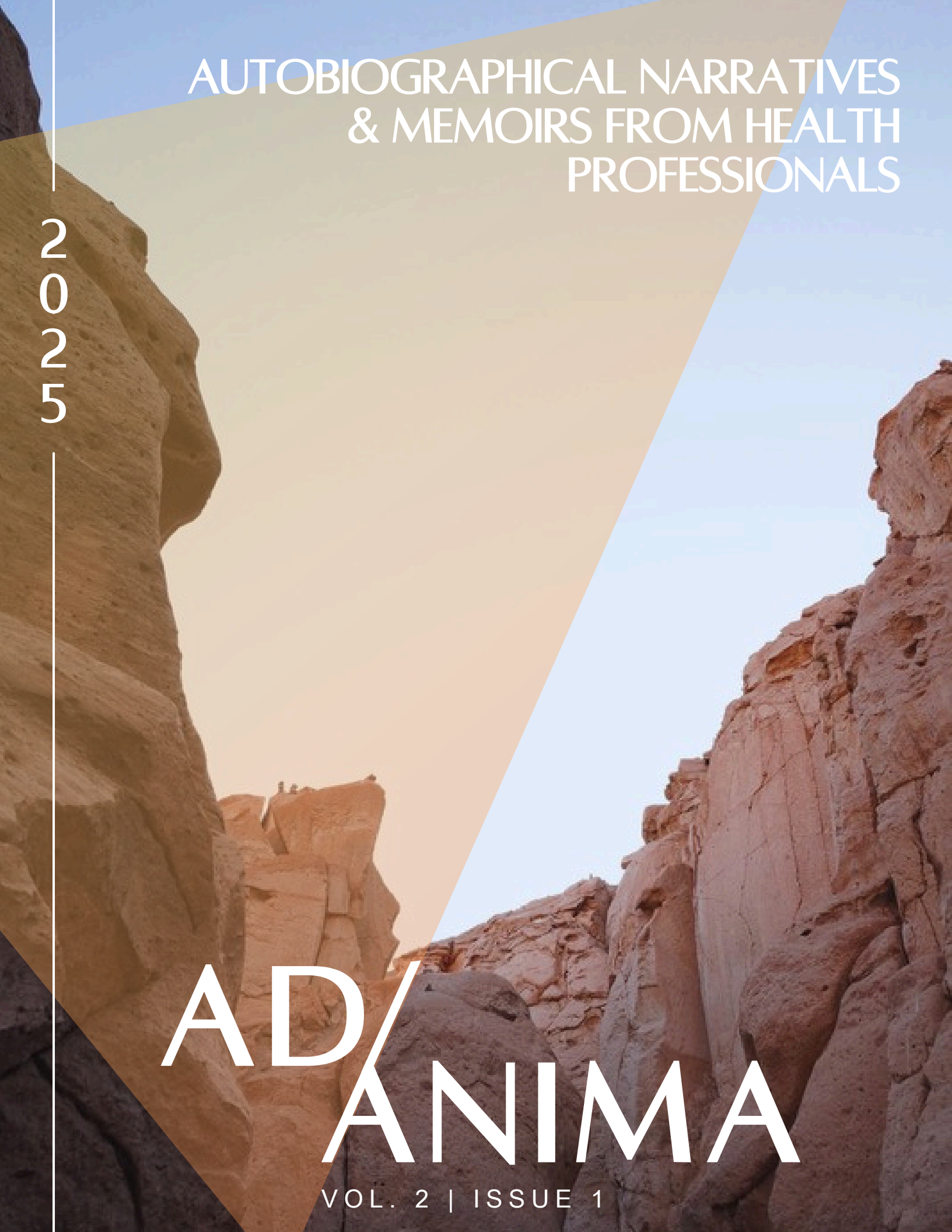

AUTOBIOGRAPHICAL NARRATIVES & MEMOIRS FROM HEALTH PROFESSIONALS

2025

AD/ANIMA

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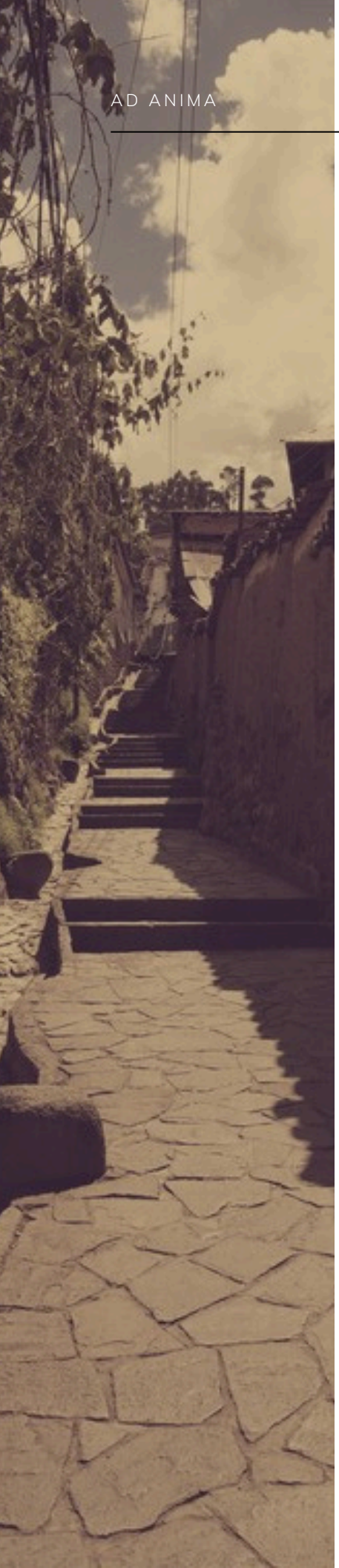


LETTER FROM THE EDITORS

As Ad Anima enters its sophomore year, it has become more than a snapshot; it has become a legacy, canonized by the passion of its contributors and dedication of its editorial and design team. Just as this journal has endured, so too does art in medicine.

