Humanism Evolving through Arts and Literature

Spring 2026

FSU
COLLEGE OF MEDICINE

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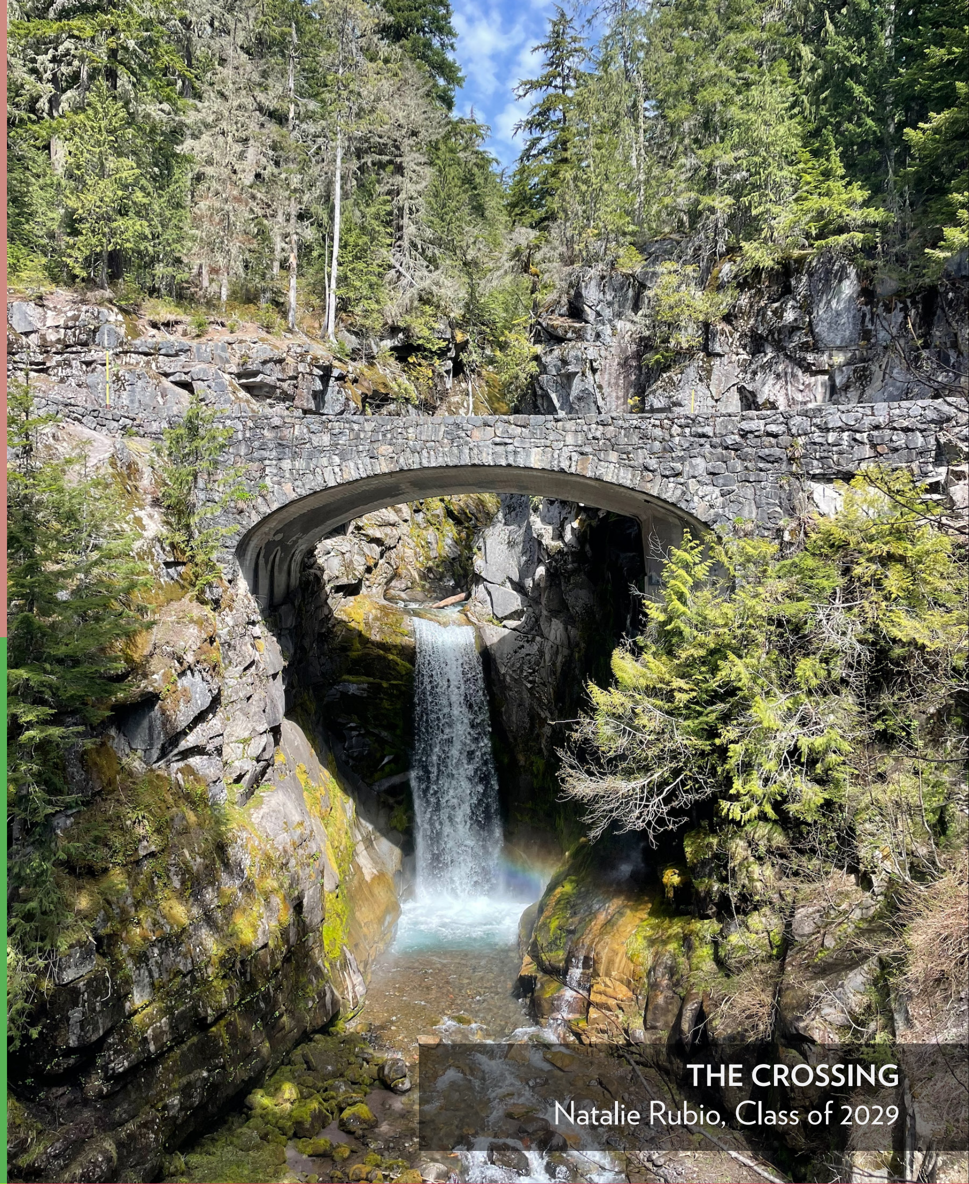

THE CROSSING
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NATURE HEALING
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Department of Biomedical Sciences

"Amid the remnants of what has withered, the butterfly lands—a gentle symbol that healing begins where life dares to return."

Earth's Painting

Kadambari Vyas, Class of 2027

With the taste of chai in my mouth,
And the silk wrapped 'round my shoulders,
I watch and listen to the wonders of the day's descent:
The smell of dirt and grass mixed with Fire's perfume,
The cold touch of marble on my feet,
The sounds of distant barks and chirps,
The taste of honey still fresh and pungent,
And my eyes linger on the beauty of the sky—

The dark night lies still but sparkles,
The streaks of orange are wild but calm,
And when I witness it:
The taste, smell, touch, sound, and sight of it all,
I know that this is Earth's painting,
And I am part of it.

Seeing Her Everywhere

Madison McCraney, MPH
Class of 2027

I got the call late on a Monday night. I initially declined my sister's call and quickly wrapped up minute 29 of a 30-minute meeting to call her back. When she answered and told me what happened, we both started living in a different world, one which someone we deeply loved was no longer in.

