

Wood, Graphite, and the Weight of Observation in Medicine

Jane Fiorentino

University of Wisconsin–Madison

Correspondence: jfiorentino@wisc.edu

Keywords

global health; medical observation;
cultural humility; pediatric care;
reflective narrative

Abstract

This reflective narrative explores experiences in pediatric wards in Ghana, highlighting the power of observation, empathy, and cultural humility in global health. Using a pencil and journaling as a lens, the essay examines the challenges of witnessing human suffering, ethical dilemmas faced by caregivers, and the role of careful observation in understanding patient care and resilience. It reflects on how these experiences shaped the author's perspective on medical practice, emphasizing the importance of attentive observation, ethical reflection, and culturally informed empathy in global health and patient care.

Body

The other day, someone asked me: if you could keep only one thing in your household, what would it be? Without thinking, the first thing that came to mind was a pencil. I didn't pause, and I didn't weigh my options — just a pencil. I felt a little silly afterward. Everyone else was saying family, pets, treasured keepsakes, and here I was holding on to a piece of wood and graphite. Yet, as I flipped through my journal from Ghana, I realized that same pencil had carried me through everything I had witnessed. That pencil had been with me in every crowded ward and every quiet

observation, teaching me how to see, not just look. It taught me to notice, reflect on, and carry forward lessons hidden in things I might have previously overlooked. In Ghana, it became my bridge to understanding, my way of recording and processing everything my eyes and heart were taking in.

In medicine, observation is often treated as a preliminary step before action. In Ghana, I learned that in settings of scarcity, observation is the action. When technology is limited and resources are thin, care begins with sustained attention to bodies, behaviors, and context. The pencil slowed me down, helping me record what my eyes and instincts were learning long before I understood their implications.

The pediatric ward was unlike anything I had seen before. One bed sometimes held two or three children. Paint curled from the walls in sheets. The air felt thick and unmoving, disturbed only by the slow rotation of ceiling fans, as if even the machinery shared in the ward's exhaustion. There were no masks. Doctors were largely absent; surgeons arrived only every 2 weeks, traveling long distances to reach the hospital. Nurses, by contrast, were omnipresent. They moved between patients with quiet authority, relying on experience, touch, and observation to guide their care. Children were grouped into just a few

quadrants with no privacy. Their bodies were swollen, discolored, and frail. Malnutrition and illness were etched into every limb, cheek, and expression. Unlike hospitals in the United States, these children were not there for a cold or routine care; they were on the edge of survival.

What struck me most was how much clinical information was gathered without technology. Nurses assessed dehydration by pinching the skin and observing how readily it tightened back into its natural tension over the tissue beneath, as it does in healthy, well-hydrated bodies. They evaluated respiratory distress by counting breaths, watching chests rise irregularly, and listening for subtle changes in crying. A child's lethargy, the way their eyes barely met mine, and the subtle slump or rigidity of their posture conveyed more than any chart or number.

As I watched care unfold, I began to recognize patterns. A boy slouched in the corner, barely lifting his head. His breathing was shallow and uneven; his fingers trembled slightly, signaling dehydration and fatigue long before any vital signs were taken. Nearby, a girl clung tightly to her mother, rocking gently. Her face was pale but alert. The way she gripped her mother's shirt and tracked every movement in the room showed me where her fear began.

Being there, it became clear that medical care is more than protocols or technology; it is a careful choreography of attention, empathy, and resourcefulness. I watched nurses improvise constantly, diluting medications by hand and carefully rationing supplies as they moved from bed to bed. I saw one nurse hesitate before administering a treatment, scanning the room to assess which child appeared most unstable, knowing that time and supplies could not stretch

to everyone at once. When supplies ran low, a doctor explained how decisions were guided by clinical stability rather than order of arrival. These choices were not arbitrary; they were grounded in sustained observation. In that space, I began to understand that medicine is not only about diagnosis or treatment. It is about noticing, prioritizing, and responding thoughtfully to human needs.

Among the many difficult scenes I encountered, one story lingered more than the others. The ward director told me about a mother who, faced with extreme hunger, had fed her child something that made my stomach twist: feces. My initial reaction was discomfort and confusion. I felt unsure how to record something so morally jarring, but over time I saw that survival often demands choices that feel incomprehensible from the outside. Yet as I spent more time on the ward, listening to staff, observing families, and beginning to understand the depth of food scarcity, the story shifted. Empathy requires resisting instinctive judgment and attending instead to the circumstances shaping behavior.

This lesson deepened when I began to notice that some mothers lied to doctors about what their children had eaten. At first, I interpreted this as simple deception. But reflecting on the story of the mother who had fed her child feces, and watching the ward over time, I began to see a more complex reality. These choices were shaped by fear: fear of blame, fear of judgment, spiritual beliefs, and the harsh costs of food and medical care. In that context, the act that initially shocked me became an act of survival. Some mothers guarded information the way they guarded their children, carefully managing what could endanger them. Over time, I began to notice how much could be revealed through behavior, pauses, and

even silence. Sitting with that realization reshaped my understanding of empathy, encouraging me to look beyond visible actions and consider the quieter forces influencing them.