Ad Anima is the testament, proof that despite the busy schedules of its contributors, passion still takes root—and *flourishes*. It's proof that, even when faced with the gruel and frustration of today's healthcare climate, where medical information abounds and being a provider demands more sacrifice than ever, our practitioners can look at medicine and see something more: poetry, prose, color, *art*.

These three narratives were not the only ones to land on our desk. We remain astounded at the breadth and depth of the healthcare experience, with pieces coming from all along the spectrum, from trainee to veteran. The final pieces were chosen to represent the vastness of what we consider the "art of medicine." We are beyond excited to be able to share them with you.

Sincerely,
Vanessa Le and Zohal Noori
Editors-in-Chief

We would like to extend our sincerest thanks to the University of California, Irvine, and especially Juliet McMullin, for their continuing support. Additionally, Ad Anima would not be possible without the tireless work of its editors, media managers, and designers. Thank you.

Ad Anima

WHO WE ARE

EDITORS-IN-CHIEF

ZOHAL NOORI

Zohal Noori is a recent UCI graduate with a degree in human biology and a passion for medical humanities and writing. She works as a medical assistant and research lab assistant while volunteering for a free clinic. In her free time, she teaches Taekwondo, practices Pilates, paints with acrylic, and enjoys Persian poetry.

VANESSA LE

Vanessa Le is a third-year medical student at UCISOM and a Forbes 30 Under 30 author of medical fantasy. She comes from Washington State and attended Brown University, where she studied Human Biology. In her free time, she enjoys gaming, writing, and especially sleeping.

MAI-LINH TON

Mai-Linh Ton, Ph.D. is an Orange County native and third-year medical student at University of California, Irvine. She enjoys combining science and art as a double major in Human Developmental and Regenerative Biology & Animation from Harvard University. She worked as a Designer at The Harvard Crimson, the undergraduate student newspaper. She became interested in narratives within medicine while completing her PhD at the University of Cambridge during the COVID pandemic. She enjoys oil painting, photography, animation, graphic design, video games, snowboarding, and rock climbing.

AMANDA TRAN

Lead Designer Amanda Tran is a second year Pharmaceutical Sciences major, but also is an avid bookworm (despite never finding time to read), a fan of anime (with too many animes on an ever growing yet to watch list), and someone with a strong sense of humor (though everyone else is probably getting tired of the hundreds of dad jokes and constant rickrolling). Before joining Ad Amina, Amanda was Editor-in-Chief of Citrus Valley High School's yearbook team, getting involved in learning about people through their experiences and becoming devoted to accurately sharing and celebrating their stories (all while crying over deadlines). Joining Ad Amina was a way to relive those days while also getting involved with the healthcare community that Amanda hopes to join after completing the Pharmaceutical Sciences major (even if it means crying through even more deadlines).

ESTHER CHOI

Esther is an MS2 at UCI. Born in Los Angeles, she is interested in the relationship between healthcare and communities and how individual narratives are shaped by this context. Esther enjoys rediscovering Southern California as an adult, finding excuses to spend time with friends and family, and eating frozen yogurt. She is currently reading *The Brothers Karamazov*.

KAYLYN MATTICK

Kaylyn is a fourth-year medical student at the University of California, Irvine. She holds a Bachelor of Arts in Global Liberal Studies and French from New York University. She is deeply interested in the overlap between the humanities, story-telling, and medicine. In her free time, Kaylyn enjoys reading, creative writing competitions, cooking for friends, playing tennis, and attempting to train her two dachshunds.

RAJEEV DUTTA

Raj is a 4th year M.D.-Ph.D. student. Since completing his Ph.D. in philosophy, he has become interested in rare and undiagnosed diseases, particularly with a neurological focus. In his spare time, he reads, loses at chess, and plays jazz piano poorly.

ZOE ADAMS

Zoe Adams is a current third year medical student at UC Irvine School of Medicine. She attended UC Berkeley for her undergraduate education, where she majored in Molecular and Cell Biology and minored in English. Zoe has always had a passion for writing, both as a writer and editor. She is excited to be able to contributed to the journal of Ad Anima and can't wait for others to enjoy these wonderful stories.

RHEA GANDHI

Rhea Gandhi is a second year medical student at UCI. She is interested in women’s health, socioeconomic determinants of health, and their relationship. She enjoys exploring different fields of medicine, especially within the OR, and partaking in research. In her free time, she loves to run, draw, paint, and read.

ALISON LAWRENCE

Alison is a third year medical student currently interested in the fields of emergency medicine and internal medicine. She is also involved in multiple interest groups on campus and serves as a director of academic tutoring services for medical students. In her spare time, she loves to write poetry, rock climb, and backpack in the nearby national forests!

ARASH KHANGHOLI

Arash Khangholi is a 2nd year medical student at the University of California, Irvine. He is a non-traditional student from the medically underserved Inland Empire county of Southern California. During his gap years between undergraduate and medical school, Arash lost his godmother to an aggressive form of bone cancer. During this time, he frequently heard the dangers of metastasis to the liver. For this reason, Arash joined the Tomasi Lab at Cedars-Sinai's Gastroenterology Division. Despite the lengthy commute and meticulous work, Arash sought to contribute to the next generation of therapies for hepatic diseases. As Arash considered a path through research, he noticed that his favorite part of the days at research were the conversations he shared with patients during his lunches or walks.
In honor of the patients Arash met at Cedars-Sinai, he pursued more clinical exposure as a family medicine scribe in his hometown. This fostered his current passion for addressing the needs of vulnerable patient populations. For this reason, he is a volunteer medical student for the student-led Crescent free clinic in Anaheim. Arash is also interested in passing it forward to the next generation of student doctors as Crescent Clinic's mentorship co-chair. Through this role he leads workshops ranging from EKG analysis to medical school application tips for the clinic's undergraduate volunteers.