Kailey Brandmaier was our neighbor and in the same grade as my sister. My oldest memory of her is when her younger sister, who was my age, encouraged me to call Kailey "short." In response, Kailey gave me an early lesson in authenticity: *Well, you're a little shit*. She didn't miss a beat. I remembered turning to her sister, Emma, with my face beet red and Emma cheering, *I knew she would curse!*

Our houses were separated by a wooden fence that we often hopped over. After one too many knocked-out teeth, her dad decided to saw the planks into a gate. How lucky were we that we could just open a gate and be in each other's yards?

When Emma and I grew closer in middle school, the four of us coined the term "Sister Friends." In 8th grade, the elder Sister Friends picked us up early from school for my birthday. I stole Kailey's phone, posted a heavily filtered selfie on her Instagram and messaged many people to inform them that it was my birthday. It was the beginning of our longest inside joke, where I always said it was my birthday, especially on days that it wasn't. It didn't stop future Kailey from letting me have her phone, record silly videos and send them to her cool friends. She wasn't ever embarrassed of us, at least, she didn't let us feel that embarrassment. This goes back to one of the many things I learned from her: life is for having fun, not worrying about what others think.

As we grew up, I got to witness her excel in soccer and play bagpipes in marching band, and I got to talk to her about my trivial younger-person drama. She first went to college for gerontology before returning for nursing, but I always told her I could see her becoming a therapist. She always gave us her undivided attention, no matter how silly the things we were telling her. She had a way of making you feel like the only important person in the world.

I moved away from home right after high school. During these years, she never stopped being there for me, joking about my non-birthdays, celebrating my wins, and reaching out to me when she knew I needed it. She showed me that you can show up for those you love, even with distance.

When I got the call, I was at the end of my second year in medical school, four hours away from my main support system. Four hours away from everyone else going through this, everyone that knew and loved her. I quickly came to the realization that the world doesn't stop for your grief. In medical school, I was already aboard a conveyor belt of information. Add to that my upcoming board examination, and the responsibilities were stacking. Truthfully, I didn't have the capacity to think about academics. I spent a week in bed, scrolling through old messages, happy fake birthdays, and photos. Mourning became my full-time job, and school was almost like an extracurricular activity. I had to make space for my grief because, if not, then it would become all encompassing.

As I started my clinical rotations, I was mentally navigating if I could be around medicine without breaking down. Sure, I had gotten through the last three months of school, but that

was me operating on adrenaline and strict timelines to survive. How was I going to deal with clinical rotations and seeing people at the end of their lives? I caught myself thinking about what specialties to pursue. Is there anything that I can go into that would allow me to completely avoid seeing death? Or do I want to try to pursue cardiology, the specialty that could've caught and prevented this tragedy?

I was most nervous about my inpatient internal medicine rotation. Seeing people sick was difficult, and it reminded me of my pain and hurt. I saw patients with severe COPD decompensation, congestive heart failure, and aspiration pneumonia requiring intubation. Throughout their hospital admission, I was relieved to see them all get better. One day, I had a patient with atrial fibrillation with recurrent episodes of ventricular tachycardia. He was admitted for an ablation. I spent the morning talking to him and his wife, learning about his medical history and their family. He showed me his Medtronic device and detailed the feeling he got during a v-tach episode. He patiently let me listen to his murmur. During the procedure, the electrophysiology team let me shock the heart back into normal rhythm. To them, they were letting a medical student cross something off their bucket list. To me, I was delivering the electricity that could've saved my friend's life. A nurse turned to me and said, "Plumbing is important. But electricity? Electricity is what keeps our lights on. It is our lifeline."

After spending months devastated by Kailey's passing, it was rewarding to see the opposite: a beloved husband and father relying on modern medicine to live a longer life. I witnessed the story of someone whose heart condition was caught early, and the beautiful life he'd gotten to live because of it.

For every few that I saw get better, I would see another get worse. I saw patients go into hospice and I witnessed the physician-family conversations surrounding end of life care. I asked my preceptor how he so eloquently traverses these conversations without becoming emotional, especially with how long he's known these individuals. He responded by saying, "When you build relationships with patients and truly know them, and even become a small part of their family, they have trust in your clinical decision making. They will know that when you are delivering the news, you are saying so because it truly is time." As for the emotional part of it, he noted the difficulties in these conversations and seeing people's end of the road. But more often than not, he gets to take care of these patients for decades before that time comes. He said it's a privilege to watch people age, because it signals that they have had the opportunity to live their life. Although he sees death while practicing, the counterpart to that will always be life, and what an honor it is to be a part of so many people's existence.

