chin. It was a shield against the frenetic environment of the ER, a soft fortress against the hard edges of the hospital. But beneath the fabric, the reality of her admission was exposed for all to see: deep, bilateral lacerations running down the length of her shins.

These were not the accidental injuries we typically see in this department. They were not the fractured ankles of weekend warriors who played too hard, nor were they the radial fractures of elderly patients who slipped on a rug at home. These wounds told a different story. They were deliberate. They were jagged. They were a map of internal pain made violently external. They were the physical manifestation of a scream that could not be voiced.

The Parental Nightmare

Standing near the nursing station, I observed her parents. They were hovering around the wheelchair, vibrating with a specific frequency of terror that I had rarely seen, even in the trauma room. It wasn't the panic of a car accident, where the threat is external, sudden, and random. It was a deeper, more corrosive fear, the fear of a threat that comes from within.

I watched her father lean in, whispering to her, trying to make eye contact with a daughter who was staring at the floor. "It's going to be okay, M," he murmured, his voice cracking with a mixture of hope and despair. "We are here. We are with you."

He was speaking to her, broadcasting his love and protection, but she was not receiving the signal. She was tuned to a different frequency, one composed entirely of static.

As I watched them, a thought struck me with piercing clarity: The impotence of protection. As a parent, your primal directive, the biological imperative that overrides all others, is to protect your child from the world. You protect them from speeding cars, from predators, from viruses, from falling. But what do you do when the threat is internal? How do you shield your child when the enemy is their own mind? How do you fight a war against your child's own chemistry?

I could see that helplessness etched into the deep lines of their faces, mingled with a profound, unspoken guilt. They looked like people asking themselves the unanswerable question that haunts every parent in the psychiatric ward: *Where did we miss the signs? What did we do wrong?* They had brought her to the hospital, the "Repair Shop" for human bodies, hoping we could fix what was broken. They wanted a cast, a stitch, a pill. But looking at M's dissociated state, I knew we were only mechanics for the chassis. We were not engineers for the engine. We could patch the tire, but we couldn't stop the car from swerving.

The Silent Transfer of Burden

I was standing next to Dr. K, a senior resident who was currently drowning in a sea of admissions. He was a man I respected, a physician who usually moved with the economy of motion of a seasoned operator. But tonight, he was slowed by the sheer volume of suffering. He took one look at the patient from across the nursing station. He assessed the complexity of the wounds with a surgeon's practiced eye, noting the depth, the likely involvement of the subcutaneous fascia, and the tension of the skin. Then, he looked at the clock on the wall.

It was the look of a man who had nothing left to give. The sheer mathematics of the night were against him; he had three complex fractures to reduce, a consult in the ICU regarding a septic joint, and a trauma patient on the way. He physically could not afford the time this patient would require.

He didn't order me to take the case. He didn't pull rank. He didn't say a word. He simply looked at the wounds, then looked at me with eyes heavy

with desperation. It was a silent transfer of burden, a moment of communication that happens only in high-stress teams where words become too expensive to spend. It was a plea: *I cannot do this. Can you?*

I knew exactly what that look meant. Given the patient's dissociated state and the extensive nature of the injury, this would not be a quick "in-and-out" procedure. This wasn't a simple laceration on a drunk tourist. Taking this case meant committing to at least another hour or two of intense, delicate work. It meant forfeiting my sleep before a crucial day of academia. It meant stepping into a psychological minefield.

But in that moment of silent communion, the hierarchy dissolved into necessity. I nodded to him. "I'll take her," I told him quietly, accepting the weight. "Go handle the trauma."

The Gendered Fortress

The initial hurdle, however, was not medical but socio-political. As the resident moved on to the next crisis, Patient M's mother approached me. She looked as though she hadn't slept in days; her eyes were red-rimmed, her clothes crumpled. She pulled me aside, her voice dropping to a desperate whisper, trying to create a pocket of privacy in the exposed corridor.

"Is there a female doctor available?" she asked. "Please ... due to her history ... it needs to be a woman."

The request hung in the air, valid and heartbreaking. It implied a history of trauma, likely sexual violence, where men were the perpetrators, not the healers. She was asking for a safe harbor. She was asking for someone who did not resemble the source of her daughter's pain.

Yet, this reasonable request collided violently with the rigid reality of our roster. Orthopedic surgery remains, stubbornly and statistically, a male-dominated fortress. It is a field often characterized by a "carpentry" mentality, heavy on hammers, drills, and brute strength, which has historically alienated women or created structural barriers to their entry. In our department of twenty residents, only three were women. The statistical probability of having a female provider at midnight was low. The other available male residents were either scrubbed into emergency surgeries behind the double doors or burying their heads in trauma files.

I was the only option. I was the representation of the very demographic she feared.

I explained this to the parents gently, trying to bridge the gap between their protective instinct and the logistical failure of the system. "I understand completely," I said, keeping my voice low and steady. "I wish I could accommodate that. But the female residents are not here tonight. The other doctors are in emergency surgeries. I am the only one available to help her right now."

The parents exchanged a look of defeated exhaustion. It was the look of people who are used to the system failing them, used to compromising on their ideal standard of care just to get any care at all. They nodded. They turned to their daughter, whispering reassurances she didn't seem to hear. Patient M offered no active resistance; there was no screaming, no refusal. She remained passive, a statue of resignation, allowing herself to be maneuvered into the treatment cubicle.

The Failure of Logic

Her parents, utterly spent, curled up on the linoleum floor in the corner of the cubicle. Within minutes, they fell asleep, a testament to the crushing, chronic fatigue of caring for a child in mental distress. Their sleep was an act of surrender, leaving me as the sole guardian of their daughter's well-being. I was left alone with M.

Before I developed the silence technique, I tried the "correct" medical approach. I tried to be the rational, explaining provider. I tried to use the script I had learned in "Introduction to Clinical Medicine."

"Hi M, I'm going to clean your legs now," I said softly, my voice filled with practiced reassurance. "It might feel cold, but it's just saline." She didn't blink. She stared at a water stain on the ceiling tiles. "I'm going to inject some local anesthetic now. You'll feel a small pinch and a burn, but then it will be numb."

I was broadcasting on a frequency she wasn't receiving. I was using logic, *Cause (needle) leads to Effect (numbness)*, but she was existing in a realm where logic had dissolved into pain. My words were bouncing off the glass wall of her dissociation. I realized then that continuing to speak was not just useless; it was intrusive. It was noise in a world that was already too loud for her. My attempt to comfort her with words was actually an act of aggression, forcing her to process language when she barely had the bandwidth to process breath.

That was when I stopped talking. I realized that the most compassionate thing I could do was simply to shut up.

The Materiality of the Procedure

I turned my attention to the physical task at hand, focusing on the ritual of preparation to ground myself. I opened the suture kit, the sound of the sterile paper tearing loud in the quiet room. I laid out the instruments with obsessive precision: the needle holder, the Adson forceps with their delicate teeth, the scissors. I poured the Betadine into the tray, its dark, iodine scent instantly filling the small space, a smell that, for any medical professional, signals the beginning of an invasive act.

I selected a 3-0 Nylon suture. In the world of surgery, the choice of material is a statement of intent. Nylon is non-absorbable; it is strong, rigid, and permanent until removed. It acts as a bridge for the skin. It requires a return visit. It implies a future. As I loaded the curved needle into the holder, feeling the satisfying *click* of the metal locking into place, I felt the familiar comfort of the mechanical. Here was a problem I could understand. Here was a tool designed to solve it.

As I cleaned the first wound, her leg flinched, a sharp, involuntary recoil. It was a biological rejection of my touch. I froze. I didn't say "relax." I simply withdrew my hands and waited. I watched her breathing, waiting for the tension in her calf muscle to ebb. When she settled, I resumed. A minute later, another flinch. Again, I stopped immediately.

This became our language. In a situation where she had lost all control, I used my stillness to give control back to her. It was a slow, grueling process, extending deep into the night. My back ached, and the thought of my 8:00 AM class loomed in my mind. But the rhythm of the work, *stitch, pause, wait, resume*, forced me into a state of total presence. I wasn't just closing a wound; I was honoring the silent trust that had been passed from the desperate resident to me, and from the sleeping parents to my hands.

