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Hope in translation: Lessons from both sides of the bed

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In my first year of residency, the most profound learning has not come in the hospital, but through the eyes of a caregiver. The day I matched to urology, my world shifted: my mother was diagnosed with stage IV cholangiocarcinoma. She was 55, healthy, vibrant, a physical therapist, and mother of four. Her cancer was inoperable, with metastases to her lungs. Her prognosis: 3–6 months.

This experience has reshaped how I think about language, presence, and the role of physicians when curative options no longer exist. It has clarified the kind of doctor I want to become.

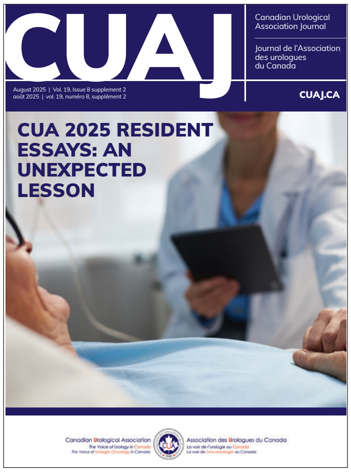
One of the clearest lessons I've learned is the weight of our words. Hope isn't just sentimentality — it's a coping mechanism, a tether to autonomy. Sometimes, it's all a patient has left. My mother is now a year and a half post-diagnosis with tumor regression. Our evidence-based training teaches us to view treatment through statistics: number needed to treat, median survival, and percent risk. But patients aren't medians. Words like "palliative" and "incurable" land with finality that can feel like abandonment. There's a vast difference between saying, "There's no treatment for this," and "Right now, we don't have a treatment that will cure this." One closes a door; the other leaves it ajar. We owe it to patients to be curious, not condescending — to leave room for hope, even when we cannot provide it ourselves. Patients are grasping for something medicine no longer offers: a sense of agency.

From within the system, I understand the constraints — limited resources, overbooked schedules, and provider burnout. But as a daughter, I've seen how the simplest gestures from her doctors — a clear explanation, a few unhurried minutes, day passes during long admissions, advocacy for services — have transformed her experience, making her feel more like a person than a prognosis.

We see the same diagnoses every day. It's easy to become desensitized to the magnitude of what we do. But for patients, this is their first diagnosis, their only surgery, their one life, and they are willing to exhaust every option to save it. We forget that, to them, we are steering the ship through uncharted waters — often their final voyage. We see them as patients, but they are so much more. They do not want to be defined by their diagnosis.

Since my mother's diagnosis, I've made a conscious effort to slow down. To explain. To listen. To remind patients — and myself — that they are not just a case on a list, but people with jobs, families, passions, and stories. They do not know how many patients I have seen that day, how tired I am, or how stretched the system is. They only know that their world is falling apart. And in that moment, I have the power to make it a little more bearable — or not.

My first year of residency has been a paradox of beginnings and endings. I am just starting my career while navigating the anticipated loss of the person who made that career possible. But it is precisely in this tension that I've found purpose. My mother's experience has made me a better doctor — not despite her illness, but because of it. In medicine, we often speak of *learning to heal*. But this year, I've also learned how to witness, sit with pain, and let hope live alongside truth. Before residency, I thought medicine would teach me how to fix things. But it turns out, not everything can be fixed — and it's in those moments, when cure isn't possible, that the real work of being a physician begins.



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