RILEY SCHERR

Riley Scherr is a fourth year medical student at UCI applying into internal medicine, with an interest in pulmonology/critical care. His interest in medical writing began in college as an anthropology major, and he currently uses poetry to process his days at the hospital. In his free time, he enjoys exercising, reading, and being in the ocean.

HERSCHEL UCHITEL

S. Herschel Uchitel is a third-year medical student at the University of California-Irvine School of Medicine. It is his second year on the Ad Anima editorial board. Prior to being a medical student, he worked as a teacher and as a baker. His clinical interests include full-scope primary care, sexual health, and end-of-life care. When he is not studying, you can find him hiking, road-tripping, reading, cross stitching, or collecting miniature objects.

JANET NGUYEN

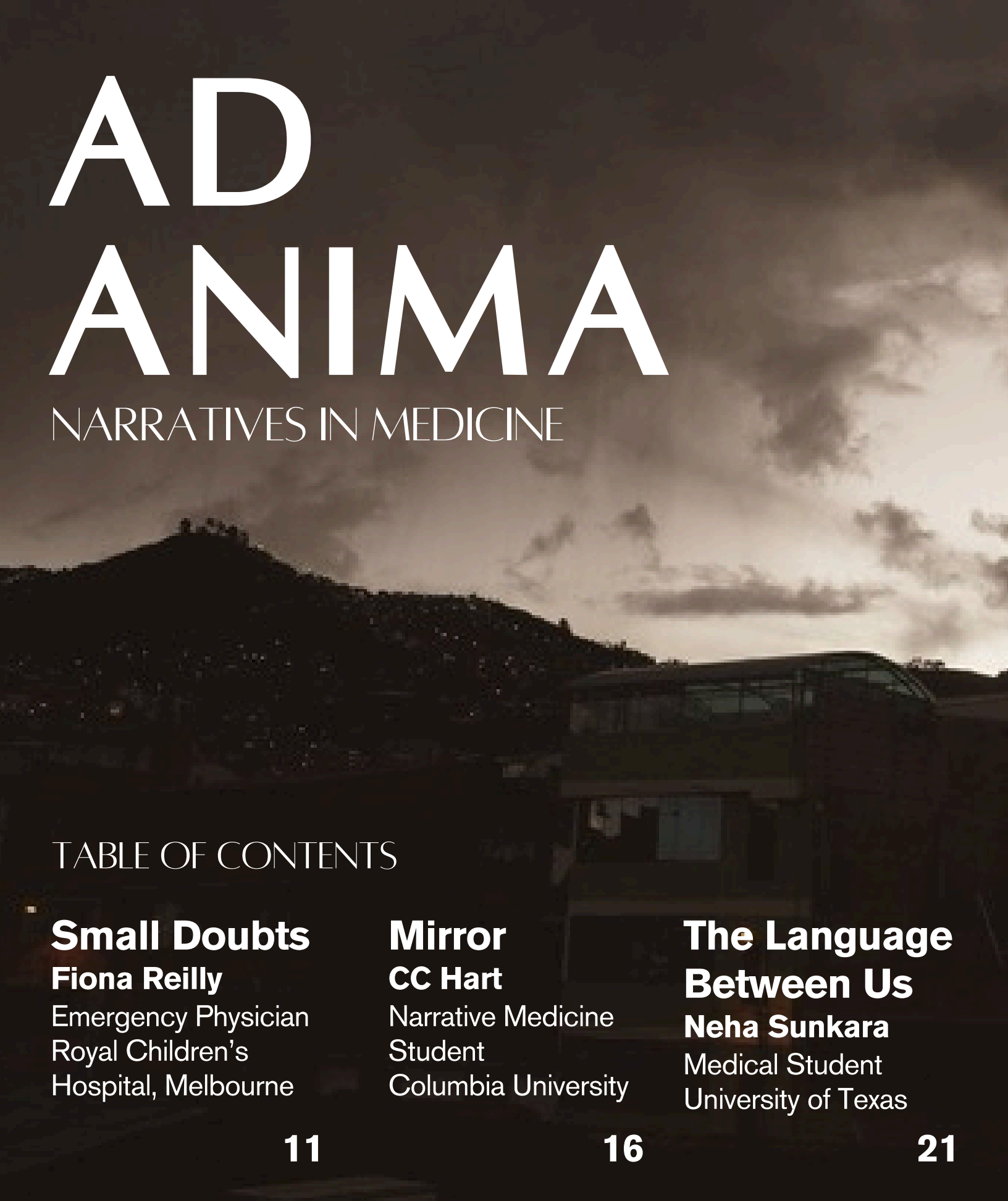
Janet Nguyen is a 4th year medical student at UCISOM. She is from San Jose and completed her undergraduate education at UCLA. Outside of medicine, she enjoys trying new restaurants, cafes, occasionally traveling, and spending time with her cat.

PIROOZ FEREYDOUNI

Pirooz Fereydouni is a second-year medical student at UC Irvine School of Medicine. He is interested in researching pain, specifically focusing on chronic back pain, and is also passionate about medical education and mentorship. His research interests are causes, management, and treatment of chronic back pain, as well as AI implementation in healthcare and medical education. Pirooz is originally from Shiraz, Iran, and grew up there until he emigrated to the US at the age of 14. He lived in the Bay Area (Walnut Creek, Berkeley, and San Francisco) for 9 years before moving to Irvine. He graduated from UC Berkeley, majoring in Molecular and Cell Biology in 2021. He then worked as a clinical research coordinator at UC San Francisco for an NIH-funded chronic low back pain study before starting medical school. In his free time, Pirooz enjoys brewing coffee, photography (portrait, landscape, and astro), camping, and stargazing.