On my rotation, Kailey was everywhere. I saw her when I saw the DAISY nomination signs that hung on the walls of the long, tortuous hospital halls, thinking of Kailey's own recent nursing award before her passing. I saw her as I interacted with nurses, wondering how they would've worked together and which of them she would have enjoyed shifts with. I saw her when my preceptor talked about going to CrossFit before clinic, envying them for their ability to still do one of her many passions. I saw her when the doctor discussed the death of a patient's sibling, thinking about how lucky I was to have her in a sisterly role growing up. I saw her in every sunrise on the way to work and every sunset through the hospital window. And yes, I do see her in the patients whose diseases have progressed, thinking of her no longer with us. I see her in the families crying over their loved ones, thinking about the night I received that call and how quickly our reality changed. But I also see her in the patients that get better. I see her undeniable love for life in the patient's gratitude for treatment. I see her unconditional support for others in the patient's loved ones, staying by their side for long hospital days and carrying the burden of their disease with them. I see her unconfounded work ethic in the patients fighting for their lives, when simple acts of eating, walking, or breathing require all their strength.

I've figured out that seeing death is unavoidable in medicine. However, providing trust for patients and families, building relationships, and caring for them on a deeper level is the heart of medicine. What a privilege it is to witness death, because it means that someone was able to live a life. As I practice medicine and care for my patients, I can only hope to see her in myself.

I can't go back, she tells the moon

Tabor Flickinger, MD

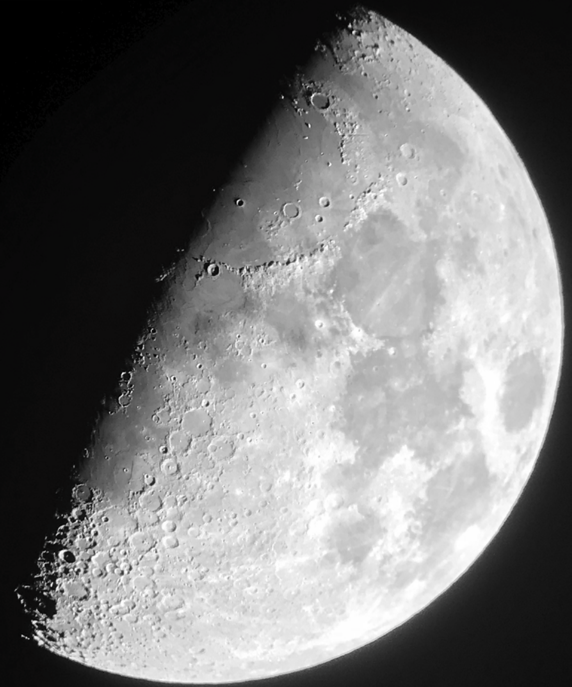
I can't, she says, but she goes
Back to the endless eyes dilated, then drug glazed,
Then fixed: pupils no longer twitching
Tighter when light touches them.

Will our next bodies slip free of apoptosis? Free
from the rip and pull of ravenous entropy? Free
from our recycled masses, borrowed a moment only?

I can't, she says, but she goes
Back to the floor littered with once sterile plastic,
Then slick with blood: always renewed.
As soon as the floor is purged, there's more.

Are we contained within the sharp outlines of our shadows?
Finished when our flesh reclines on slabs of stainless steel?
Or is there an energy beyond equations, beyond these inert eyes?

I can try, she says, as she goes
Back to the night shift, bringing her light and her wish
For more than she sees: her star—almost spent but not quite—
Casts relentless radiance at the dark.



Dr. Flickinger is a clinician-educator and associate professor of internal medicine at the University of Virginia. Her work has appeared in Cordella, Intima, *and* Pulse.

THE MOON
Aidan Perez, Class of 2029

2026

Daniel Van Durme HUMANISM IN MEDICINE ESSAY CONTEST

Sponsored by the Florida State University College of Medicine Chapman Chapter of the Gold Humanism Honor Society, in partnership with ***HEAL: Humanism Evolving through Arts and Literature.***

The essay contest is named in memory of Daniel Van Durme, MD, a professor of family medicine and the senior associate dean for clinical and community affairs at the Florida State University College of Medicine until his death in 2023. Dr. Van Durme was a strong leader in family medicine, global health, patient-centered care, and medical humanism. A long-time advocate and supporter of HEAL, Dr. Van Durme's energy and passion for helping others was an unfaltering inspiration to the entire FSU College of Medicine community.

Entries in this year's contest answered the following question: "Practicing the art of medicine is shaped by our experiences, including encounters that provoke awe, grief, or connection. What influential moment(s) have impacted you, thus guiding the foundation and future application of your practice of medicine?"

One Goodbye, Three Lives, and a calling to Psychiatry

Livia Hochman, Class of 2027

At 11:00 a.m., the operating room felt different. I was in my second rotation of third year, and it was my first time working in the operating rooms. I was still learning how to hold retractors without shaking and forcing away the habit of touching anything non-sterile. That morning, I stood against the wall in green hospital scrubs that still felt like a costume as I watched a team prepare for an organ procurement.