Part II: Reflection

The Anatomy of Motivation

The admissions interview for medical school is a highly curated ritual. It is a performance of altruism, where candidates sit across from stern-faced professors and recite the sacred cliché: *"I want to help people."* This phrase is the password to the guild. To say anything else is to risk rejection. It is

the social contract we sign: we feign pure selflessness, and they pretend to believe us.

While I have always viewed this simplistic declaration with a degree of healthy cynicism, it would be dishonest to say my own motivations were purely selfless. In the solitude of self-reflection, unburdened by the need to impress an admissions committee, I can identify a "Triad" of pragmatic drivers that pushed me toward this field.

First, there is the *Respect*. It appeals to the ego, the desire for social standing. To be a doctor is to hold a title that commands automatic deference in almost every culture. It serves a distinct vanity, a desire to be someone who matters when they walk into a room. Second, the promise of *Financial Stability*. Growing up, and now living as an adult in a precarious economy where the cost of living spirals upward, the certainty of a physician's income, however delayed, is a powerful lure. It represents safety. Third, and perhaps most dominantly, the addiction to the *Challenge*. I have always been drawn to hard things. The sheer difficulty of medicine, the intellectual rigor, the physical endurance, the barrier to entry, was not a deterrent, but the primary allure. I wanted to do what others couldn't. I wanted to climb the mountain because it was steep.

However, as I advance in my training, navigating the exhausting reality of clinical years, I have come to realize that this triad is merely the scaffolding. It is the external structure, but it is not the foundation. If these were my only drivers, I would have burned out long ago. The ego bruises easily; the money is years away; and the challenge often feels like punishment.

The true core, the primary weight that tips the scale, is the *intrinsic fascination* with the profession itself. This is the "Fourth Element", the profound satisfaction derived from the work, from the blend of manual skill, intellectual problem-solving, and human interaction. I sensed this potential before I even applied- that was my main motive- but understanding it is an evolving process. It is a realization that cannot be fully grasped in a lecture hall; it only crystallizes *in media res*, in the messy, unscripted reality of clinical practice.

The Price of Admission: Modern Asceticism

This realization is particularly vital given the immense price of admission. Being a medical student in my thirties places me in a different temporal

and economic reality than my peers outside of medicine. My friends are currently achieving the milestones of adulthood: they are buying apartments, traveling for leisure, starting families, and building savings accounts. They are living in the "now."

In contrast, I remain in a state of suspended adolescence. I am economically dependent, time-poor, and perpetually exhausted. Medicine demands a form of modern asceticism. It requires the sacrifice of the present for a hypothetical future. It demands that I refuse to go surfing when the waves are perfect because a test is coming up. It demands that I miss weddings and birthdays for shifts that pay in experience rather than currency. It is a jealous profession that demands a monopoly on one's prime years. I trade my sleep, my youth, and my freedom for the privilege of holding a scalpel.

The Student's Puzzle vs. the Patient's Reality

For the first few years of clinical rotations, the "Golden Ticket" of being a student shielded me from the true weight of this sacrifice. This ticket grants a unique form of access, a voyeuristic pass to the theatre of extreme medicine. We stand in trauma bays, observing the chaos; we scrub into organ transplants, watching a heart beat in a chest cavity; we witness life-saving surgeries. We are tourists of suffering.

But there is a deception in this access. As students, the clinical scenarios we are presented with are often akin to "children's puzzles". They are simplified problems with large, obvious pieces. A patient presents with classic chest pain; we apply the textbook algorithm (ECG, Troponin, Aspirin); and the picture comes together effortlessly. We are trained to solve these four-piece puzzles, where the edges are smooth and the solution is binary. We feel smart because the problems are designed to be solvable. We are graded on our ability to connect the dots.

Patient M represented a different order of complexity. She was not a textbook case. She was a 1,000-piece puzzle with no edge pieces and a picture that kept shifting. She offered no clear narrative, no verbal cooperation, and no "classic" presentation. The standard medical algorithms for history-taking, "Where does it hurt?", "Rate your pain from 1 to 10", crumbled in the face of her silence and the complex overlay of her psychiatric background. She defied the logic of the multiple-choice question.

A Dormant Language

Perhaps my ability to endure that silence, to instinctively shift from "fixing" to "witnessing," was not entirely learned in the sterile lecture halls of medical school. It was, in a sense, a dormant language I had learned long ago.

Without betraying the privacy of my own blood or diving into specifics that are not mine to share, I will say only that the landscape of mental anguish is not foreign to me. I have navigated the hushed corridors of a home where the air grows heavy with unspoken pain. I have seen the way mental illness can warp the atmosphere of a room, creating a gravity that pulls everyone down. I know what it looks like when the mind turns against itself, and I know that in those moments, the presence of a witness is often more powerful than the intervention of a technician.

I recognized the frequency on which Patient M was broadcasting because, in the obscure geometry of my own history, I had heard that static before. This personal resonance bridged the gap that my textbooks could not. It was a familiarity with the darkness that allowed me to sit in it with her, without rushing to turn on the lights. It allowed me to understand that her silence wasn't stubbornness; it was survival.

The Shift in Satisfaction

This is where the nature of my satisfaction shifted during that night shift.

In previous high-drama moments, like a successful CPR on a 40-year-old male or a trauma resuscitation, the satisfaction was often external. It was about the adrenaline, the visible "save," the clear victory of life over death. It fed the ego. It validated the "hero" narrative. It was loud and triumphant.

But with Patient M, there was no audience and no glory. The procedure itself, suturing skin, was technically straightforward. No one was watching. The parents were asleep. The patient was silent. There was no applause.

Yet, the sense of accomplishment I felt afterwards was distinct and far more resonant than any trauma resuscitation. It didn't come from "saving" her in the dramatic sense. Rather, it came from operational adaptability.

I realized that for the first time, I wasn't just translating symptoms into a diagnosis; I was navigating a failure of the standard protocol. The "text-

book" approach for an uncooperative patient would have been to demand cooperation or sedate them chemically. Instead, I had to improvise a new method of care based on non-verbal cues and patience.

The "good sleep" I experienced that night, despite the exhaustion and the looming exam, stemmed from a new kind of professional confidence. It was the realization that I could handle the "Grey Zone", that I could still function as a healer even when the patient couldn't function as a partner. The satisfaction lay in the competence to bridge the gap between her broken reality and the medical care she needed, proving to myself that the "Fourth Element", that intrinsic drive, was strong enough to sustain me even in the quiet, difficult dark.

Part III: Action & the Paradox of Repair

The Failure of the Translation Model

In the controlled, sanitized environment of medical school, clinical interaction is taught as a linear process of translation. We are trained to function as sophisticated biological decoders. The patient provides the input, usually in the form of a verbal narrative like *"I have a sharp pain in my chest"* or *"I can't bear weight on my ankle."* The medical student then translates these subjective complaints into objective data points: onset, character, radiation, severity. We act as data processors, relying entirely on the patient to provide the raw material. When the input is clear, the output, the diagnosis and treatment plan, flows with algorithmic logic.

However, the chaotic reality of the emergency room, particularly in moments of acute crisis, often disrupts this clean signal-to-noise ratio. Patient M represented the total collapse of this translation model. She did not provide the input. There was no "Chief Complaint" to analyze, no history of present illness to document in chronological order. There was only a physical resistance to the very help she needed.

The standard medical instinct in such scenarios, an instinct honed by the pressure to see patients quickly and clear the bed for the next admission, is to increase the "volume." Doctors often speak louder, demand cooperation more sternly, or, when that fails, utilize chemical sedation to bypass the resistance entirely. To sedate her would have been the efficient choice; a dose of Midazolam would have made the suturing easy. But standing there at

midnight, looking at her rigid posture, I realized that force, whether verbal or chemical, would be a fundamental failure of my role. It would "fix" the laceration, certainly, but it would break the patient.