AD ANIMA

NARRATIVES IN MEDICINE



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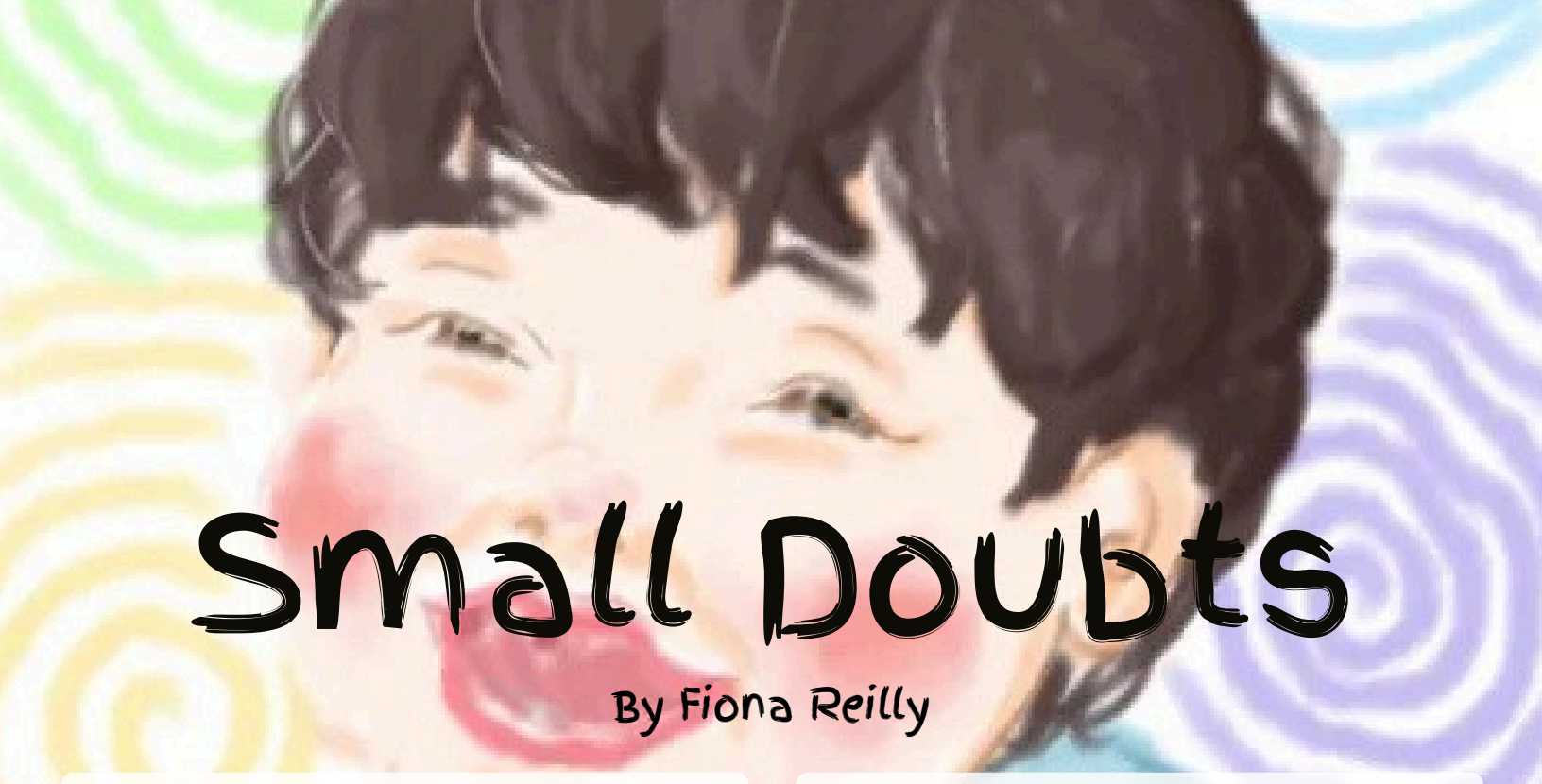

Small Doubts

By Fiona Reilly

The question is, how does a baby manage to break his arm like that? The baby, with trusting eyes and dark swirls of soft hair on his eleven-month-old head, seems less bothered than he should be that two of his three arm bones are broken. His mother says he overbalanced while grabbing the edge of the coffee table the day before. At least, this is the account given to her by the baby's uncle, who was looking after him at the time. She also says the baby can't yet walk but likes to pull himself up on the edges of things—the coffee table, the sofa, their bed. He stands there, excited by his new-found strength and higher-up view.

His mother stands quite still in the consult room, almost too still, her T-shirt tucked neatly into her jeans. The father, slight and serious, seems genuinely puzzled to find himself in the emergency department on a weekday morning. The X-ray of their baby's arm looms on the screen behind us, labelled with the baby's particulars and a large white R for right arm. Even from the other side of the room, even without a medical background, the break in the radius and the ulna is obvious, like a pair of candy cigarettes snapped in two. As their doctor, I choose each word carefully. "The fracture in your baby's arm is not fully explained by the way he fell," I say. Sometimes it's better to let the statement hang in the air and see what seeps through the cracks.

The father is trying to fathom what I mean. He blinks and nods. "When you say...not fully explained?" The question dangles.

I hesitate before answering. "It's unusual for a baby to fracture their arm in the way that's been described."

