

*Between Sun and Sea*

By: Megan Perry

Robert D. Sparks Writing Contest

Carver College of Medicine

University of Iowa

March 6th, 2026

When I was in the sixth grade, I was obsessed with Greek mythology. Maybe it was my older brother's influence, or the popularity of the *Percy Jackson* series at the time. I checked out every mythology book available in the school library and devoured the stories, returning one only to check out another. One of my favorite myths was that of Daedalus and Icarus, a masterful craftsman and his son, who were imprisoned on the island of Crete. Icarus spent his days gazing out the window of their tower, staring at endless waves and wondering what was beyond. One day, ingenuity granted him his long-sought freedom and exploration. Feathers were collected from birds that flew before him. Straps were cut from sandals, leaving his father's feet bare. Wax sealed the materials into wings, and he was empowered to fly. His father warned him before the escape: if he were to fly too close to the sun, caught in thoughts of what he could do, instead of what he *should* do with his newfound wings, the wax would drip, the feathers would loosen, and he would fall into the ocean below.

I was reminded of this myth last summer during a hospital rotation in Riobamba, Ecuador. My precepting physician and I were attending to a patient we had seen every day that week. At this point, I was familiar with her terminal cancer diagnosis and the pleural effusion we were simultaneously treating. I listened to her lungs with my stethoscope. The right side was clear, but the left? The left was like static on a radio dropped underwater. I watched as the doctor told her she needed to stay in the hospital, that she needed another procedure. She began to cry. She had children, she told us. She had a husband. I didn't know these things about her. She began to sob. She only wanted to spend her time with her family. I had deciphered her diagnosis, seen her labs, listened to her breathe, translated her words; I didn't know *her*. The doctor informed her that it was our responsibility to continue to care for her, to perform procedures, and to prolong her life. A thoracentesis was needed, and after that, surgery was the indicated therapy. She would

have to travel to Quito for care. “I only want to see my children,” she pleaded. My eyes glazed over, and I looked toward the window to keep my tears from falling.

Outside the window, vast against a rare sunny sky, stood Chimborazo. Many people think that Mount Everest is the highest point on Earth. While true in the sense that Mount Everest is the highest climb, Chimborazo is, in fact, the closest point to the sun. The volcano sits on the bulge of the equator, so while not the tallest mountain in the world, it reaches the highest point in the sky. Looking at its enormity through the glass, as the patient cried in front of me, I could feel trails of warm wax trickling down my back, wind whipping against my skin and through my hair. My stomach flipped as I descended down, down, down towards deep blue waves. It felt as though I had flown so high- learning to interpret medical Spanish, understanding her condition and the treatment she required, seeing my learning in clinical practice- only to fall when I realized she didn't want it, that it wouldn't help the way I thought.

At the Carver College of Medicine, we are taught the acronym ‘ICEE’ when we begin to practice our patient interviews. The goal is to help us remember to ask each patient about their Ideas, Concerns, Expectations, and Effect on life. As an overhead buzzer beeps, we all knock on the door of a simulated exam room and proceed to take a history from someone acting as a patient. After the history, the rubric gives us points for asking our ICEE questions. While seemingly a silly mnemonic, it is my favorite part of the patient interview. After I have collected symptoms and begun to formulate a differential diagnosis, I get the chance to discover what the patient truly wants out of their care. In this way, there is a score and emphasis placed on therapeutic reasoning, not simply diagnostic evaluation. Patient-informed therapeutic reasoning is highlighted as an important element of our training, yet somehow, it gets lost in broader conversations of clinical reasoning and structured decision-making.

Clinical reasoning is a cornerstone of medical education. It's a term we hear constantly throughout our training— “continue to develop your clinical reasoning skills.” It begs the question: what exactly *is* clinical reasoning?

While it seems to be straightforward, clinical reasoning within the medical field is actually quite ambiguous. It is defined as the process of combining a physician's clinically relevant knowledge with patient information in order to guide workup and treatment. It is discussed as a fluid process, in which the mental representation of a patient's condition is updated with the acquisition of new information, until a diagnosis and treatment plan are reached (Gruppen, 4). In other words, as labs and imaging convey new information to a clinician, they can update the constructed disease model that was formed based on a patient's presenting symptoms. This is similar to how it was presented to my medical school class as we approached our clinical rotations: as a model to guide our workup and the diagnostic categories we assign our patients to.

Yet clinical reasoning is often focused primarily on diagnosis rather than treatment. It is frequently “devoted to diagnostic reasoning, not therapeutic reasoning” (Gruppen, 4). A diagnosis is often labeled as “right” or “wrong”. “There is the prospect of a ‘correct’ diagnosis and the attraction of being able to classify reasoning as successful or unsuccessful... in contrast, therapy is much more difficult to classify. It depends on many variables... it is much more a ‘matter of opinion’ or judgment than a universally correct solution” (Gruppen, 4). This highlights that while we can learn a logical approach to a diagnostic problem, it doesn't truly lead us to the perfectly correct therapeutic solution. Therapeutic reasoning lies on a grey scale, rather than a dichotomy of black and white, right or wrong. It is akin to physicians relying on their “gut feeling” about a patient, or when they utter the words “in my experience.”