She was twenty-three.

Her name was scribbled on the board with the words "organ harvest" written in dry erase marker. A month ago, she had been found unresponsive from an overdose and despite best attempts, she never awakened. For weeks, her family waited at her bedside in the ICU, hoping for some sign: a squeeze of the hand, a flicker behind closed eyelids. There was nothing. When neurologic testing determined that there was no hope of recovery, the decision was made to donate her organs.

I had seen death before. I had studied it in the slides in pathology and memorized it for exams, but this was different. This was not an abstraction or statistic. This was a young woman with chipped purple nail polish and a hospital bracelet that still had her birthday printed on it.

Before we brought her to the OR, there was an organ walk. The hallway outside the ICU filled quietly with nurses, respiratory therapists, technicians, and physicians. The individuals who had been involved in her care for weeks lined up on both sides. Her stretcher rolled slowly down the hall between them. Her mother placed her hand on her daughter's arm the entire time. Her father walked stiffly, his eyes straight ahead, bracing himself for what was coming.

No one rushed. No one spoke. The only noise was the hum of the wheels and the sound of someone crying softly towards the back. I had prepared myself to study anatomy and learn the technical process of procurement. What I found myself doing was watching a family say goodbye to the physical body of someone they loved, knowing that in a few hours, parts of her would be beating, filtering, detoxifying in three different hospitals across the country.

In the operating room, something occurred that I will never forget. Her mother sat at the head of the bed as we began to remove life support. We played her favorite songs as the sterile room softened. For a moment, it didn't feel like an operating room. It felt like a vigil.

When the ventilator was removed, we waited. There is something profoundly humbling about waiting for a heart to stop beating. The monitor tracked each electrical pulse in real time. Her mother leaned in close, whispering something I couldn't hear. I stood against the wall, trying to calm my breathing. Nothing prepares you for watching the final beats of a twenty-three-year-old's heart while her mother sits inches away.

When the monitor finally went silent, there was a pause, a collective stillness. Her mother kissed her forehead. Then she was gently led out.

In the moments that followed, the mood changed. The surgeons and transplant team rushed in. Three transplant

teams in three different hospitals were preparing recipients. Somewhere else in the country, three patients lay anesthetized, waiting. It struck me then. While we stood in one room saying goodbye, in three other rooms surgeons were preparing to say hello to hope.

Her heart, kidneys, and liver were to be transported by helicopter to three different states. Three different recipients would awaken with a second chance because her family, in the depths of unimaginable grief, chose generosity.

The experience changed something in me. On the surface, it was a surgical milestone. On a deeper level, it forced me to address the human story that led her there. She was twenty-three years old, and she had overdosed. That detail stuck with me.

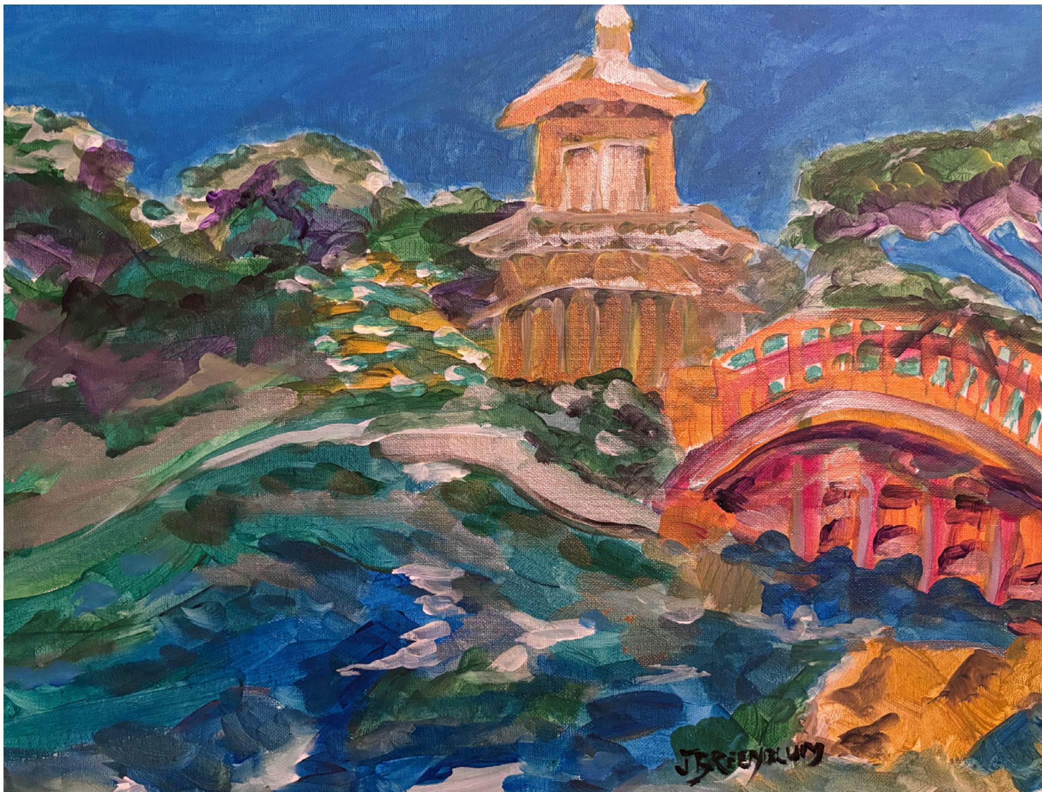
I kept thinking about what preceded the overdose and what were the silent struggles that existed long before the ICU lights and ventilator alarms became reality. I thought about the moments when intervention might have altered her trajectory. Standing in that operating room, I realized that while surgeons were restoring life downstream, I felt called to work upstream.