The way that's been described is this: The day before while both his parents were at work, the baby fell over in the playroom. A run-of-the-mill, twenty-times-a-day kind of fall. According to the uncle, he was hanging

onto the coffee table, balancing well. The uncle went to the bathroom. He heard crying and came back to find the baby lying on the rug, his arms to the side. He thought nothing of it; after all, it was a twenty-times-a day fall, cushioned by the plush rug, a nappy, and two layers of pants. When the parents came home from work, they found the uncle carrying the baby because the baby was crying a lot. The mother, thinking he wanted comfort, took him from the uncle's arms, but this made him scream. It took a while to figure out that his right arm was the problem, and by then it was too late to see a doctor. The baby screamed again that morning when they tried to dress him, so they brought him to the emergency department.

The father frowns as it sinks in; the mother's face remains unreadable. The uncle, her brother, has recently arrived home from overseas and offered to help with babysitting in return for staying with them.

"Can I speak directly with your brother?" I ask her. "To understand better what happened."

I'm told his phone is off, or broken; right now they can't seem to reach him. "He's probably on his way to the hospital," the mother offers.

The baby, meanwhile, is lying on the giant hospital bed between us. He kicks both legs, looks at me and smiles, and I remember he's not an exhibit to be pondered, but a living human child.

Other than not moving his right arm much, the baby seems to be enjoying the attention, looking from one of us to the other. It would be helpful if he could tell us what happened, but he can't.

Babies have limited ability to injure themselves—they're simply not strong or coordinated enough. They can roll off beds or change tables (from five months onwards) and fall time and again as they learn to walk, although this rarely results in significant injury. Sometimes the clue is in the injury itself, asking us to pay attention, to notice a divergence from the usual pattern. There are patterns to everything, including children's injuries. Nothing is random. If you're a ten-year-old who bounces off a trampoline onto the ground, you'll have a supracondylar fracture of your lower humerus, Gartland II-III. If you're three years old and the same ten-year-old double-bounces you on the trampoline, you'll have a fracture of your upper tibia. If you're a six-year-old in the back seat of a car, wearing a seatbelt, and you hit a power pole at high speed, you'll have seatbelt injuries to your collarbone and might also have internal injuries to your liver, pancreas, and small intestine where the seatbelt presses in as your small body is flung forward.

Babies are surprisingly resilient and pliable. It takes considerable force to fracture a pair of forearm bones. Not the kind of force that occurs by overbalancing or getting your arm twisted in your cot. More like the kind of force when a person of adult size steps on your forearm. Or a person of adult size throws you against a wall, or the floor.

Earlier, I'd left the baby with his parents to go somewhere I could think without being disturbed. In our emergency department, it's a storeroom too small to be converted into another patient cubicle. I call my colleague Mariam. "Meet me in The Cupboard? Just want to run something past you."

Mariam looks at the X-ray with me, her face intense with concentration. Nothing gets past her; nothing phases her. "Hmm. How did they say it happened?"

I tell her. Overbalanced from standing height onto a plush rug. Lying on his back, arms to the side. Crying when his arm is moved but not inconsolable.

"This fracture makes perfect sense for a seven-year-old falling off monkey bars, or an eleven-year-old at soccer where the big kid on the team lands heavily on your arm," she says.

I nod slowly. I don't want to pre-empt her. "Doesn't fit, does it?" she says finally. "Very unlikely to have happened to an eleven-month-old from that mechanism of injury. What do you think?"

"Same as you," I say.

She nods, pleased we agree. "Well, it's good to share the burden of these decisions. Talked to Child Protection yet?"

“Not yet,” I reply.

“And the uncle?”

“Uncontactable.”

“’Course he is,” she says.

We’re trained to look harder for certain injuries. A pattern of bruises like fingerprints, grabbing a baby’s face or arm. A single bruise behind the curve of the ear, caused by a whack. A bruise on the inside of the upper lip from a hard hand across the mouth. Bruises of different ages, or bruises in places that don’t make sense, like the small curve of a baby’s back. Sometimes the injury turns out to be the latest in a series of plausible injuries, but too many of them. Sometimes the injury comes with a plausible story. I ask for the story to be repeated, at different times, believing I can hear the ring of truth. It sounds clear, doesn’t it? I try to uncover blind spots in my assessments. Neglected babies are more likely to suffer physical abuse, but the absence of signs of neglect offers no guarantee against it. I try to keep an open mind. As Mariam often says, people with more education tend to make better liars. I try to take everything into consideration, but the waters are almost always muddy. On the one hand, an unexplained injury. On the other hand, a child protection notification, a weight, a stigma, a seed of doubt, a lot of questions.

Except in very clear-cut cases with reliable witnesses, there are many steps and many hours of thought and worry between a child’s serious injury and an adult being charged with assault and child abuse. The next step is to fix the baby’s fracture but also search this child’s skeleton for signs this has happened before. There is an outside possibility of brittle bone disease, although there’s no family history. I admit him to hospital, so that the social worker can observe the dynamics between parent and child, between parent and parent, and interview the baby’s uncle, if he ever appears. If the bone scan shows other, older, fractures, the baby might be removed from the care of his parents while an investigation takes place. There is the possibility of a permanent child protection notification, like a red flag over the family, and many steps and months ahead, there is the possibility of the uncle being charged. The only thing I am certain about is this: there will be the development of an enveloping and suffocating anxiety, a sense of never being able to trust anyone with your child again. I weigh each of these in my mind. The decision to take this step burdens me, fills me with doubt. What if I’m wrong and this family is subjected to unnecessary scrutiny and judgement? What if I’m right?

- -

“What’s the worst-case scenario?” the mother asks. I don’t tell her the worst-case scenario. I tell her the version of the worst-case scenario that I think she can bear at this time. “He’ll need a general anaesthetic to straighten the bones, and six weeks in a

plaster cast. He'll also need some other bone scans and tests." The father nods slowly. The mother begins to cry.