The Orthopedic Optimism vs. the Psychiatric Reality

I must confess a certain bias in my choice of medical specialty. I am drawn to Orthopedics because of its inherent, structural optimism. It is a field defined by tangible solutions. *There is a fracture? We will fix it.* It is a carpenter's philosophy applied to the human form. I love the binary nature of bones: they are either broken or they are whole. There is a deep satisfaction in looking at an X-ray, seeing the chaos of a comminuted fracture, and restoring order with the brutal elegance of metal and screws. We are the architects of the skeleton. We deal in hard materials and concrete outcomes.

But standing over Patient M, that orthopedic optimism collided with a psychiatric reality that defied fixation. I could suture the skin. I could achieve a perfect cosmetic result. I could prevent infection. But I could not "reduce" the fracture in her soul. I could not place a plate on her psyche to hold it together. The tools of my trade, needle drivers, forceps, scissors, were woefully inadequate for the actual pathology in the room.

This realization created a cognitive dissonance. I was a builder standing in a ruin that could not be rebuilt with my materials. The standard medical instinct in such scenarios is to retreat into the technical, to focus solely on the wound and ignore the person. But I couldn't do that. I had to abandon the "Carpenter" mindset and adopt a role I hadn't trained for: The Witness.

The Improvisation of Protocol (the Ad-Hoc Algorithm)

As a candidate aspiring to an orthopedic residency, my mind is conditioned to rely on established protocols. A surgeon preparing for a procedure memorizes the steps like scripture: the approach, the dissection, the fixation, the closure. It is a rigid, reliable script designed to minimize error. But in that dimly lit cubicle, there was no script.

I employed a technique I later termed "Calibrated Operational Pauses." The mechanism was simple in theory but required rigorous self-discipline in practice, effectively creating a new "surgical" sequence:

1. *Action:* Engage the needle.
2. *Observation:* Detect the somatic flinch, the tightening of the calf muscle, the subtle withdrawal of the foot.
3. *Reaction:* Immediate cessation. I would withdraw the needle, lay my hands flat on the sterile drape, and wait.

This sounds peaceful, but biologically, it was a battle. My body, pumped full of cortisol and caffeine from the long shift, wanted to move. My hands wanted to finish. I am a person who likes to check boxes and complete tasks. To sit perfectly still while adrenaline is coursing through your veins requires a muscular effort akin to holding a heavy weight. It was an isometric exercise in patience.

This was not a passive waiting game; it was an active clinical strategy. By stopping exactly when she tensed, I was establishing a somatic contract. I was telling her: *I hear you, even if you aren't speaking.* This approach required me to suppress my own fatigue and the urgency of the department, prioritizing the patient's immediate capacity over the system's demand for speed.

Reframing Success: The Two Types of Hemostasis

Dealing with uncooperative patients is an inevitable obstacle in a medical career. Clinical rotations can show you the pathology, the broken bones, the tumors, the infections, but they rarely prepare you for the friction of human resistance.

With Patient M, the result was not "optimal" in the cinematic sense of the word. There was no cathartic breakthrough. She did not suddenly snap out of her dissociation; she did not thank me with tears in her eyes. She remained silent, staring at the ceiling, until the very last suture was tied.

But from a professional standpoint, the outcome was absolute. I documented in the chart that hemostasis was achieved. Physically, the bleeding had stopped, the wound edges were approximated, and the risk of infection was minimized. However, I was painfully aware of the limitation of that phrase. While I had achieved physical hemostasis, the psychological hemostasis, the stabilization of the internal turmoil that led her to this moment, remained a distant, arduous goal, one well beyond the reach of my needle or my training.

The Drive Home: "Stuck in Reverse"

The procedure took nearly two hours, longer than it should have. By the time I finished, the department had quieted down. The parents woke up, offering a silent, heavy gratitude with their eyes before wheeling their daughter out.

I walked out of the hospital into the cool night air, the adrenaline finally fading, replaced by a crushing fatigue. I got into my car, the interior cold and smelling of stale coffee. I turned on the ignition, and the radio, picking up exactly where it left off, began playing Coldplay's *"Fix You"*.

The synchronicity was almost painful. As I drove down the empty highway, the lyrics washed over me, taking on a literal, visceral meaning that I had never heard before.

"When you try your best, but you don't succeed ..." I had tried my best. I had stitched perfectly. But had I succeeded? I had treated the symptom, but the disease, the despair that drove the blade, remained untouched. I felt the gap between the medical definition of success and the human definition of healing.

"When you get what you want, but not what you need ..." She needed peace. She needed safety. All I could give her was Nylon 3-0 sutures and Lidocaine.

"Stuck in reverse ..." That was her. That was the dissociation. The refusal to move forward. The locking of the gears.

And then the chorus hit: *"Lights will guide you home, and ignite your bones, and I will try to fix you."*

The line hit me with the force of a physical blow. "Ignite your bones." "I will try to fix you." It encapsulated the entire paradox of my chosen profession. I am training to be a "fixer." I want to be the mechanic of the human body. I want to ignite bones and make them heal. But that night, driving home in the dark, I felt the profound limitation of that ambition.

There is an arrogance in the medical promise to "fix." We can fix the hardware. We can plate the femur and nail the tibia. But the software, the ghost in the machine, is often beyond our reach.

The "good sleep" I experienced that night was complex. It wasn't the sleep of a hero who saved the day. It was the sleep of someone who had accepted the terms of the engagement. I realized that sometimes, "fixing" isn't about solving the problem. It's about mitigating the damage. It's

about being the one who sits in the dark and sews the skin back together, so that if the patient ever decides to heal the inside, the outside will be ready.

I had closed the wound. I had reduced the risk of infection. I had done my job. And as the song faded and I pulled into my driveway, I realized that while I couldn't fix *her*, I had, in some small, quiet way, helped her hold herself together for one more night. And perhaps, for a student on the verge of becoming a doctor, that has to be enough.

Part IV: Progression

The End of the Golden Ticket

As I approach the final months of my medical degree, the "Golden Ticket" I have held for years is about to expire. For a medical student, this ticket grants a unique, almost magical form of access: we are permitted to enter the most private and dramatic moments of human existence: open-heart surgeries, traumatic births, the final moments of death, without bearing the crushing weight of the final decision. We participate, we observe, we learn, but ultimately, the legal and moral liability rests entirely on the shoulders of the attending physician. We are tourists in the land of responsibility. We can walk away when the shift ends, but the attending carries the patient home with them.

Now, standing on the precipice of graduation, I feel the impending shift in gravity. The encounter with Patient M served as a stark preview of this new reality. In that quiet cubicle, with the parents asleep and the resident overwhelmed elsewhere, the safety net was gone. I was not just an observer learning a technique; I was the sole provider of care.

The realization that I will soon be the one answering the page at 3:00 AM, with no one behind me to take the burden, is terrifying. It brings to mind the brutal honesty of the fictional Dr. Gregory House: "It is in the nature of medicine, that you are gonna screw up; you are gonna kill someone. If you can't handle that reality, pick another profession."

Until now, I have been shielded from this truth by my student status. I have been protected by the hierarchy. But soon, I will have to face it nakedly. I will be the one making the call, and I will be the one living with the consequences.

Bridging the Educational Gap

Reflecting on my training through the lens of this encounter, I recognize a significant gap between our curriculum and the reality of the "Grey Zone." Medical education is excellent at teaching us the rigid architecture of disease. We spend years memorizing the Krebs cycle, drawing complex diagrams of metabolic pathways, and reciting mnemonics for the cranial nerves. We are trained to treat the biological machine with precision. We are tested on multiple-choice questions where there is always one correct answer.

However, life is not a multiple-choice question. We are far less equipped to treat the complexity of the human spirit.

Our simulation centers are filled with high-fidelity plastic mannequins and actors who play "textbook" patients. They list symptoms clearly, they answer questions logically, and they play by the rules of the scenario. We are rarely trained on how to handle a patient who refuses to speak, who is dissociated, or who cannot be reached by logic or reason. We learn the mechanism of action for every sedative and antipsychotic drug, yet we remain novices in the mechanics of human connection when words fail. We know how to talk, but we don't know how to listen to silence.

To improve the formation of future physicians, I believe we must introduce "High-Friction Simulations." We need scenarios where the standard protocols fail, forcing students to abandon their memorized algorithms and rely on adaptive intuition. We need to teach that active listening is a clinical skill as vital as auscultation. We must train students to listen not just to the patient's history, but to their body language- to read the somatic signals of distress as clearly as we read an ECG trace. Technical competence, like suturing, is hollow if it is not guided by the ability to interpret the patient's physical and emotional cues in real-time.