The art of medicine is not simply the suturing of vessels or transplanting of organs. It is the recognition of the silent struggles patients have been fighting long before they come to us in crisis. Watching her organs save lives was extraordinary. Watching her mother sit with her as her favorite songs played and her heart slowed to its final beat was life changing.

Their grief was quiet and devastating. It is in this silence, however, that I have understood the privilege of being invited into someone's most vulnerable moments. That day strengthened my desire to pursue psychiatry. Some people assume psychiatry is removed from the urgency of operating rooms. I see it differently. The brain, the organ that suffered irreversibly in her case, is the seat of hope, pain, memory, and identity. Practicing psychiatry is to act before the silence becomes deadly. It is to be with patients in places that are unbearable and to help them find language for what feels unspeakable.

I can't change what happened to her. But I can spend my career with the patients who are still within reach, like the college student quietly spiraling, the young adult numbing pain with substances, or the teenager who believes no one would understand.

At 11:00 a.m. that morning, as music played softly in a sterile room and a mother said goodbye, I began to understand the physician I hope to become. I will be one who remembers that behind every chart is a life, behind every diagnosis is a story, and behind every crisis is an opportunity to intervene sooner, with compassion. That understanding now forms the foundation of how I will practice medicine.



TRANQUIL LOTUS POND
Jesse Greenblum, MD

ABOVE THE CAMPFIRE
Sihini Atalugama, Class of 2029

the PASSENGER SEAT

Shelby Beck, PA Class of 2026

My first real patient as a clinical year student was not in a hospital or a clinic exam room. She was in the passenger seat of my car, adjusting her oxygen tubing and asking me to change the radio station. "Put on Taylor Swift," she said, as she always did. This was my nana. Two months ago, she was diagnosed with metastatic lung cancer. I started my clinical rotations that same month.

Almost overnight, my worlds began to overlap—medicine in training and medicine in life. From 4 a.m.-12 p.m., I was in clinical rotations on the psychiatry unit, learning medicine through real patients and real complexity. By 1 p.m., I was driving to my nana's house and taking her to pulmonary rehab. In the hospital, I could move in and out of patient encounters as part of my role. With her, there was no such separation. She never wanted to talk about her cancer. She wanted to talk about her grandchildren, her new favorite Hallmark movies, and the New York Yankees.

Most drives followed the same pattern. I would ask how she was feeling, she would answer briefly, then redirect the conversation. Always to Taylor Swift—lyrics, songs, concerts she would never attend but loved to imagine. At first, I assumed she was avoiding reality, but sitting with that pattern over time, I realized it was something else. She was choosing where illness did and did not get to exist. In medical spaces, her identity was narrow: patient, diagnosis, chart, rehab appointment, oxygen requirement. Those spaces were necessary, but they were also consuming. The car rides created a boundary. They were one of the few places where illness was not allowed to dominate the narrative. In that space, she was not being managed or monitored, and she was simply herself. That distinction changed how I understood healing.

Throughout my clinical experience, I have found that healing is often tied to measurable change—better labs, imaging, function, outcomes. Progress that can be documented and charted. But metastatic disease does not follow that logic. There is no upward trajectory to track, no recovery curve to celebrate. Yet something meaningful was still happening in those ordinary moments. Her disease progressed. Her prognosis did not change. She did not reorganize her life around her diagnosis, and what did remain steady was her sense of self. She continued to make room for the parts of her life that mattered to her, even as her world became smaller.

After pulmonary rehab one afternoon, I took her to the new sourdough pizza place in town. We sat in a small booth, sunlight twinkling through the window, the smell of fresh bread in the air. She studied the menu carefully, like the choice actually mattered. In a way, it did, as it was one of the few decisions in her day that belonged entirely to her. Between bites of pizza, she told me a story I had never heard before. When she was younger, she used to keep coasters with her ex-boyfriends' faces on them. Her friends would tease her when she met someone new and say, "Looks like he's going to end up being one of your coasters." She laughed so hard she almost choked. Nothing about that moment fit the clinical language I was learning. But I understood something important: this was not distraction from illness—rather, it was resistance to being reduced by it. She was carrying her history, her humor,

and her identity forward with her. And in that sense, she was no different from many of the patients I had seen in the psychiatry unit that morning—people who still needed care, structure, and treatment, but also needed to be listened to, understood, and seen as whole.