I think instead about the best-case scenario, the one where the baby's uncle suddenly appears and confesses that, entirely against the parents' instructions, he let the baby sit on the high kitchen bench, because he looked so cute up there. And he turned away for only a second, but that was enough. That he felt intensely guilty, but he didn't really think there would be a fracture.

In my experience of thirty years, the best-case scenario has never happened.

- -

As for the baby, the sweet dark-haired baby with the badly broken arm, I am forced to accept that I may never know the truth of what happened. Being a paediatric emergency doctor is to spend many hours awake in the middle of the night, wondering if you foretold the signs that might prevent a future serious injury or death, or wrongly suspected an innocent parent. There is only the murkiness of the situation and my realization that there are many bad options.

The baby might return to a home where he is mistreated, injured, or killed. The baby might be taken from a home where his parents are loving and kind. The baby's home is where a seed of doubt now lives, mistrust growing into the floorboards, rotting away the foundations until one day the house collapses. Maybe his father stops working to watch the uncle when he's with the child. Maybe his mother does. Maybe it was an accident, a true accident, but the story of the accident is never revealed. Could it have been a fall from a table or bench when this had been expressly forbidden by the parents? Or his uncle's playful toss into the air, a sudden distraction, a stumble, a missed catch?

As I watch the baby and his parents leave the emergency department for the ward, I sit with the discomfort and doubt. It never leaves me.

Mirror

By CC Hart

For her January birthday, I gave Ruth a heart-shaped brooch paved with scarlet crystals. My neighborhood boutique had two of these, one larger, one smaller. I chose the smaller, which seemed less weighty should Ruth wish to wear it tacked to her hospital gown. “A heart for your heart," I told her. “A gift and good-luck charm rolled into one.”

Ruth didn’t believe in amulets, but she did trust in the expertise of her cardiologist. He’d diagnosed her with aortic stenosis and recommended surgery to replace her stiffened valves, a risky yet necessary procedure. Ruth trusted my expertise as well. I’d been her massage therapist for over a decade. Every Thursday evening, my fingers foraged for taut muscles in Ruth’s cranky lower back, soothing her discomfort with a combination of soft-tissue mobilization and passive stretches.

Like all healthcare professions, dual relationships are frowned upon between licensed massage therapists and their clients. But Ruth and I had an instant affinity for each other and a fondness that was nurtured by my many visits to her home, with its mid-century furniture and overflowing bookshelves. During these weekly visits, we swapped novels and then critiqued them together. We loved San Francisco’s foggy summers, hated the crowded 38 Geary bus, and felt deeply connected to our ethnic identities. I playfully referred to Ruth as the Jewish mother I’d never had, and I was her girleen, Ruth’s only Irish-American child. While my own mother was older than Ruth, they had similarly fixed views of the world. They were no-nonsense Silent Generation women: cautious, conservative, and skeptical. And they were both lonely in their latter years.

“Come see me at Saint Mary’s,” Ruth said at the end of our last appointment. “I should be okay to have visitors a few days after my surgery.”

“Of course!” I told her. “Cross my heart…I’ll be there!” I promised I would see Ruth at the hospital as soon as she was permitted guests. At that moment, I believed I was making a truthful statement, that she could count on me for companionship during her recovery. I thought I could manage the dull ache in my arm that would pulse when I saw the IV needle nestled into her vein, thought I could breathe through the stinging pain that would shoot down my legs at the sight of the bandages on her chest from the open-heart procedure. After all, I’d learned the term *mirror-sensory synesthesia* a few years before, and I’d become a minor expert at documenting the conflated perceptions that make me feel other people’s bodies as if they are my own. I’d been the subject of university studies focused on physiological models for mirror neurons and vicarious pain, and my own findings on the topic had been published in a peer-reviewed scientific journal. I’d also surrounded myself with the friendship of fellow neurodivergents, some of whom had similar sensory experiences and who could support me as I navigated the fraught environment of the Cardiac Care Unit.

I couldn’t get myself to visit Ruth in the days directly after her surgery. However, when I learned she’d been transferred to a skilled nursing facility, I returned to the boutique and bought the larger heart brooch. I would bring it to Ruth for Valentine’s Day, hoping I could make the gift a peace offering of sorts and a consolation for my delayed visit. But once again, even with ample time blocked off in my schedule, and with RUTH written in large block letters on my calendar, I faltered.

A few weeks later, on a rainy March morning, I baked Irish soda bread from a recipe my mother taught me, packing it into a wicker basket with a jar of homemade lemon curd. I called Ruth’s youngest daughter and apologized for my absence, fibbing about how busy I’d been.

“She’s back home now," Anna said. “Mom keeps asking when you’re coming…”

“I’m taking Friday off,” I told Anna. “It’s Saint Patrick’s Day. Tell your mom I’ll drop by before noon.”

But the bread went stale as I lay in bed that day thinking of my great-grandfather Thomas, an emigrant from Kerry who’d been trampled as he swept the streets of Springfield, Massachusetts. I pictured him run over by the draft horses and ice wagon, his legs so mangled amputation was the only option. Even this envisioned injury, so distant in the past, sent shocks of pain down my legs and a fierce arc of electricity across my chest. The wrongful death settlement from that accident sent my grandmother to nursing college. Her RN salary sent her own daughter, my mother, to the same school. My older sister was a nurse as well, working as an organ transplant coordinator at a large urban hospital. All three of these family members were capable of caring for dozens of patients every day, yet I couldn’t drag myself out the door to see a person I adored who, while slow to recover, no longer bore the dressings of her medical procedures.