For these care providers, truth in medicine often emerged through what bodies did rather than what patients could articulate. It surfaces in hesitation, in the places where eyes linger, in what remains unsaid. In one quadrant of the ward, a boy with legs swollen as tight as skin could stretch whimpered as a nurse balanced him on her lap. She checked his temperature with the back of her hand, followed the shallow rise of his chest, and pressed gently into his abdomen. After each touch, she paused. She watched his face closely, reading discomfort in the tightening of his jaw and the brief catch of his breath, asking nothing of a body too weak to answer.

Across the room, a mother held her infant upright against her chest, whispering prayers I could not understand. Her eyes moved constantly, darting toward the nurses and back to her child, searching for a signal, a promise, permission to hope. I wrote quickly, trying to capture not only what I saw but what it felt like to stand there: the heavy stretch of waiting, the vulnerability patients and their families carried as they were watched, and the quiet endurance that persisted even in that space.

Across Ghana, hospitals and clinics functioned almost interchangeably, bound together by the same shortages. Supplies moved unpredictably, access to laboratory testing was limited, and waiting for confirmation could mean waiting too long. Protocols differed from what I had been taught, not because they were careless, but because they had to be more responsive. Children were treated for malaria even when tests were unavailable or inconclusive, because in that

context, suspicion itself carried weight. I watched clinicians read bodies closely: a child whose skin burned with fever, another whose palms were pale and cool, and a toddler too weak to sit upright. I realized that danger could be recognized not through numbers alone, but through stillness. Through a child who no longer reached for their mother, or whose cry had softened into a faint sound. The clinicians counted breaths by watching ribs rise unevenly, noted how a child clung or did not cling to a mother's shirt, and listened to the pitch of a cry. Decisions were made quickly and deliberately, and treatment often began before certainty arrived. Experience replaced laboratory confirmation, and careful attention became essential. What could be seen, felt, and heard became the most reliable diagnostic tool. Observation did not supplement care; it made care possible.

Being there felt wrong at times. Walking through the ward with a notebook in hand felt intrusive, even voyeuristic. I questioned my presence constantly. What did it mean to observe suffering I could not alleviate, and was writing an act of preservation or extraction? I felt helpless, even guilty, at times, and worried that documenting someone else's pain might be exploitative. Yet observation, I learned, does not require ownership or solutions. It requires humility. The pencil did not fix anything, but it forced me to witness without turning away. It demanded that I stay with discomfort long enough to learn from it.

Amid the heaviness, small acts of humanity stood out sharply. A nurse made a silly face, and a child too weak to lift his head let out a quiet laugh. In another corner, a mother quietly offered words of encouragement to a fellow mother, her voice soft but steady. Nurses moved from bed to bed, whispering guidance or a quick joke, easing the

ward's tension in subtle ways. Beyond these gestures, I was struck by the trust the mothers extended to us — strangers and outsiders, Americans whose histories are so intertwined with exploitation. They let us see the realities of their sick children up close, granting us a window into their vulnerability. These moments mattered. I came to see that care is not only in treatments or protocols, but in the gestures that acknowledge each child and family as fully human. It is also in the courage it takes to let someone witness that humanity, and in the quiet courage of a provider who observes without rushing to heroic action.

Months later, I continue to reflect on what Ghana taught me. Scarcity revealed that care does not depend solely on abundance; it showed me how much can be done with attention, presence, and improvisation. Observation revealed that empathy is not passive; it is honed through careful watching, listening, and waiting. It must react and resonate with what it is given. I saw that medical knowledge alone was not enough; understanding the cultural context shaped how care was delivered and how it was received by patients and families. Putting into words the shock, discomfort, and fleeting moments of grace I witnessed transformed experience into responsibility. Writing became a reminder that

what we observe carries weight long after we leave. That bearing witness is not neutral, and it shapes the way we move through the world.

The pencil stays with me because of what it allows me to do. For me, observing carefully is part of acting ethically; it shapes when I intervene, when I listen, and how I consider care when resources are limited. Through it, I carry forward the voices, struggles, and resilience of people whose lives I was allowed to glimpse. The act of writing forces me to pause and truly observe, and in creating a record of what I witnessed, it allows those lessons to endure. It does not offer answers or absolution. It ensures, however, that my experiences are held carefully, thoughtfully, and with intention, shaping the way I think, feel, and act long after I leave.

Seeing, I learned, is never neutral. Every observation is layered: each detail carries physical, emotional, and contextual significance. Attending to patients, their environment, and moments of discomfort is itself a form of care. That is why a pencil is more than a simple object. It is a tool for witnessing, remembering, and honoring the weight carried by those who pay attention.