That lunch forced me to confront a gap in medical education. We are trained to manage disease, but not identity. We are taught how to intervene in bodies, but not how to protect personhood. We learn how to stabilize physiology, but not how to preserve meaning. Healing, I realized, is not only about change. It is about continuity. It is about preserving the parts of a person that illness cannot treat and should not take.

As a student, I am trained to diagnose, treat, and manage disease. That training is structured, systematic, and necessary. But my nana showed me that medicine also operates in quieter dimensions—ones that do not show up in notes or plans. Healing can look like normal routines. Healing can look like choosing what illness is allowed to touch. Sometimes healing is not restoration of health. It is protection of self. Sometimes it sounds like Taylor Swift on the radio and an oxygen tank in the backseat. Sometimes it looks like pizza in a small booth and stories that have nothing to do with cancer. Not because illness has disappeared—but because life has not.

Now, when I walk into patient rooms during clinicals, I hear my nana's voice more than my internal checklist. I still ask the necessary questions and gather the history, following the structure I'm being taught. But I also notice what patients redirect away from. What they return to. What they protect. I pay attention to what they choose to talk about when they're given the space to choose.

She has become my internal compass in clinic. A reminder that before patients are diagnoses, they are people managing how illness fits into their lives. She taught me to look for who someone is before I look for what they have. That is the kind of healing medicine should remember.

The Neonatal Unit on Christmas Eve

Laura Webb

There is no magic in an evening spent
on a sterile ward, having been gifted
the night shift (again). I glance up from charts
to the blue-black sky outside, wishing for
the swell of dawn. It's not even midnight.
In all these years, I've never once spotted
Santa's sled, the swoosh of a shooting star
or a glory of angels overhead.
Just tired eyes counting down to 8 a.m.
and neat rows of cots and incubators,
each patiently awaiting Christmas morn
and a single permitted visitor.

One baby won't settle: Mina. I'm sure
she hadn't been named yesterday. *Mina.*
It's nicer than a number. Or 'Bed 5'
or 'The 27-weeker'. Thick glass
muffles her cries as though underwater.
Her world is this strange primordial box,
being fed and changed by the hands of gods.
I reach inside, feel the fluttering pulse
beneath tissue-thin skin, listen softly
to her chest, touch the fontanelles which run
like deep rivers across her head. These bones
haven't fused into Pangaea just yet.

The cries ebb away and a tiny hand
grasps my thumb, opening a channel with
the world above.

For a long time I linger, entranced by the downy hair,
the miniature fingers, the freckles sprinkled
like grains of sand, the gentle
rise and fall of breath,
the wonder
of Mina.

Dr. Webb is a resident doctor in Brighton, UK, whose work explores themes of illness and healing, folklore and ecology. She co-edits the science poetry journal Consilience *and is studying towards an MA at the Poetry School.*

Listening Beyond the NOiSE

Alexis Kendall, Class of 2026

The first thing I noticed about the patient was her smile. Despite the visible discomfort she was experiencing, her abdomen distended and tender, she greeted me with warmth when I entered the room. Her mother sat beside her; a vigilant guardian whose worried eyes followed my every movement. It was my third week on internal medicine rotation, and I was eager to prove myself, to demonstrate my budding clinical acumen to the attending physicians who seemed to effortlessly navigate the complex landscape of diagnoses and treatments.

“Good morning, I'm the medical student working with the attending physician today,” I introduced myself, clipboard in hand, ready to take a thorough history as I had been taught.

The patient nodded, adjusting herself on the bed. “I've been dealing with this pain for almost two months now. It's getting worse.”

Her medical record was already open on the computer. The emergency department note prominently mentioned “probable alcoholic cirrhosis” and “ascites consistent with liver failure.” Previous encounters documented “alcohol use” and “suspected non-compliance with medical advice.” These clinical breadcrumbs had already formed a narrative before I even met her.

During pre-rounds, my resident casually remarked, “Room 507 is another liver case. Probably end-stage from alcohol.” The team nodded knowingly. When medicine becomes routine, patterns emerge, and with patterns come assumptions. I didn't recognize it then, but I was being inducted into a culture in which efficiency sometimes outpaced curiosity.

As I began my history-taking, I asked about alcohol consumption as it appeared central to her diagnosis.

“I drink socially, maybe a glass of wine at dinner with friends once or twice a month,” she explained, her voice steady. “I know what you're thinking, but I've never been a heavy drinker.”