I am not afraid of illness, nor am I squeamish at the sight of blood. I'm quite the opposite: curious about pathophysiology and fascinated with human anatomy and biomechanics. This scientific interest has supported my long career in manual therapy and fostered my commitment to evidence-based practices. Still, I get psychosocially sabotaged by the convergence of my vision, my mirror neurons, and my skin. When I witness a person with a cut above their left eyebrow, I will feel a pang above my right eyebrow, as if I am looking at a mirror. Simultaneously, I will feel a burst of scintillating pain that travels across my skin, coursing from my sacrum to my heels, following the path of my dermatomes. If the injuries I see are extensive, those fiery bolts also wrap around my arms and across my torso. Although I've never been jabbed by a cattle prod, it seems analogous to my experiences viewing other people's bodies. Mirror-sensory synesthesia is my very own aversion therapy, making it almost impossible for me to be in the presence of wounded people, even when that body trauma is caused by a life-saving surgical procedure.

Just before Passover, Ruth returned to the hospital. Her heart wasn't healing as expected, and her blood pressure was unstable. There was grave concern that she was too weak to walk and that this inactivity would lead to muscular atrophy, further complicating her fragile condition. Through a mutual friend, I learned that her two older daughters and only son were visiting from New York. I consoled myself with the knowledge that Ruth's biological family was far more important during these difficult days than my lapsed friendship. And, I would be sure to see Ruth in a few weeks, for Mother's Day. Perhaps she would be home again. I could bring pink peonies, her favorite flowers, gift her a mini-massage, and maybe even help with her physical therapy exercises.

I did not see Ruth on that second Sunday in May. Throughout June, she bounced from Saint Mary's to an acute care rehab, to her home, then back to the hospital. By the time Independence Day arrived, I knew better than to trick myself into believing I would show up with sparklers and a strawberry shortcake. For months, I had tried to convince myself that I could subvert my neurocognitive differences and the social miscues they foster by adorning my visit in the trappings of holiday cheer. This strategy backfired and left me bereft, certain that I had never deserved Ruth's affection.

In the early autumn, I called Anna, intending to get an update. Instead, I outed myself. "It sounds like I'm making this up," I said. "I have physical pain when I see other people's injuries. I've been like this my entire life." I told Anna about my mirror-sensory synesthesia, my neurodiversity advocacy, and the nonprofit organization I founded with a group of fellow synesthetes and researchers. I also revealed to Anna that I'd never told my own mother about my sensory differences. "It's difficult for me to talk about; I'm an outlier...not the only one, though. There are other people like me

in this world, but still...I feel like a fraud." Anna let out a slow breath that almost sounded like a sob. "You know, that's exactly what Mom says about my migraines. She thinks I'm faking it, that I should suck it up and get over myself." Anna worked for Ruth's real estate business and felt daunted when she needed to call in sick. "It's debilitating...I try to work even when I'm hurting and can barely see...just to keep my mother happy. But I'm furious. She doesn't believe my migraines are real. She thinks that they're no different than an ordinary headache."

Talking with Anna helped me uncover a source of my frustration with my mirror-sensory synesthesia; I fear the facts of my neurocognitive world come across as confabulation. I'm afraid to witness other people's injuries because I hate the physical sensations that come with my synesthetic phenomena, and I'm terrified nobody will believe it's really happening. I get so caught up in this conundrum that my best intentions get thrown under the bus by the truth of my nonconforming brain.

I do my best to counter this cognitive dissonance with self-care. I meditate. I go to therapy. I try to be transparent about my limitations in the company of my friends, many of whom are queer, in recovery, or open about their disabilities–people with a history of feeling like outsiders. But the support provided by mental healthcare and intersectional communities isn't always enough to overcome the shame I feel from failing to act on my compassion, from ghosting people I care for when they most need comfort and support.

The last time I tried to see Ruth was the Friday after Thanksgiving. I did not choose the date because of its proximity to a holiday. I had no intentions to show up with pumpkin pie or a bouquet ablaze with fall color. I'd learned that Ruth was back at Saint Mary's, and that her health was precarious. I hoped that my respite from work along with two nights decompressing outside of the city, would offer the emotional capacity for me to get myself through the hospital doors. I hoped to be at her bedside when she was awake so I could apologize for my absence during her protracted convalescence. I thought I might be able to explain my sensorium in a way that made sense without sounding like a bid for pity. But, I got stuck in traffic on my way back to San Francisco and didn't return to the city until late that evening. The next morning, I learned that Ruth died.

I did not attend her funeral; how could I? I was too embarrassed by my chronic flakiness to be in the company of Ruth's family, especially Anna, who bore so much of the burden for her mother's care. I did not dare insert myself into the circle of the mourners, many of whom had been consistently attendant during Ruth's nine months of medical complications, others who'd been lifelong and reliable friends. I lit a candle on my mantle, a pale consolation for the shiva I missed and a feeble replacement for the opportunity to grieve in the refuge of community, to find sparks of connection amidst sorrow.

In our early autumn conversation, Anna mentioned that Ruth had given up on me, proclaiming, "It looks like I'm not her Jewish mother anymore..." I did not share with Anna

that I had neglected to see my own mother inher final weeks of hospice for the same reasons that I no-showed Ruth; I was afraid to feel that all-too-familiar searing pain. Two decades ago, and by some strange grace, including a broken-down car and several canceled massage clients, I arrived at my mother's bedside to find her close to death. I held her hand from late morning until midnight, shepherding her out of this world with all the love I could offer, the only family member present at her passing. But I could have so easily failed my mother in her final hours; I did fail her in the days prior when I left her lingering in a dingy nursing home. This is the legacy of my mirror-sensory synesthesia. I know myself to be empathic and caring in temperament, yet I cannot count on myself to show up for people I love when they are hospitalized. Even when I am sure it's the merciful choice, even with an abundance of tenderness in my heart, I fall apart. My synesthesia creates interpersonal barriers built on a foundation of fear, guilt, and regret. It's revelatory as well, a mirror that shows me to myself exactly as I am: reticent in the company of the injured and completely unable to ignore the physical discomfort generated by my aberrant brain.

