“The quiet weight we carry”

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I sat there, consumed by my own pain, the silence broken only by the sound of my ragged breathing and the slow, rhythmic rocking of my body on the seat. A sharp, excruciating wave tore through me, an ache so intense it stole the breath from my lungs. It came and went in a sudden, violent rush. I reached down instinctively, my hand catching what it could, but most of it slipped through my fingers.

What remained was what I clung to most desperately.

When I looked down, I saw more than what was lost. I saw my dreams, my hopes, my imagined future, no longer within reach.

Suddenly, I’m pulled back, snapped out of thought by the sharp beeping of monitors and the low, urgent sounds of a patient writhing in pain. The noise is all too familiar, echoing like a memory I never asked to keep.

It was my first day on the maternity day assessment unit (MDAU), and I’d barely had time to breathe. Every bed was full, with anxious patients in the waiting room and midwives moving quickly from station to station. I remember feeling the weight of it all — not just the clinical workload, but the emotional enormity that hung heavy in the air. MDAU is unlike other parts of the hospital. The stakes feel different. The conversations are more delicate. Hope and devastation sit side by side, sometimes separated only by a curtain.

That morning, I was assigned to shadow a registrar managing early pregnancy complications. I was eager to observe, though internally bracing myself for what might arise. I hadn’t disclosed my own experience of loss to anyone on my team — something I carried like a private scar, invisible to others but always there.

Our third patient of the morning was a woman in her early thirties - “ Sarah”. She had arrived with bleeding and mild cramping at eleven weeks’ gestation. Her voice was calm but clipped, like someone trying to stay afloat in rising waters. She clutched her partner’s hand tightly. Her ultrasound had already been performed, and the registrar gently delivered the news: there was no foetal heartbeat. It was, unmistakably, a miscarriage.

Sarah nodded silently. There were no tears, not just yet. Instead, her expression settled into a quiet vacancy I recognised all too well — a look I had once seen in my own reflection in the bathroom mirror. That hollow, suspended moment when the world stops making sense.

The registrar moved through the clinical discussion: options for management, expected course, follow-up. I stood beside her, taking notes, trying to focus on the medicine, the

protocol — anything to keep me from spiralling inward. But when Sarah finally spoke, looking not at the doctor but at me, her voice cracked ever so slightly.

“Have you ever seen this happen before?” she asked, eyes locking with mine.

I froze.

It was a simple question, but one laden with subtext. It wasn’t a query about my academic knowledge. It was emotional, raw and human. An invitation, perhaps, to connect on something more than medical facts.

I could have answered clinically — “Yes, I’ve seen many cases,” or “It’s not uncommon.” But that wasn’t what she was asking. I could tell.

In that split second, I felt my heart surge with the urge to say, “Yes. I’ve been through this. I know the ache. You are not alone.” I imagined how those words might have comforted her. How I had once longed to hear the same from someone — anyone — who had walked this painful path before me.

But I didn’t say them.

Instead, I offered a gentle nod and said, “Yes, I’ve seen this before. I’m so sorry you’re going through it. There’s no hurry to decide right this minute, take your time to talk it over, and if there’s anything else I can do for you, please let me know.”

She gave a soft nod, acknowledging what my condolences, and her eyes began to well up as she began to look away.

That moment haunted me for days. I kept replaying it, wondering if I had failed her somehow by holding back, by hiding behind the student role. Was I cold? Dishonest? Or was I, as we are so often taught, being “professional”?

The internal conflict stemmed from a question I hadn’t seriously considered until that point: *Should doctors — or medical students — disclose their personal experiences to patients in emotionally charged situations?* And more importantly, *what does it mean when we choose not to?*

In the hours that followed, I kept imagining two parallel realities. In one, I share my story, and Sarah feels less alone. We connect. She sees her pain reflected and validated. In the other, I say nothing, preserving a certain distance — the traditional boundary of professionalism.

I thought about what self-disclosure might have meant in that moment. Would it have centred me instead of her? Would it have minimized or diminished her suffering, turning her grief into

a shared space rather than allowing her to own it fully? Or would it have offered her comfort - the kind I so desperately needed in my own experience?

I also feared the vulnerability of it. In admitting my own loss, would I be seen as less competent? Less emotionally stable? Would I undermine the image of the calm, composed future doctor I was meant to embody?

More than that, I feared exposing a wound that I thought had healed. Medicine teaches us to be compassionate yet contained. But where is the line between empathy and enmeshment? Between humanity and over-identification? I had not anticipated how much of myself I would confront on that rotation.

This experience changed how I understand the doctor-patient relationship, particularly in the emotionally fraught spaces of reproductive loss, grief, and identity.

First, it challenged my assumptions about professionalism. I had always equated professionalism with emotional distance, with a kind of benevolent detachment. But what I've come to realise is that professionalism doesn't have to mean suppression. It can also mean knowing when and how to show up as a whole person — thoughtfully, deliberately, and with awareness of context.

There are no absolute rules about self-disclosure in medicine, but this experience has made me appreciate the nuance required. Disclosure isn't inherently wrong, nor is it automatically therapeutic. Its appropriateness lies in *intent*, *timing*, and *focus*. If it's done to comfort the patient, with their needs at the centre, it can be powerful. If it risks shifting the focus to the clinician or their unresolved pain, it can do harm. More than anything, I've learned that the decision to disclose should never be impulsive. It should come from a place of clarity, not a need to relieve our own discomfort.

Secondly, I've come to realise how ill-equipped we often are, as medical students, to navigate the emotional realities of patient care. Our training focuses heavily on science, protocols, and clinical systems, yet during placements, there is little space or encouragement to reflect on the profound human experiences we encounter - what it means to witness suffering firsthand, or to quietly carry our own unresolved grief into the clinical environment.

This has made me think deeply about what kind of doctor I want to become. I want to be one who doesn't flinch from pain - mine or my patient's. I want to sit with discomfort, to honour

what patients are feeling without rushing to fix or explain. I want to be someone who can be present, even when I don't have all the right words.

And yet, I also want to protect myself. I've realised that being a compassionate doctor doesn't mean bleeding emotionally for every patient. It means developing boundaries that allow me to care *sustainably*. My experience with loss is part of who I am. It informs my empathy, but it does not define me, nor should it define every patient interaction.

If medical training is to truly prepare us for the realities of this work, it must include space for emotional reflection and narrative. We need to be taught not only how to diagnose and treat, but also how to *feel* — responsibly, ethically, and with self-awareness. That includes examining our own stories and deciding how, or if, they belong in the room with our patients.

In retrospect, I believe I made the right choice in not disclosing that day. My silence wasn't a rejection of empathy; it was an act of restraint rooted in respect for Sarah's experience. Her pain didn't need to be matched or mirrored. It needed to be held. Witnessed. Validated.

Still, the urge to connect more deeply remains. And perhaps, one day, I'll be able to draw on my past in a way that truly serves a patient's healing.

For now, I carry that encounter with me, not as a failure, but as a formative lesson. In medicine, as in life, what we choose to say matters. But sometimes, what we choose *not* to say matters even more.