The history of clinical reasoning further exemplifies this idea that it cannot capture all of the complexities of medical decision-making. Methods of clinical reasoning originate from computer science, economics, and probability theory. The goal of clinical reasoning is to weigh multiple factors in order to get the best outcome in a highly important decision. However, the problem with this basis of clinical reasoning is that human beings—physicians, clinicians, patients—don't make decisions like an algorithm or a computer. Rather, "people (including physicians) are often irrational, illogical, and badly flawed reasoners" (Gruppen, 6). I would go further to say that people maintain lived experiences, emotions, and influences that cannot be separated from the decisions that they make. On the one hand, it is logical to teach a fundamental method that standardizes the way in which we make decisions. On the other hand, it is reasonable to assume that human beings will stray from this model, particularly in light of more complex therapeutic decisions.

The motivations behind the decisions that physicians make are complex. There are extensive systemic and legal pressures. There are extrinsic and intrinsic motivators. There are institutional and cultural precedents, and there are constraints of resources. Algorithmic, logical thinking models cannot capture the myriad of circumstances that patients and physicians face, and to me, it is evident that they cannot capture the *people* involved in the decision-making.

When I began my medical school clinical rotations with shifts in the hospital Emergency Department, I found myself between patients, talking with my attending physician. We discussed why a patient was given a medication by an outside hospital— a medication that didn't seem relevant to their care. If anything, we were concerned it might worsen their condition. He asked another provider if they knew of a particular indication for it, and they shook their head. I looked at him, my eyebrows furrowed, puzzled. He shrugged, "sometimes doctors do something just to

*do something.*” I let that statement find its way into my swirling thoughts of pathophysiology and possible risk-benefit scenarios. I nodded hesitantly, but was still left somewhat confused.

“What do you mean by that?”

“Do you want to hear what a patient once told me?” He asked. I nodded again. “This man came into the ER one night in very bad shape. He was on multiple chemotherapies for late-stage cancer and was clearly decompensating. We asked him why he was on chemotherapy. Do you know what he said?” I shook my head. “He said, ‘because it makes my doctors feel better.’” My eyebrows shot up. My attending repeated the phrase, as if reliving the moment and the weight of the words.

*“Because it makes my doctors feel better.”*

As much as I wanted to impress my first attending faculty, on my first ER shift, on my first day of clinical rotations, I found myself at a loss for words. I didn’t have a smart question to ask, a mechanism to clarify, or really anything medical on my mind. Sometimes we do something simply to do *something*. Because it makes *us* feel better.

As I continued to gain clinical experience, I found myself returning to this story throughout my interactions with clinicians and patients. I found these questions on my mind:

*Does this go against everything we stand for as physicians? Against the virtues of altruism and putting the patient first?*

*Isn't it selfish to do something for ourselves, to make ourselves feel better?*

I debate with myself:

*When we make ourselves feel better, is it always at the cost of the patient? Or does this sometimes help?*

*Where is the balance between this almost selfish desire to feel helpful and actually helping?*

This internal deliberation came to the forefront during my psychiatry rotation. I spent four weeks working on a combined internal medicine and psychiatry floor. The first morning, I shadowed the team, getting a feel of things and adjusting to the workflow of the unit. In the afternoon, a new patient was admitted, and I felt comfortable taking her on as *my patient*.

This “ownership” of patients is something I am still getting used to. I spent my pre-medical years in clinical roles where I wasn’t legally allowed to answer patient questions or give clinical advice, because I wasn’t a provider. I spent years learning, in classes and with simulated patients, practicing the things that I would say to *my patients*. And for the first time, I have *my patients*. Moreover, I have the luxury of time during my days at the hospital. I don’t have the busy schedule of the residents and the attending. I can sit down and color with *my patient*. I can sit down and make a safety plan. I can sit down and dig through their chart to create a timeline of their care over the past decade. I can track the medications and therapies they have tried. I can look for any mention of a source of motivation and happiness for them. So, that is what I did; I devoted my spare time throughout the day to these activities and *my patient*.

The honesty of the situation is that part of why I did these things was because I felt utterly helpless otherwise. The team was at a loss for how to care for this patient, whose mental health and hospitalizations had reached a point of chronicity. I was determined to do *something, anything* that I could with the luxury of time and the little knowledge that I had, for *my patient*. Eventually, *my patient* was medically stabilized, transferred to another floor, and discharged. It

was determined that involuntary hospitalization was, in fact, more detrimental to their psychiatric care than it was beneficial, because of their unique circumstances and condition.