The Foundation of a Physician

I used to believe that my career would be defined by the high-octane moments: the rare diagnoses that stump the department, the complex surgeries that last for hours, the moments that feed the ego and justify the "hard things" I was drawn to. I thought the foundation of my professional identity would be built on brilliance and technical virtuosity.

I was wrong.

My perspective hasn't fundamentally changed, I still desire the challenge, the respect, and the financial stability that first drew me to medicine. I am still a pragmatist in his thirties, not a naive idealist. But the *foundation* beneath those desires has hardened and matured.

The encounter with Patient M taught me that the true test of a physician is not how they perform when the lights are bright and the team is watching. The true test is how they function in the shadows, when the patient is difficult, the hour is late, and the only reward is the quiet knowledge that you did the right thing, you got the job done.

As I look toward the future and my aspiration to secure a residency in orthopedic surgery, I anticipate a career defined by biomechanics, fixation techniques, and tangible structural repairs. I look forward to the concrete satisfaction of mending bone. Yet, I carry with me the understanding that the most defining moments of my career may not happen under the bright lights of the operating theatre, but in the quiet, obscure corners of the hospital. The experience with Patient M did not just teach me how to close a wound; it taught me how to be a physician. It demonstrated that behind the sterile field and the surgical drapes lies a complexity that no textbook can capture. That night was the first time I truly felt the weight of the profession, and it is that weight- heavy, terrifying, and profoundly meaningful, that I am now ready to carry.

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The Shape of Mrs Sharma's Sunflowers

A Meditation on Love, Loss and Life

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Patient details, names, and specificities have been altered to maintain privacy and confidentiality.

Prelude: Frankenstein's Monster

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

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

Students offered some answers: fear, guilt, revulsion.

She shook her head.

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

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

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

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

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

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

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

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

Part I: Meeting Mrs Sharma

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

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

I pulled up a chair and began with the usual.

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

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

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

Then I moved to red flags.

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

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

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

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

I cleared my throat gently.

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

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

I took a slow breath, steadying my voice.

"Do you feel safe at home now?"

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

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

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

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

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

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

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

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

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

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

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

Part II: The Orthopaedic Ward

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

Older women, in particular, appear often.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What I could do was notice her.

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

Part III: Assumptions

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

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

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

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

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

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

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

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

She nodded vaguely. "People come and go."

"And family?" I asked gently.

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

"I had a son," she said.

The room seemed to still.

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

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

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

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

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

I nodded, unsure of what to say.

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

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

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

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

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

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

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

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

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

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

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

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

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

She leaned back against the pillow.

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

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

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

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

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

She paused.

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

I stood there longer than I meant to.

I had come thinking I understood something of her story.

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

Part IV: Loneliness

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

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

Yet loneliness remains largely invisible in clinical encounters.

It does not appear on drug charts.

It is not quite captured by vital signs.

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

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

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

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

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

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

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

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

1. Osler W. *Aequanimitas*. Philadelphia: P. Blakiston's Son & Co; 1904.
2. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspect Psychol Sci*. 2015;10(2):227–237.
3. Cacioppo JT, Cacioppo S. Loneliness in the modern age: An evolutionary theory of loneliness. *Adv Exp Soc Psychol*. 2018;58:127–197.
4. Eisenberger NI. The pain of social disconnection: Examining the shared neural underpinnings of physical and social pain. *Nat Rev Neurosci*. 2012;13(6):421–434.
5. Valtorta NK, Kanaan M, Gilbody S, Ronzi S, Hanratty B. Loneliness and social isolation as risk factors for coronary heart disease and stroke: Systematic review and meta-analysis. *Heart*. 2016; 102(13):1009–1016.

Part V: Origins

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"And why did you stop teaching?"

"I married," she said simply.

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

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

"What was it like when you first arrived?"

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

She shifted the shawl again.

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

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

She smiled, approving.

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

She leaned forward conspiratorially.

"Do you want to know something?"

I nodded.

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

She looked at me knowingly.

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

Then she surprised me again.

"Do you fear growing old?" she asked.

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

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

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

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

"Why?"

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

She tilted her head.

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

Her eyes drifted toward the window.

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

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

She considered the question with tenderness.

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

A long silence unfolded.

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

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

I laughed more loudly than I meant to.

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

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

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

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

I turned to go.

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

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

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

Part VI: Mrs Sharma's discharge

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

"You're escaping," I said gently.

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

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

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

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

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

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

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

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

"Who is he?" I asked softly.

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

I blinked. "Your ex-husband?"

She nodded slowly.

"You still have contact with him?"

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

She looked at the window rather than at me.

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

There was no bitterness in her voice.

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

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

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

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

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

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

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

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

She shook her head.

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

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

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

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

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

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

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

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

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

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

Part VII: The Room With No Monitors

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

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

I started with the basics.

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

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

There was a brief silence when I finished.

The facilitator leaned back in his chair.

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

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

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

One student said, "She sounds incredibly resilient."

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

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

The facilitator let the comments accumulate without judgment, then

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

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

"And after the second conversation?"

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

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

No one spoke for a few seconds.

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

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

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

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

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

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

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

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

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

He circled the outer ring.

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

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

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

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

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

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

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

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

'Frankenstein', I thought to myself.

On the ward, that had felt abstract.

In the classroom, it felt like a quiet directive.

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

Part VIII: The Anatomy of a Medical Student

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

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

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

That state is temporary.

Left unexamined, it decays.

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

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

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

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

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

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

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

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

Part IX: Mrs Sharma's Note

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

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

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

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

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

There was nothing elaborate in it.

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

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

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

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

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

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

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

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

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

I remember the shawl.

The bags lined neatly at her feet.

Her smile, tired at the edges but still steady.

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

And then she was gone.

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

But I did not absorb her absence so easily.

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

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

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

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

Everything else remains beyond my reach.

And perhaps that is the point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

what it is you are letting go of.

I think about her more often than I admit.

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

Who was Mrs Sharma?

A schoolteacher from Gujarat.

A survivor of quiet devastations.

A woman who carried her loneliness with dignity.

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

And what did she teach me?

That I must hold my future lightly.

That survival is its own form of authorship.

That accompaniment matters more than interpretation.

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

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

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

Epilogue: Forgiving Frankenstein

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

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

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

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

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

Mrs Sharma never asked me to understand her life.

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

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

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

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

to remain close, even when understanding is imperfect;

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

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What Prognosis Cannot Predict

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Introduction

This is the story of two weeks of a woman's life. At first glance, the case seems relatively straightforward. There was no major conflict, no tragic adverse event, no medical errors or non-compliance. You might wonder why I picked it. But as we dissect layer by layer, from outward appearance to medical reality and ethical ambiguity to find the person and relationships underneath, I hope you understand why this experience has stuck with me. I hope to demonstrate that it's not just the extraordinary and shocking that should demand our thoughtful reflection as practitioners, but the seemingly ordinary and mundane too, who so often are brushed over as they aren't a thorn in anyone's side.

The pathway I will take you through this journey differs from the uni-directional linear one we are so familiar with in the medical world. Presentation, history, exam, differentials, investigations, results, diagnosis and management. We tend to progress through these components as we tell a story about a patient, checking them off the list and moving along. And we grumble and shake our heads when those chatty patients, you know the ones, present to the emergency department and attempt to begin their history with "It all started when I went to the grocery shops 10 years ago, I met my lovely wife Betty that year! ..."

And I get why. As doctors we are investigators. We need to line up the evidence and rule out life-threatening diagnoses, create differentials and order tailored investigations to confirm or deny our hypotheses. It makes sense to cut out the fluff and get the pertinent information, put it in order and get on with it.

But when we take this linear approach and apply it to the non-medical

stuff, it gets messy. Life doesn't proceed in an orderly fashion. It ebbs and wanes, twirls and twists, crescendos and decrescendos like some sort of untrained hurricane. And when you consider that each of these lives, these hurricanes, is interacting with hundreds of other hurricanes, well, that just tells you that no human story is linear, nor predictable.