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Anna now owns the little heart pin that I gave to Ruth on her last birthday. I have the larger brooch. It lives in a small glass dish on my desk. It has never served as an anchor for a scarf, nor has it clasped my collar or lapel. If I were to wear it, I would not be able to see the crimson bauble unless I viewed it through reflection. I don't want to see that pin in a mirror. I want it directly in front of my eyes. It's my memento of Ruth, of the synesthesia I was too scared to reveal. It's my reminder that, in some cases, the truth truly hurts.

The Language Between Us

BY NEHA SUNKARA

I don't remember her name.

I remember the way her hands trembled when she folded the intake form into a perfect square, as if making it smaller would make its questions more bearable. I remember the color of her headscarf—maroon, like dried blood, like something that had once bloomed bright but now lived in shadow. I remember her eyes—the crescent they became in a smile, and the quiet hollowness they held when she wasn't smiling.

She arrived at the free clinic just after sunset, when the waiting room had begun to dim and quiet in that holy, breathless way, the air loosening like the day itself was finally exhaling. The folding chairs groaned under the weight of hours, of bodies waiting with paper cups of water and deep wells of silence. I sat at the front desk, playing the part of someone useful. When the receptionist called in sick, they told me, *just check people in*. No one warned me what it would feel like to be someone's first gatekeeper.

She spoke to me in Spanish—fast, urgent, unrelenting. I could catch only pieces, like trying to gather water with a sieve. *Dolor de estómago*. *Mareos*. *No tengo seguro*. Pain, dizziness, no insurance. But it wasn't the words I felt most—it was the weight behind them, the way she gripped the desk with both hands, as if something inside her might spill out if she let go.

I asked her to repeat herself. Again. And again. I watched her mouth slow down for me, her consonants softening, her vowels thinning out like candle smoke. She waited while I stumbled through questions, while I searched for verbs I should've

remembered from high school, while I apologized with my eyes because my tongue betrayed me.

And then came the silence. The kind that settles into the ribcage.

I picked up the phone to call the interpreter.

She waited.

Twelve minutes.

Twelve minutes where her pain sat unspoken.

Twelve minutes where I could feel her shrinking.

Twelve minutes where I was the wall, not the bridge.

When the interpreter arrived, her voice unfurled—sharp, vivid, whole. Like she had been underwater and finally broke through to breathe and grasp a lifeline. She spoke in full sentences now, not fragments. She had been in pain for weeks, nausea that turned food into fire, fear that maybe it was something worse. She didn't want to go to the ER. She couldn't miss work. She couldn't afford it. She had waited until the ache became unbearable because the system—one built on high costs, long waits, and the unspoken warning that care comes with a bill she couldn't pay—had taught her how to stay silent.

That night, I sat in my car in the clinic parking lot, watching my reflection in the rearview mirror like it belonged to someone else. My hands shook. My chest felt tight. I wanted to cry, but the tears wouldn't come. I kept thinking about what it means to speak—to really be understood. And what it costs when you aren't.

We talk so much in medicine about communication, but rarely about the violence of miscommunication. About what it does to a person to have their pain lost in translation. About how language is not just a tool—it is a gate. And sometimes, we are the ones holding the key. Or dropping it.

There's a quiet brutality in being misunderstood. A sense of erasure, of being made invisible not by malice, but by limitation. By the kind of silence that doesn't come from peace but from exhaustion. Resignation. Fear. We don't always recognize it, but it's there—in the tightened jaw, the glance toward the exit, the way someone grips a form like it's the last thing tethering them to this world.

I've come to believe that illness speaks its own dialect. One of urgency and fear and unspoken histories. And sometimes, the most dangerous thing we can do is treat it with grammar instead of grace.

Some of our patients speak Spanish. Some speak dialects even the interpreter service can't trace. Others say nothing at all. Their silence speaks for them. But silence doesn't mean peace. Sometimes, silence is just where the fear lives. And if we don't lean in—don't listen closely—we miss it entirely.

There is no phrasebook for suffering. No perfect translation for grief.

And no universal language for trust.

I'm still learning what it means to listen.

Not just to the words, but to the pauses between them.

To the glances toward the floor.

To the trembling hands.

To the sigh after a sentence.

To the story that never quite makes it out of someone's mouth.

There is a world inside each patient, and sometimes, it collides with ours like glass against stone. Their culture, their language, their grief, their gods. Their definition of healing. And ours. And between us: translation. Or mistranslation. And the haunting silence of what's left out.

The harm isn't always in what's said—it's in what's missed. In what never had a chance to be spoken. In the twelve-minute waits. In the faces that give up mid-sentence. In the way someone's dignity slips through your fingers, and all you can do is pretend not to notice.

Medicine can be miraculous. But it can also be indifferent.

The body is only part of what we treat. The rest—language, history, trust—often goes undocumented, even though it's just as urgent.

I wish there was a way to chart hope. To input connection as a vital sign.

I think about her sometimes when I'm filling out intake forms. I wonder how many patients sit across from us with fear clenched between their teeth, rehearsing the words they know in a language that doesn't fully carry their meaning. I wonder how many leave unseen, unheard, unfinished.

I don't remember her name. But I remember what she taught me.

That the human body isn't the only thing that can be fractured.

That the first wound in healthcare is often the feeling of being unseen.

That connection, when it happens, is nothing short of sacred.

And maybe I couldn't save her from her pain.

Maybe I couldn't even understand all of it.

But I hope, in some small way, she knew that I was trying.

I hope she felt, for even a moment,
that I saw her.

Even if I couldn't find the words.


Hal Anima