Her mother interjected, “Her father had problems with alcohol. He passed from cirrhosis ten years ago. But my daughter has always been careful because of that.”

I nodded, making notes, but I could feel doubt creeping in. The resident's words echoed in my mind. Why would her liver be failing if she only drank occasionally? Patients often underreport alcohol use; this was emphasized repeatedly in our lectures. Was she being truthful?

“Any other symptoms besides the abdominal pain and swelling?” I continued, trying to maintain neutrality.

“I've lost weight without trying. About fifteen pounds in the last three months. And I'm always tired. At first, I thought it was just stress from work, but now...,” she gestured to her swollen abdomen.

When I presented to the team, I mentioned her denial of significant alcohol use, but it was met with knowing looks. The attending physician maintained a more professional

stance but still concluded, “Let's proceed with management for alcoholic cirrhosis.”

That evening, I read about liver disease, memorizing the clinical manifestations and treatment approaches. I was determined to be thorough, but I realized later that I was reading selectively, and focusing only on confirming what we already “knew” rather than questioning our premise.

The following morning, everything changed. The radiology report arrived: “Significant ascites with omental thickening and nodularity. Findings concerning peritoneal carcinomatosis. Recommend CT with contrast and gynecological consultation.”

The attending physician frowned, reviewing the images himself. “Order a CA-125,” he instructed, no longer casual but intensely focused.

The CA-125 returned markedly elevated to 1,250 U/mL. Not liver failure. Ovarian cancer.

I remember standing outside the patient's room, paralyzed by the weight of this revelation. How had we missed this? Or rather, why had we not even considered it? The answer was uncomfortable: we had allowed assumptions to guide our clinical reasoning. We saw what we expected to see.

When I entered the room with my attending, the patient must have read our expressions.

“It's not my liver, is it?” she asked quietly.

“No,” the attending physician replied. “We found evidence suggesting ovarian cancer. We'll need to do more tests to confirm and determine the extent.”

Her mother clutched her hand, tears forming. The patient herself remained still, absorbing the information with remarkable composure.

“I knew something wasn't right,” she finally said. “But I didn’t know how to describe it in a way that people would believe me.”

Those words pierced through my professional facade. She had known we didn't believe her. And she had been right.

In the following days, as oncology became involved and treatment plans were developed, I spent extra time with the patient. Not just examining her or reviewing symptoms, but listening, truly listening, to her stories, her fears, her hopes. One conversation particularly stayed with me.

“You know what hurts almost as much as this diagnosis?” she asked me one afternoon. “Feeling dismissed. When you're Black and female, you get used to fighting twice as hard to be heard. But in a hospital, when you're vulnerable and scared, you just hope someone will listen without judgment.”

Her words illuminated the invisible barriers that had shaped her experience and our care. It wasn't just about alcohol or liver disease; it was about who we deemed credible, whose pain we prioritized, whose stories we believed.

As her case unfolded, I learned that she had actually sought medical attention three times in the past six months, each time with worsening symptoms. Each time, her concerns were attributed to weight gain, stress, or suspected alcohol use. Each time, an opportunity for earlier diagnosis was missed.

This realization transformed my approach to medicine. I began to question not just my diagnostic reasoning but the implicit narratives that shaped it. I became acutely aware of how easily biases about race, gender, socioeconomic status, and substance use could infiltrate even the most well-intentioned clinical care.

Before the patient was transferred to oncology, she held my hand and said something I'll never forget: “You're still learning, and this is an important lesson. Remember me when you have another patient whose story doesn't fit in the textbooks.”

Three years into my medical training, I had memorized pathways and mechanisms, mastered the language of disease and treatment. But this patient taught me what no textbook could: that medicine at its core is a human endeavor, vulnerable to human failings, dependent on human connection.

Her case fundamentally altered how I approach clinical reasoning. I now consciously challenge my initial impressions, question the labels in medical records, and remain vigilant against the whispers of bias that can distort clinical judgment. Most importantly, I listen with intention, with humility, and with the awareness that a patient's lived experience is an essential diagnostic tool.

The patient's cancer was already advanced at diagnosis, her prognosis poor. But her impact on my development as a physician was profound and lasting. She reminded me that behind every case is a person whose dignity and truth matter as much as their pathology. In teaching me to see beyond the whispers, she helped me become the kind of doctor I truly aspire to be.

AMERICAN ALPS
Natalie Rubio, Class of 2029

3RD PLACE | Daniel Van Durme Humanism in Medicine Essay Contest

A Grammar of Care

Vrutti Patel, Class of 2028

There is a kind of knowledge that does not live in textbooks. It does not announce itself in lectures or arrive with a diploma. It is seen slowly, through the pores of experience.