I offer an alternate approach to telling this woman's story, Jay, we'll call her. Rather than a linear case history or a moment of insight, I'll take a spiral approach. First encircling the case from the outside, the most superficial layer you could say, then dissecting one layer deeper, and deeper. I will repeatedly return to the same encounters, observations and tensions, each time attempting to delve deeper into an unexplored vantage point to accumulate meaning. This mirrors how I experienced our relationship in practice, not as a series of discrete events or chronological order of analysis, but as a layered process of noticing, misunderstanding and correcting.

Throughout this process, as I reason and feel my way through many smaller tensions, I come to several personal reflections and aspirations about myself and the broader medical field. The main reflection that flows through all of these others though, is the need to seek the complexity in even the seemingly more straightforward cases. You will always find it, and your care for the patient will improve markedly as a result.

Spiral 1: Myself and Jay

Breathing forcefully normal, eyes determinedly (but rapidly) blinking and attention 'casually' intent on reading the patient list, I trudged after the palliative care team down the hallway. We had just left a room with a woman surrounded by pictures of her family, her daughter present holding her hand as the exceptional palliative care consultant knelt at her bed and spoke gently to her, ensuring her pain was under control and firmly telling her to let the team know if she needed anything, anything at all. It was probably the 3rd or 4th patient we'd seen that morning with a similar story. Metastatic cancer, affecting the lungs, liver, bone or even the throat and signalling end of life for these people. Each of them with a lifetime of experiences, relationships and stories.

I was a wreck. Embarrassed that I seemed more out of control than the patients or their families I did my best to hide my feelings. Guilt washed over me in waves, what right did I have to witness this, and even worse, to

feel the pain. They must have it so much worse. I felt relieved it wasn't my mum, my brother, my friend, and the guilt intensified. How cruel of me.

As we walked into the next room, I felt like I was forcing my feet forwards through honey. Not again, I can't face it again. A new patient, a new life to discover and grieve in the same breath.

But this one was different.

Sunlight streamed in through the massive glass window, bathing the bed in a warm glow. In its centre, seemingly emitting the light herself, was a middle-aged woman. She was sitting up in bed, laughing at her adult daughter who stood to the side. She greeted the team warmly and she and her daughter dismissed the notion of them coming back at a better time as if it were ridiculous. The team didn't spend much time with her at all. Like, less than 2 minutes. As we left, I questioned the intern why we were involved in her care and found out she was in hospital to monitor for adverse events while on a new treatment for her refractory cancer. "She has refractory lymphoma," the intern explained, "but she's not in hospital because she's dying". They were just doing their due diligence checking in, and upholding a major principle hammered into us in the palliative care term – early involvement of the palliative care team, i. e., as soon as someone receives a terminal diagnosis, not when they're on their deathbed.

My Emotional Response

Finally.

A happy case on oncology and palliative care term. I had known I wasn't cut out for this term from the get-go. I cry in almost every movie I watch. I cry imagining sad scenarios that aren't even real. And my fear had only been realised when I had dragged myself up to ward rounds and endured tragedy after tragedy. Don't get me wrong, it was an honour to be invited into that space, and I admired the team beyond words. I knew their work was so important, and helping people die in comfort and dignity, in the place and way they want is so important. I just knew I couldn't handle it.

So Jay, the woman emitting sunshine, was a bubble of fresh air in a suffocating ocean.

I knew immediately I wanted to do her for my written assignment.

In the oncology and palliative care term, each student was required

to do a case assignment. It involved detailing their medical case (history, presentation, investigations and progress), and looking at it through a specific biomedical lens, e. g., pharmacology. I had been dreading finding a patient to do this on, as I knew it would no doubt involve lengthy discussion with that person and time writing up the report. Activities no doubt resulting in massive accumulation of time engaging with these sad topics at an intimate level and sitting with the intense feelings they evoked in me.

I resolved to go and talk to Jay privately, to obtain consent to do my case report on her, and to take a detailed history and examination. I did so that very day.

The Medical Side

Perhaps more reluctantly than eagerly, I come to the medical details. Not because they are unimportant but because they are so often allowed to eclipse the person they belong to. Still, Jay's story cannot be told without them. Her relationship with medicine, hope and uncertainty has been shaped profoundly by the sequence of diagnoses, treatments, remissions and relapses that make up her medical history.

Jay was a 64-year-old woman admitted to hospital for close monitoring at the commencement of Epcoritamab, a novel immunotherapy she was receiving as part of a Phase III clinical trial for refractory follicular lymphoma. The admission itself was precautionary not reactive. She was being monitored for cytokine release syndrome and immune effector cell–associated neurotoxicity, complications that existed only as probabilities on a consent form but which had the potential to become suddenly and frighteningly real.

Her journey with cancer had begun almost four years earlier, in a way that felt deceptively benign. Jay had a renal ultrasound as part of an investigation for a urinary tract infection with lower back pain, that revealed an incidental finding of splenomegaly with multiple hypoechoic masses. What was expected to be a routine screen for pyelonephritis rapidly escalated into a life-altering diagnosis. Further imaging demonstrated extensive lymphadenopathy both above and below the diaphragm, along with hepatic and splenic lesions. An ultrasound-guided liver core biopsy confirmed stage IV diffuse large B-cell lymphoma.

Jay underwent six cycles of R-CHOP chemotherapy. The treatment was gruelling but effective. A post-treatment PET scan showed a complete metabolic response, and she was told she was in remission. She then had two cycles of maintenance Rituximab, followed by regular four-monthly surveillance.

Jay was cancer-free for 2 and a half years.

Then, a year before I met her, the story shifted again. Jay presented to her general practitioner with a three-month history of progressive left inguinal lymphadenopathy, swelling of her proximal left leg, left hypochondrial pain, night sweats, and profound fatigue. A biopsy of the inguinal lymph node was consistent with grade 3A follicular lymphoma, and PET imaging revealed widespread lymphadenopathy above and below the diaphragm, consistent with stage III disease.

Salvage chemotherapy with R-ICE was commenced, carrying with it the hope that this would once again turn the tide. However, a post-cycle PET scan showed only a partial metabolic response. Further cycles were deemed unjustified, and Jay was confronted with a new and unfamiliar label: 'refractory disease'.

Jay was then offered participation in a Phase III clinical trial for Epcoritamab in combination with lenalidomide and rituximab. When I met her, she had just started this new treatment. It felt like Jay was at a threshold of a new chapter with her cancer, not cured but not out of options. She was in the space between promise and uncertainty that modern oncology so often inhabits. The way Jay spoke about the medication and trial conveyed the miracle of modern medicine. It was clear she felt so grateful to access this cutting-edge drug, and spoke about the remarkable efforts of her haematologist to get it to her.

I gathered all this information from Jay in one of the most welcoming clinical interactions I have ever had. I approached her, explained my role and requested if I could chat to her to further my learning. I wish I could say I was responsible for building the strong student-patient rapport that ensued but in truth she did most of the work. At times it felt like she was asking me more questions than I asked her, ever interested in my studies, relating my experiences to those of her daughter when she studied paramedicine, and delighting in my recent move to the area, giving me countless recommendations for food and activities to balance out my studious life. The first time I went and spoke to Jay I spent 2 hours with her.

My Emotional Response Revisited

I came away with a reinforced version of the impression I had walking away with the team. More informed, sure, and aware of the diagnosis and management pathway. But the way she spoke about it and the optimism she was brimming with left me even more reassured that this was in fact, finally, a happy oncology case. I felt, more than knew, that these new treatments were going to work for her, and she wasn't really a palliative case at all. I assumed hope was synonymous with survival.

Spiral 2: The Haematologist

Jay gave me permission to access her electronic medical record and read any notes and scans, as well as use her for my assignment case. I thanked her profusely, and took some time to look through her notes, hoping to learn more about the trial medication she was on. The information in the record was relatively sparse, and I decided to seek out her treating haematologist, a doctor I had been taught by previously, to ask some questions.

The second 'spiral' of this case took place in a small, cramped office. The haematologist sat facing the screen while I awkwardly brought my chair up to the side to observe the scans he was showing me. There was no family, no patient, just the two of us and the glow of her PET scans.

