

REFLECTIONS

The room with the oranges: Reflections on palliative care, suffering, and becoming a doctor

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Abstract

Early clinical exposure during internship plays a critical role in shaping a doctor's professional identity, particularly when encounters extend beyond curative medicine into palliative and end-of-life care. This reflective narrative describes experiences from a small rural medical centre, Mundiappally, where interns were involved in both emergency cardiac care and prolonged palliative care. Through the transfer of a patient with acute myocardial infarction and the care of a terminally ill cancer patient, the author reflects on the transition from protocol-based learning to real-world clinical practice. The narrative highlights the emotional and ethical challenges of managing suffering, the limitations of pharmacological pain control in end-stage disease, and the importance of presence, dignity, and communication in patient care. It further explores the evolving understanding of what it means to be a doctor, moving from technical competence to compassionate responsibility in the context of end-of-life care.

Keywords: palliative care, medical internship, doctor–patient relationship, end-of-life care, medical ethics, professional identity

Introduction

The transition from medical student to intern marks a significant shift in responsibility, perception, and emotional engagement with patients. While undergraduate training, including structured communication frameworks such as AETCOM (Attitude, Ethics, and Communication), provides a theoretical foundation for patient interaction, real-world clinical exposure often challenges these frameworks in ways that cannot be fully anticipated.

During the early weeks of internship, I was posted at a small rural medical centre in Mundiappally, a quiet space away from the bustle of our medical college. The centre primarily admitted patients requiring palliative and end-of-life care. With fewer than ten patients at any given time, it offered an intimate and often silent view of both suffering and care. This posting slowly became one of the most defining experiences of my early medical career, reshaping my understanding of medicine beyond protocols and procedures. In many ways, it shaped the person and doctor I am gradually becoming.

Early days: acute care exposure

One of my earliest experiences involved the transfer of a patient with acute myocardial infarction to our tertiary care centre. The diagnosis of ST-elevation myocardial infarction

was made in a setting of limited resources and very early clinical exposure.

During ambulance transfer, my co-intern and I continuously monitored peripheral pulses, driven more by instinct and anxiety than experience, aware of how quickly things could change. There was a quiet fear throughout the journey, a kind that comes when you realise the weight of responsibility without experience. However, the patient was successfully transferred, underwent timely percutaneous coronary angioplasty, and was later seen recovering in the ward.

When we met her again, she recognised us and said with a smile, “ഈ പിള്ളേരാ എന്നെ ഇവിടെ വരെ കൊണ്ടുവന്നേ!” (these kids brought me here). We smiled, relieved in a way we did not fully know how to express. That encounter stayed with me — not only as reassurance, but as a reminder of how thin the line is between uncertainty and responsibility. It was one of my earliest moments of realising that I was no longer just a student, but someone who had begun to bear responsibility for life before.

Palliative care: beyond protocols

Among the small number of patients in Mundiappally, one patient, a middle-aged woman with advanced metastatic malignancy, had a profound impact on my understanding of care. She was bedridden, as extensive disease burden had gradually taken over most of her body, sparing very little. She was dependent on opioids for pain relief and admitted for end-of-life care.

Initially, I found it difficult to go beyond clinical routines. My interactions were shaped by structured communication training, and I often felt uncertain about how to move beyond protocol into something more human, especially with a patient whose prognosis was already clear.

Over time, however, repeated interactions reduced that distance. Conversations became more natural. I began spending more time at her bedside, often with nurses during long nights when pain would keep her awake. Despite escalation of analgesia, including increasing doses of morphine, her pain would at times remain distressing and difficult to control.

These moments quietly challenged everything I thought I understood about pain management. I had assumed that stronger medication would always mean relief. But her

condition slowly taught me something different — that suffering is not always linear, and not always fully reachable through medicine alone. There exists, I realised, a space beyond protocols that medicine can approach but not always control.

In between those difficult hours, she often spoke of home. Of simple food, of small routines, of ordinary days she longed for again. She would sometimes ask if she could go back, even briefly. She made small requests for fruit, and I remember her mentioning oranges — carefully peeled, as if that simple act still belonged to a normal world she had not fully let go of. These moments quietly reminded me that personhood survives even when the body is failing.

Ethical and professional reflection

This experience raised several ethical and professional questions that I continue to reflect on.

Firstly, it highlighted the limitations of medicine in controlling suffering completely. Even with appropriate escalation of opioids and supportive care, pain and distress may persist. This challenges the assumption that clinical competence is defined only by symptom resolution or successful intervention.

Secondly, it drew attention to the emotional burden of witnessing prolonged suffering. As an intern, there were moments of helplessness that I could not resolve through knowledge or action. Yet, I began to understand that presence itself is a form of care. Sitting quietly with a patient, acknowledging distress without always being able to remove it, became a part of clinical responsibility in itself.

Thirdly, it raised ethical questions around communication in palliative care. Promises made in moments of vulnerability — especially when spoken with genuine sincerity — carry meanings that extend beyond intention. The balance between hope and honesty is delicate, and not always easy to navigate in early clinical practice. I still remember holding her hand at times, speaking words of reassurance, hoping they brought comfort, while also beginning to understand their weight.

Finally, it reinforced the importance of dignity in end-of-life care. Beyond clinical parameters, patients remain individuals with relationships, memories, and emotional worlds that continue even as illness progresses. Preserving that individuality became, for me, one of the most important responsibilities of care.

Personal transformation

These experiences contributed significantly to my evolving professional identity.

As a medical student, much of my learning was structured around protocols, guidelines, and examination-oriented frameworks. Communication often felt like something to be performed “correctly” rather than lived. However, clinical exposure in a palliative setting gradually changed this perspective.

I began to understand that being a doctor is not defined only by technical competence, but also by the ability to remain present in situations where cure is no longer possible. The discomfort that comes with witnessing suffering did not disappear, but it became more familiar, more human, and in some ways, more bearable.

The transition from a protocol-driven mindset to a more patient-centred way of being was gradual. It involved accepting that medicine has limits, and that these limits do not reduce the value of care. Sometimes, they define the very space in which care becomes meaningful.

Lessons from Mundiappally

Early exposure to both emergency medicine and palliative care during internship provided me with a foundational understanding of the breadth of medical practice. While acute care emphasised urgency and decision-making under pressure, palliative care highlighted the importance of presence, continuity empathy, and dignity.

This experience reshaped my understanding of what it means to be a doctor. It is not defined only by cures or interventions, but also by the ability to stay with patients through uncertainty and suffering, with compassion and respect.

The lessons from Mundiappally continue to remain with me. They serve as a reminder that even when medicine cannot always cure, it must always care.

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