Growing up in a small town means learning that the body is a gamble. It means learning it from the man who drove forty-five minutes to the nearest emergency room to treat his chest pain and arrived too late for the window that might have saved him. It means learning it from the elderly woman three streets over who was treated for her infection by a general practitioner doing the work of four specialists because there were no specialists, not within reasonable reach. It means learning it from waiting rooms where the staff are so stretched that they have become efficient in ways that have quietly eliminated the unhurried aspects of medicine. It means learning that medicine is not distributed equally. That geography is also a diagnosis. That where you are born quietly decides what you are given.

I did not have language for this as a child. I only had the feeling of persistent unease that something was structurally wrong with the gap between suffering and its remedy. That unease never resolved. Over time, it simply found a more useful shape. Years later, working as a medical scribe in an emergency room, I met urgency again, but this time from the inside of it.

There was one night when a man came in with his left arm pressed to his chest as if he were holding something he was afraid he'd lose. He was an old man, perhaps sixty years-old, the sort of man who looked as though he never needed anyone's help in his life and who now found it degrading to need it. "Any chest pain?" she asked him. A pause. "Some." The physician drew her stool in instead of standing over him and she let the pauses exist. When he said, without her asking him to, "I've been ignoring it for three weeks because I've had to go to work," something changed in the room. Not dramatically. Quietly. She wrote something down in his chart and first put her pen down before saying, "I'm glad you came in tonight."

Six words. I entered them in the chart because they were medical in their own way, the kind of medicine that heals shame as well as the symptom. Observing all of this, I learned that the practice of medicine is not just what is ordered, what is charted. The practice of medicine is also what is chosen.

Hospice taught me a different grammar. In the emergency room, there had been the electricity of intervention, the body that could be pulled back, saved. In hospice, there was the grammar of acceptance. Not the grammar of defeat. Acceptance. There is a difference, and it took time in the corridors to understand it.

I remember a woman whose room always smelled of lavender, a small sachet her daughter pinned above the bed, the kind of detail that has nothing to do with clinical care and everything to do with it. The daughter visited every afternoon and talked to her mother, not at her, not past her, but to her, in the belief that the act of being heard has little to do with the ability to respond. One afternoon, the attending physician entered the room for what I had thought would be a routine examination. Instead, she sat down fully, as if she had nowhere else to be, and inquired of the daughter how she was sleeping. Whether she had anyone at home. The daughter looked surprised, the way people sometimes look when the act of being inquired about is like a foreign language to them. Then she breathed, long and slow, and said, “Not very well.” The physician nodded, using no clinical language and no language of referral. She simply nodded and said, “That makes sense.” And stayed.

What that physician did in staying wasn't in any protocol. It was a decision, one made quietly, in a space where no one kept score. And it was, I understood then, entirely the point. Now I sit in lecture halls and carry all of this with me, the neighbor who drove forty-five minutes too late, the man who suffered in silence for three weeks, the sachet of lavender hung over a woman's bed to die. These aren't clinical memories. They are moral ones. The reason that the knowledge building inside me has somewhere to go.

I am still becoming. Becoming is not a waiting room with a space you occupy until the real work of the day begins. Becoming is the work, the daily work of paying attention, of being present, of allowing what you see to actually register. Medicine called to me through a series of rooms, each of which I found myself standing in, watching, absorbing, storing. A small town, resources depleted before the town's needs were even clear. An emergency room, the pre-dawn hours, the quiet urgency of the space. A hospice corridor, thick with the scent of lavender, of endings, of the grace of those who had chosen to stay. I am a student, a student of the space between, the space that as a child, I first noticed, between a person in pain and the care that should already be waiting for them. It is a space that, to date, I have not closed. It is a space that, to date, I have only become more precisely aware of each year, of the size of the space, and of the reason for its existence. The waiting taught me that. I intend to spend the rest of my career answering it.

When the Unit Holds Its Breath

Devina Wadhwa, MD

The call breaks the rhythm
of the unit—
Code Blue—
a voice not meant
for this floor.

We are trained
to sit with agitation,
to slow the room,
to notice breath.

This is different.

Chairs are pushed back.
Someone reaches for gloves.
Someone else freezes,
already counting.

Patients watch
from doorways left ajar,
from couches worn smooth
by waiting.
They are experts in fear.
They recognize it immediately.

The code gathers us
into a shape we did not choose—
hands moving where words fail,
time narrowing
to what can still be done.

Later, the unit exhales.

The carts return.
The doors close softly.

Group resumes,
though no one names
what has passed between us—
how the boundary between care and collapse
thinned without warning.

Psychiatry teaches
that pain can be spoken,
that safety can be built,
that minds can be held.

The code teaches something else:
that those who hold others
are also held together
by fragile breath,
that trauma does not check credentials,
that healing spaces are still human ones.

The patients know this.
We do too.

Dr. Wadhwa is a psychiatrist working in rural and remote Canada, a certified yoga teacher, and a photographer. Her writing explores grief, presence, and the unseen emotional landscapes of both patients and physicians.