He scrolled in silence for a while, then began to speak. His voice was flat, not unkind, but with the practiced neutrality of someone who has had to say hard things many times. He pointed out areas of uptake, compared them to previous scans and named the pattern for what it was: refractory disease with very limited options.

When he moved on to talk about the trial, the contrast with my internal story became almost audible. I had been carrying around an unspoken assumption that this new drug was, if not a miracle, at least a strong contender. In my mind, it sat as the satisfying next step in a narrative that curved gently towards improvement.

He did not describe it that way.

He called it "a reasonable last shot." He talked about "modest response rates," about the small pool of long-term survivors in the early data, about the fact that, for many participants, the benefit was measured in months rather than years. He acknowledged that it was an important opportunity

to refine treatment options and to learn what might help the next cohorts of patients like her.

He was not dismissive of Jay as an individual. He spoke about her as a good candidate, someone whose prior treatments and current functional status made her eligible. He circled back to the importance of her values and preferences. I could hear that he wanted what was best for her. But 'best' in this context did not sound like the guaranteed certainty I had been subconsciously assuming. It sounded like informed risk in a landscape of diminishing choices.

Sitting in that chair, I felt a small but distinct snap in the narrative I had been carrying.

All along, I had treated her optimism as evidence that we were on firm therapeutic ground. I thought that medicine had pulled a rabbit out of its hat once before and was about to do it again. Hearing him describe the trial instead as a slim personal chance nested inside a broader research agenda forced me to confront how much of my comfort had been built on wishful thinking.

Nothing in that room was dramatic. No one cried. No new catastrophe was revealed. He did not say, "There is no hope." He said, "There is some hope, but it is small, and it sits alongside uncertainty and the need to learn for future patients." The change was not in her condition – she was still upstairs, chatting to the nurses, planning what snacks her daughter would bring in – but in the angle from which I was looking at the same situation.

I walked out of his office carrying two parallel stories that would not quite line up. In one, Jay was the happy case, the bright spot on a heavy ward, about to benefit from cutting-edge therapy. In the other, she was a woman taking a calculated risk at the outer edge of what we could offer. I realised her success was far from assured and that the purpose of the clinical trial extended beyond her. His motivation extended beyond her wellbeing.

The facts hadn't changed. My access to them had.

And with that, the 'straightforward' case I had clung to began unravel.

Spiral 3: Time, Illness, and the Long View

Back at my desk that evening, I opened the electronic notes again to piece together the bits of history I had not fully grasped in our earlier conversations. On the screen, Jay's life flattened into date-stamped entries. Ul-

trasound. CT. Biopsy. R-CHOP cycle 1, 2, 3. PET: complete remission. Rituximab maintenance. Discharge letters. Follow-up appointments. The paper trail of four years compressed into a list I could scroll through in under a minute.

On the ward, her story had felt like a fresh chapter. In the clinic, it had felt like a plot twist. In the notes, it was something else again. A long, looping narrative of remission and relapse, of hope rising and dipping in ways my two-week snapshot could never convey.

I traced the progression: the incidental finding on renal ultrasound, the shock of the initial lymphoma diagnosis, the harsh but curative chemotherapy; the fragile normality of those two and a half remission years. Then the slow intrusion of fatigue and night sweats, the swelling in her leg, the new biopsy results with a different histological label but an equally heavy weight. Salvage chemotherapy. Partial response. Refractory disease.

Reading it all at once, the contrast with my own time horizon was jarring. I had met Jay near the start of yet another treatment, and my feelings about her situation had been shaped almost entirely by that entry point. A neatly framed 'before' and 'after' had comforted me: before trial, after trial; before hope, after hope fulfilled. I had imagined myself catching her at the upward curve of a graph.

The notes told a less tidy story. There were months of waiting between scans, stretches of "watch and wait" that would never make it into a case summary because nothing dramatic had happened, but which must have been thick with quiet anxiety. There were routine clinic letters that summarised "stable disease" in two lines, sign-offs written in the same font as the most devastating news.

What I had labelled a happy case was, in reality, one small segment along a much longer oscillation between fear and relative safety. Her cheerfulness on the ward was not the naive relief of someone spared catastrophe, but the practised posture of someone who knew catastrophe well and had learned how to live alongside its possibility.

This disturbed me because it forced me to notice how much I preferred the version of her story that aligned with my own needs. I wanted a case that could be resolved within the timeframe of my term, preferably with a good outcome, preferably with a lesson I could write up neatly.

Yet as I scrolled through PET reports and chemotherapy protocols, it became harder to maintain the illusion that prognosis and hope occupy the same axis. Jay's optimism had outlived remission and returned along-

side relapse. It had accompanied her into salvage chemotherapy and now followed her into an experimental trial. It had been present in clinic when refractoriness was named out loud.

Hope, I began to see, was not a simple reflection of her estimated survival time. It was something more stubborn and more relational, threaded through conversations with her specialists, her family, and, somewhat to my discomfort, with me.

Spiral 4: Knowledge, trust, and agency

The more time I spent with Jay, the more it became clear that she did not fit the caricature of a 'bravely ignorant' patient clinging to denial. She knew the vocabulary of her disease. She could list her previous regimens, recall approximate dates, summarise side effects. When we talked about the trial drug, she wanted to know how it worked, where in the immune cascade it intervened, why it might succeed where others had faltered.

Her questions were not aggressive or mistrustful. They carried a practical curiosity that felt almost collaborative. When I admitted I did not know the detailed mechanism beyond what I had hastily read the night before, she laughed and said, "Well, you'll learn. You lot always do." There was no accusation in it, only a gentle expectation that knowledge would catch up to the reality already unfolding in her body.

Her daughter, a paramedic, often stood at the bedside, arms gently crossed, occasionally translating medical shorthand into the family's own vernacular. Her son-in-law and husband were frequent visitors, comfortable navigating ward routines, asking after bloods and scan results without deference or hostility. Watching them together, I was reminded that medical literacy in families is rarely evenly distributed, and that expertise circulates quietly in conversations long after the team leaves the room.

Trust sat in the middle of all this, both obvious and uneasy. Jay often said things like "I trust my team" and "They've got me this far." The successful treatment of her first lymphoma had left a deep imprint; medicine had already, in a sense, saved her life once. That history infused her current situation with a kind of residual faith, even as the language shifted from curative intent to experimental options.

From my vantage point as a student, this trust was both reassuring and unsettling. On one hand, it felt right that she did not have to bear the

entire cognitive and emotional load of each decision alone. On the other, I found myself wondering how her previous positive experiences with the system affected her sense of what was being offered now.

When the trial was discussed, I heard phrases like "another option," "promising data," "good candidate." I also knew, at least in theory, that a trial is designed to generate knowledge for future patients as much as it is to help the person in front of you. That dual purpose was invisible in the warmth of the ward interactions. It sat underneath, in protocol documents and ethics applications I would never see.

Jay did not strike me as someone misled or coerced. She was, within the constraints of her situation, choosing. Yet I could not shake the feeling that the scales on which she weighed that choice included variables that I, as a healthy outsider, could barely comprehend. She had experienced cumulative fatigue from years of treatment, fear of running out of options, gratitude for time already gained, loyalty to a team who had walked with her through multiple crises.

If anything, her agency complicated my comfort further. It would have been easier, in some ways, if she had seemed confused or doubtful, if I could point to a clear gap in consent and reassure myself that I would never allow such a thing when I was a doctor. Instead, she knew enough to ask good questions, had enough trust to say yes, and enough courage to live with the consequences.

The 'happy case' now had an edge I had not recognised at first: her optimism and trust were not simply feel-good accessories to effective treatment, but active forces shaping how she stepped into ethically fraught territory.

Spiral 5: The Edge of Care – Trial and Ethics

Beneath the surface, I knew there was another narrative running: the study protocol, with its inclusion criteria, dosing schedules, and adverse event grading scales. Somewhere, a sponsor's spreadsheet listed her as a participant number, her data points destined to join others in a statistical analysis. The same intervention that, for her, represented a last chance at controlling her disease also represented, for the trial, a contribution to knowledge whose primary beneficiaries might be strangers she would never meet.