If I were Machiavellian, asserting a doctrine of “Universal Egoism”, I might argue that my actions were driven by my own self-interest. My sense of “ownership” of *my patient* would speak to a ubiquitous trait of human beings to acquire, to an inevitable selfishness. Maybe it's naivety, or a bias rooted in the peers and physicians I have met in my medical education, but I believe in a simpler explanation— that most healthcare workers want the best for their patients. My motivations were founded in wanting the best for *my patient*.

This perspective cast my experience in Ecuador in a different light. I had initially viewed the interaction as a cultural difference in practice—one with less emphasis on shared decision-making or a patient’s expressed wishes. But with time, I began to see something else in that moment: the humanity in the care team’s recommendations. The care team’s insistence on treatment may not have come from disregard for the patient’s desires, but from a deeply human impulse—to help someone suffering in front of them.

Typical clinical reasoning failed each of these three patients in different ways.

It failed the Ecuadorian woman with a pleural effusion, where logic pointed to procedural intervention.

It failed the Iowan man on chemotherapy when a decision was made in desperation to help a patient’s prognosis.

It failed *my patient*, when every illness script and pattern indicated that they should be in the hospital.

There isn’t a one-size-fits-all model for these situations. When we push too hard for diagnoses and treatment, we miss the underlying desires of our patients. When we let our

emotions and desire to help take the forefront, we put our patient in the background. We make human decisions clinically, and we make clinical decisions humanly. We melt wax in the golden heat of the sun, we drench feathers in the salty spray of the sea.

Clinical medical education helps us learn the science and skills that allow us to improve the lives of others. In medical education and healthcare, we work tirelessly to learn, treat, innovate, and improve. We are trained to fly—higher, faster, better—with each step in our education. But in that ascent, it becomes easy to lose sight of what is beneath us: the patient’s values, their humanity. If we forget to ask not just *what can I do*, but *what should I do*, we risk becoming untethered, flying too close to the sun.

At the same time, I am often driven by my emotions and humanity. I grew up dancing, writing, painting, and creating. My passions center around storytelling and emotional experiences, and I, like other healthcare workers, simply want to help. However, our emotional desires alone cannot determine our medical decision-making. There is a necessity in evidence-based practice, reliance on scientific principles, and fundamental diagnostic understanding. These are still foundational to the practice of medicine. Decisions based only on our personal biases, relationships, and experiences risk an untethering in the opposite direction, towards icy waves.

Is the answer to remove the human behind the reasoning?

Is it to lean into the human emotions and experiences that drive us?

Or is it to find a space in between?

A mentor of mine, an oncologist, told me that this balance is something learned slowly over the course of a career. Sometimes, the right decision is obvious. If a patient develops myocarditis from an immunotherapy, you stop the treatment. However, often the answer is far

less clear. In those moments, he explained, physicians can remove themselves from the decision, and present patients with two paths: continuing aggressive treatment, or stepping back—doing less, even doing nothing. In his experience, when that second option is presented not as failure, but as a legitimate choice, many patients choose it. It speaks to this notion that “humanism in medicine is not only what we extend to patients, but also what we allow them to see in us” (Pendyala and Berg). It is not simply the provision of treatments, but the vulnerability to say when we no longer think we can treat, or feel helpless, or simply want the best for them.

To me, clinical and therapeutic reasoning are grounded in these principles. They should balance the pursuit of our work with a deference to the patient before us. We must remember we are human beings, often experiencing emotional hardship along with our patients. We must know when to soar and when to stay close to the ones we serve. It’s the ability to dip and dive, but not go so far as to lose sight of the practical decisions we need to make. There’s a patch of blue sky between the extremes— a stretch in which ingenuity and science allow us to diagnose, empathy and compassion allow us to care, and humanism in medicine allows us to offer our patients both.

## Works Cited

Gruppen, Larry D. "Clinical Reasoning: Defining It, Teaching It, Assessing It, Studying It."

*Western Journal of Emergency Medicine*, vol. 18, no. 1, 2017, pp. 4–7.

<https://doi.org/10.5811/westjem.2016.11.33191>. Accessed 6 Mar. 2026.

"Machiavelli: Doctrine of Statecraft, Dual Morality, and the Role of the Prince." *Political*

*Science Solution*, 18 Sept. 2023,

<https://politicalsciencesolution.com/machiavelli-doctrine-of-statecraft/>. Accessed 6 Mar.

2026.

"Ovid's Icarus." *The Rise of Icarus: The Resurgence of The Fall of Icarus as a Modern Myth*,

curated by Sophie Kamhi, Class of 1954 Intern, *Hood Museum of Art*, Dartmouth

College, <https://sites.dartmouth.edu/vsfd18/ovids-icarus/>. Accessed 6 Mar. 2026.

Parsa, K. "What Chess Taught Me About Clinical Reasoning and Humanism." *KevinMD*, Mar.

2026,

<https://kevinmd.com/2026/03/what-chess-taught-me-about-clinical-reasoning-and-humanism.html>. Accessed 6 Mar. 2026.