It was surreal to think about how every single patient my eyes had glossed over reading randomised control trials for class or study, had been

another Jay, another person. Of course I had known this, but I had never been so involved in a trial participant's care, never talked to them so much.

I had learned about this duality in lectures. We had been told to distinguish clearly between clinical care and research, to avoid the "therapeutic misconception" that assumes an intervention is always primarily for the patient's individual benefit. On paper, the separation made sense. At the bedside, it did not feel separate at all. The cannula that delivered the trial drug was the same plastic we used for antibiotics. The nurses who checked her were the same ones who adjusted other patients' opioids. Her haematologist was both her clinician and a principal investigator.

When she did develop a low-grade fever and mild confusion overnight, it was, in one sense, expected. These were listed events, anticipated, graded. The team responded calmly, escalating monitoring, adjusting medications, documenting it meticulously.

It felt wrong, almost indecent, to know that somewhere this episode could later appear as a single entry in a results table: "Grade 2 CRS in X% of participants." I also knew that without such data, future patients and clinicians would be deciding almost blindly. The abstract good of knowledge was, at that moment, balanced precariously on Jay's flushed skin and restless hands.

I became uncomfortably aware of my own position in this arrangement. Unlike the haematologist, I bore no formal responsibility for the trial or its outcomes. Unlike Jay, I bore none of the physical risk. Yet I was learning a great deal from being there. I was observing, asking questions, later writing reflective notes that, in their own way, turned her experience into a kind of curriculum for me.

The teacher in this situation had never agreed to that role directly. Yes, she had consented to me speaking with her, to me being present. She had been generously open, even delighted, to share her story. But she did not choose for her suffering, her side effects, her resilience, to become the raw material from which I would carve out my professional identity. That part was simply how the system worked.

This awareness sat heavily with me. It disturbed the easy gratitude I had initially felt about 'finally finding a good case' for my assignment. What did it mean that my educational gain was entangled with her exposure to risk, with her willingness to inhabit this uncertain space at the edge of established care?

I did not find an answer. Instead, I found myself coming back to her

trust and her agency, and wondering what kind of doctor I would need to become to be worthy of both, in a context where the lines between treatment and research are never entirely clean.

Spiral 6: The Student's Hands – Doing Less, Feeling More

Throughout my time with Jay, I was acutely aware of how little I could do. I could not alter her regimen, tweak her doses, or offer alternative options. I did not sign her consent forms or interpret her scans. My role in the team was officially observational.

At first, this felt almost shameful. On other rotations, I had clung to small acts of "usefulness" – writing notes, chasing pathology, doing blood pressures, checking cannulas. With Jay, most of that work was already covered. The team was efficient, the nurses meticulous. There was no obvious gap for me to fill that would make the ward round move faster or the documentation neater.

What remained, unassigned and therefore somehow less legitimate in my mind, was time. Time to sit. Time to listen. Time to talk about things that would never make it into a discharge letter.

On the afternoons when I had no tutorials, I found myself drifting back to her room. Sometimes we talked about her disease, her past treatments, the side effects she feared most. Sometimes we did not. She told me about her daughter's first ambulance shift, about trips she had taken before she got sick, about the small rituals that made the hospital room feel less foreign – her own pillow, a particular brand of tea, a playlist she kept returning to.

There were moments when I felt a tug towards asking more, probing the depths of her understanding of the trial, checking – for my own reassurance – that she grasped the seriousness of her situation. Each time, I had to decide whether that urge was driven by genuine concern for her, or by my discomfort with sitting alongside hope that did not align neatly with prognosis.

I began to experiment, tentatively, with restraint. If she wanted to talk about the café down the road, I let the conversation stay there, resisting the impulse to steer it back to illness to prove I was "doing learning". If she wanted to revisit stories she had already told me, I listened again, noticing how different details emerged when she was more tired, or when her daughter was present, or when she had just come back from yet another scan.

None of this would have satisfied the part of me trained to measure contribution in tasks completed. Yet slowly, I started to recognise that being consistently, attentively present was not a consolation prize. It was a form of care, especially in a context where so much of what happened to her body was outside both our control.

This recognition was uncomfortable because it demanded a different metric for my own worth. Instead of asking "What did I do?", I had to ask "How did I behave in the space I was given?" Did I crowd it with my anxieties, my need for answers, my eagerness to impress? Or did I make room for her way of holding hope, even when it grated against my accumulating knowledge of survival statistics?

If anything, Jay seemed to sense this tension more clearly than I did. On one of the last days I saw her, she said almost offhandedly, "You don't always have to ask clever questions, you know. It's nice just having you here." It was such a simple comment, but it jolted me. In my head, I had been constantly assessing whether our conversations were "worthwhile" in educational terms. She was evaluating something else entirely: whether my presence made her feel more or less alone.

The happy case I had claimed at the beginning of the term had, by this point, frayed at the edges. The prognosis remained poor. The trial outcomes were unknown. She had already weathered more pain and uncertainty than I could fathom. And yet, in that small remark, I glimpsed a kind of reciprocity that did not depend on cure, or even on meaningful symptom improvement. It depended on attention.

Spiral 7: Leaving

I did not see a clear endpoint to Jay's story. There was no dramatic crash, no tidy resolution, no final "goodbye and thank you" scene. My term, however, did have an end date. On my last day, I went to the ward intending to tell her I was leaving. She was out of the room having a scan. I waited for a while, then got called away to another commitment. By the time I could return, she was sleeping, her daughter curled up in the visitor's chair scrolling through her phone. I hesitated at the doorway, did not want to wake her, and ended up slipping away with a quiet wave to her daughter and a vague promise to "visit if I'm ever back on the ward."

On the train home that evening, I realised that I had been unconsciously

expecting closure that matched the emotional weight of our interactions. A conversation that would define the relationship, some explicit acknowledgment of its significance to both of us. Instead, what I had was a half-finished goodbye and a lingering sense of incompletion.

It felt wrong, at first, to write about our relationship from that place of ambiguity. Who was I to draw conclusions when I did not even know how her trial would turn out, whether she would tolerate further cycles, whether she would live to travel again or die within the year? The temptation was to wait, to somehow seek out the ending before allowing myself to reflect.

But medicine rarely gives us neat endings. Patients move away, transfer care, die between clinics, improve unexpectedly, relapse after we have rotated off the team. The emotional arcs we imagine for them are constantly interrupted by the logistics of rosters and timetables.

Sitting with the unfinishedness of my time with Jay forced me to confront how much of my discomfort came from my own need to turn stories into lessons. The ASCONA brief asked for a narrative about a student–patient relationship and its contribution to my professional development. Part of me wanted that contribution to be clean: a defined turning point, a clarity gained, a moral resolved.

What I had instead was a tangle: hope that persisted in the face of bleak statistics; a clinical trial that was both opportunity and experiment; a relationship in which my most significant offering may have been simply not looking away.

Leaving without resolution did not negate any of that. If anything, it made it more honest. My professional identity was not forged in a single moment of insight, but in a series of imperfect encounters with her reality and my own limitations.

Spiral 8: Seeking Complexity in the "Straightforward"

When I first chose Jay for my assignment, I told myself – and a few classmates – that it was because her case was "less tragic" than the others on the ward. I framed it as a sensible act of self-preservation: pick a story that would not crush me, that I could manage emotionally while still ticking the boxes of the task.

Looking back now, that justification feels too simple. What drew me to

her was not the absence of tragedy, but the way hope sat so prominently in the room that first day. It was easy, in that moment, to see her as the exception – the bright, resilient patient in a sea of decline. It was harder, and took much longer, to notice the complexities underneath that light.

Her optimism was not naive. It had survived previous crises, been recalibrated after each relapse, stretched to accommodate the knowledge that treatments fail and bodies can only be pushed so far. Her trust in the team was not blind. It had been earned over years, tested in side effects, sustained through long waits and ambiguous scan results. Her willingness to enter a clinical trial was not a simple refusal to accept death, but a layered decision made in conversation with family, shaped by her history with medicine, and constrained by the shrinking list of alternatives.

In other words, the "straightforward" patient I had been so relieved to find was only straightforward from a distance. Up close, her story, like everyone else's on that ward, twisted and folded back on itself. The difference was that the edges were softer, the crises more spaced out, the suffering less visible at first glance.

Recognising this has altered how I think about "easy" patients more generally. It is tempting, especially when overwhelmed, to gravitate towards those who fit our preferred narrative arcs: the compliant, the grateful, the ones whose conditions respond predictably to treatment. It is also easy to treat them as emotional rest stops, brief reprieves between more dramatic cases.

Jay taught me that doing so risks missing the very tensions that could deepen our practice. The ethical friction of research-as-care. The quiet exhaustion of long-term survivorship. The subtle ways in which our need for meaning and resolution can distort how we listen.

If I had stayed at the surface – enjoyed her company, written up her case as "a good example of patient-centred hope," moved on – I might have walked away with a pleasant story and very little change. Instead, allowing myself to be unsettled by her situation, and by my reactions to it, has left a more durable mark.

The main reflection that runs through all of this is deceptively simple: even the apparently uncomplicated patients deserve, and in fact require, the same depth of attention we instinctively grant to the obviously complex ones. Complexity is not the preserve of rare diagnoses or dramatic crises. It is there in how people make sense of risk, in the stories they tell themselves and us, in the compromises they accept and the lines they refuse to cross.

For me, the shift is not in suddenly becoming able to "see everything," but in adopting a stance that assumes complexity is present, even when I do not immediately recognise it.

Progression: How I Hope to Practise

If Jay's story has changed anything concrete about how I intend to practise, it is this: I want to resist the reflex to collapse a patient's narrative into the neatest possible arc just because it makes me feel more competent or less afraid.

In practical terms, that means a few commitments I am trying, even now as a student, to cultivate.

First, I want to listen for the tension between prognosis and hope without rushing to resolve it. When a patient expresses optimism that seems "out of proportion" to what I know from the data, I would like my first question to be, "What does that hope look like for you?" rather than "How do I correct this?" Sometimes, certainly, there will be misunderstandings that require gentle clarification. But sometimes, as with Jay, hope will function less as a prediction and more as a way of inhabiting time. Learning to tell the difference feels important.

Second, I want to recognise presence, attention, and ethical restraint as real forms of care, not just placeholders until I am "useful enough" to prescribe or operate. My time with Jay showed me how easily a student can either intrude – asking for more detail than is kind, probing at raw places for the sake of curiosity – or shy away entirely, absenting themselves to avoid discomfort. I would like to occupy a middle ground more deliberately: to show up, to notice, to accept that sometimes the best thing I can offer is to stay, quietly, when there is nothing to fix.

Third, I want to keep questioning the structures that make cases like hers both possible and necessary. Trials are essential; so is honesty about whose risks underpin whose benefits. As I move further into medicine, I hope to pay attention to how recruitment is discussed, how information is framed, how we talk about "options" when there are, in truth, very few. I do not yet know what advocacy or boundary-setting will look like from inside the system, but the unease I felt watching her navigate that crossroads is something I want to hold onto rather than smooth over.

Finally, and perhaps most importantly, I want to make room for ongoing

reflection, not just episodic crises of conscience. Writing about Jay has been one such space. Participating in Balint-style groups and narrative medicine sessions during my training has shown me that sharing these stories with colleagues – not to diagnose them, but to inhabit them together – can transform private discomfort into collective learning. I hope to seek out, and when possible help create, such spaces in whatever teams I work in.

Progression: What Training Could Do Differently

My encounters with Jay did not clash with my formal education so much as expose its seams. We had been taught the science of lymphoma thoroughly, the protocols, the survival curves, the mechanisms of new drugs. We had touched, in lectures, on research ethics and consent. We had been encouraged to be empathetic, to communicate clearly, to provide "holistic care."

What I had not been prepared for was the emotional and ethical dissonance of standing at the intersection of all those domains as a student: watching someone older than my parents consent to a trial that might extend her life or might only add toxicity; feeling both privileged and uneasy to be present; realising that my need for narrative completion was, in that moment, irrelevant.

If medical training is to enhance our awareness in such situations, a few shifts seem necessary.

We need more opportunities to explore cases not because they are rare or spectacular, but because they reveal the ordinary complexities of long-term illness and relational care. Rooms like Jay's should not be relegated to side notes in teaching sessions in favour of more dramatic emergencies. They should be central texts.

We need explicit spaces where students can talk honestly about the ways their own needs – for competence, for closure, for a "good case" – influence which patients they gravitate towards and how they interpret what happens. Without that, such dynamics remain unexamined and silently shape practice.

We also need teaching on research ethics that starts from the lived bedside experience, not only from abstract principles. Seeing how consent processes play out in real time, how trust and desperation and hope intersect, should be something we are invited to reflect on with guidance, not something we stumble through alone.

And we need institutional commitment to reflective practices that are sustained, not one-off. Balint groups, narrative writing, debriefs that focus on relationships rather than only on clinical decisions – these are not luxuries. They are safeguards against the slow erosion of curiosity and compassion. They help doctors tolerate ambiguity and moral discomfort without shutting down or defaulting to cynicism.

If there is one concrete change I would wish for, it would be that every oncology and palliative care term includes protected time for students and clinicians to sit together and talk about one patient purely as a person in relationship with them, not as a problem to be solved. To ask, "What is it like to be with this person? What is it like to be ourselves with them?" and to let that conversation shape how we practise.

Closing the Spiral

I still do not know what happened to Jay. I sometimes catch myself imagining different endings: that the trial worked and she is somewhere planning another trip; that it didn't, and she died surrounded by the same photos I saw on the wall that first day; that her story followed some stranger curve entirely that I would never predict.

What I do know is that my time with her has unsettled some of the neat lines I once drew between good and bad outcomes, realistic and unrealistic hope, useful and useless roles. It has made me more wary of my own relief when a case feels "straightforward," more curious about what lies beneath an apparently simple narrative, more willing to acknowledge that my presence in a patient's story is both formative for me and potentially burdensome for them.

The spiral structure I have used to tell this story is, in a sense, the same structure by which I experienced it: circling back to the same room, the same smile, the same optimism, each time seeing something slightly different. Light and PET scans. Agency and risk. Trust and trial protocols. My own fear, and my own quiet learning.

If medicine is, as we are often told, both science and art, then relationships like the one I had with Jay are where that duality is tested. The data mattered deeply in her case. So did the stories she told herself, and me, about what those numbers could and could not dictate. My professional identity will continue to be shaped by such encounters, not as tidy morals but as ongoing questions I carry forward.

Perhaps the most honest way I can end this is not with a conclusion, but with a commitment: to keep seeking the complexity in the patients who at first appear to offer me easy comfort, and to keep carving out spaces in my training and practice where such complexity can be named, shared, and borne together.

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History of the Foundation of Psychosomatic and Social Medicine

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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 1992 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

1 Winnicott, D.W. (1953). Transitional objects and transitional phenomena. *International Journal of Psychoanalysis, 34*, 89–97.

of the jury at 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.

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.

"It was through reflecting on my experience with Laszlo that a more uncomfortable truth came into focus. There exists another kind of responsibility; One that does not come with protocols, checklists or assessments. It cannot be memorized nor can it be numbered. This responsibility lies in holding space for emotional care alongside practical care, recognizing that the two must work in tandem. Medicine cannot be separated from its core purpose."

Jood Ghunaims

"Listening to him, I began to understand that his body was not merely expressing psychological distress, nor failing in isolation. It had become a territory in itself, bearing the marks of a broader devastation. His pain, his fatigue, his insomnia were not private symptoms but inscriptions of a collective wound, where individual suffering, communal loss, and territorial destruction collapsed into a single experience."

Pedro Henrique Docema Rodrigues

"I imagine a system where, after such an encounter, I could go to a mentor and say, "He spoke of Vietnam and nightmares and his wife and son, gone within weeks of each other. I feel out of my depth. Can we think together about what I have opened and what can be offered now?" I imagine a ward where there is space to hand over not only blood results but stories, where the psychosocial wound is acknowledged as something the team shares responsibility for, not something smuggled into a spare moment by a student."

Sepanta Sadafi

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