A CLOSE READING OF CREATIVE WRITING IN *SCOPE*, THE MEDICAL SCHOOL LITERARY MAGAZINE AT SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE

A Dissertation

Presented to

The Faculty of the Curry School of Education

University of Virginia

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

---

by

Heather Anne Burns, M.F.A., M.A.

December 2015

ABSTRACT

A growing body of literature examines the link between medical students and creative writing. It focuses mostly on reflective writing seminars with specific objectives in mind. There has been nothing found in the literature that examines medical student creative writing for its own sake. This dissertation looked at medically related creative writing contributed to a medical school literary magazine in Illinois from 1994-2013. Using literary analysis and coding for medical humanities attributes (Gold Foundation I.E.C.A.R.E.S.), this dissertation's study assessed the ratio of medically related works to non-medically related works, identified kinds of magazine contributors, and determined incidence of medically related topics. It also provided a close reading of several pieces in relation to medical humanities attributes. It is hoped that this study will open further avenues for looking at creative writing as an important tool in medical education.

ACKNOWLEDGEMENTS

I am grateful for the oversight my advisor provided through the stages of completing this dissertation and for the enthusiasm and encouragement of my dissertation committee. I could not have completed this work without the guidance and support of faculty and staff at the Curry School of Education, the Office of the Dean of Students, and the Office of the University Provost.

I am also grateful for the enthusiastic support of my family and friends.

TABLE OF CONTENTS

LIST OF TABLES

(NB: Tables designated by a number and an "a" are in Appendix A)

CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

Since the late 1980s and early 1990s, seminars and courses in the medical humanities designed to reflect on the art of medicine have been formally included in the medical school curriculum. Assignments generally include reflective and creative writing. Many medical schools in the country have such courses and programs. They are one visible way which the medical school curriculum has developed to meet the need of improving the doctor-patient relationship and fostering the critical element of empathy within professional training (Marcus, 1999). Class titles such as Art and Medicine, History of Medicine, or Literature and Medicine involve a substantial amount of writing from the students and rely on small group sharing. Beginning in the late 1990s and early 2000s, pilot classes on poetry writing and illness narratives in such schools as the University of California, Irvine and Columbia University College of Physicians and Surgeons showed that participating student response was positive and that the writing assignments were therapeutic and helpful for teaching students about empathetic relationships with patients (Shapiro & Rucker, 2003; DasGupta & Charon, 2004).

While medical students may encounter some general sensitivity training in medical school, lessons on specific topics such as the doctor-patient relationship are not emphasized in the traditional curriculum. Scholars argue that little is done in the traditional curriculum to foster empathy and compassion because starting in the cadaver

lab, every effort is made to foster and reward the disembodied scientific and analytical mind (Shapiro et al, 2009). Problems can result later and lead to clinicians who are perceived as uncaring and unworthy of patients' trust. Too often, patients and families complain that the doctor-patient relationship is missing the human element of compassionate connection. Studies show that humanistic training is critical to develop medical students' professionalism which can assist in favorable patient outcomes (Hatem & Ferrara, 2001; Stepien & Baernstein, 2006; Chen, et al, 2007; Stratton, Saunders, & Elam, 2008; Karnieli-Miller, et al, 2010).

The ability to understand and communicate the emotions and feelings of fellow human beings is an attribute most people have to varying degrees. In early development, humans demonstrate empathy in our ability to imitate facial expressions and vocal tones. As we grow cognitively and emotionally, we are able to understand more complex situations and our ability to empathize can be trained (O'Malley, 1999; Marcus, 1999). In terms of health care, while one may not expect the physician to know the exact pains of one's illness, one hopes that he knows what it is like to be in pain and endure suffering and appreciates that sometimes decisions are difficult. Literature and humanities courses with a creative writing component have helped students better understand the patient's perspective.

Research Questions.

One alternative for assisting students to foster more creativity and compassionate understanding as they grow in medical professionalism could be through the medical school literary magazine rather than through medical humanities courses. This study

investigates the contents of one such journal and shows how medical humanism themes are interspersed throughout the volumes.

An interview with the Director of the Program in Humanities and Medicine at the University of Virginia shows that student writing from medical humanities courses is important to some people in the medical school community (personal interview, 2010). Instigated and encouraged by supportive faculty over fifteen years ago, a student literary magazine called *VERITAS* was developed at UVA and became a strong student-driven project. There are a handful of other types of medical student literary magazines in the country. Medical student writing is a relatively unexplored topic, but interest in it is growing (Shapiro, 2009).

We see from the literature that some professors request writing from their students, quite often in the clerkship year (Rucker & Shapiro, 2003, Charon, 2006; Jones, Cohn, & Shapiro, 2012). But what about writing that is not connected to a class, rather, is writing for its own sake? Could such writing assist in developing and conveying the necessary attributes of medical humanism that are deemed important for the profession (Cohen, 2007)? This research looks at one small literary magazine called *SCOPE* from the University of Southern Illinois School of Medicine and answers these specific questions:

- To what extent and how does creative writing in *SCOPE* reflect the medical humanities attributes of **empathy, compassion, integrity, respect, altruism, excellence, and service**?

To help answer this larger question, I address these specific questions:

- In what ways do authors in *SCOPE* articulate their relationship to medical humanities attributes?
- How frequently do authors in *SCOPE* explicitly or implicitly expose medical humanities attributes?

My study also explores the themes and topics in the fiction and poetry of *SCOPE*. I chose the magazine for a variety of reasons on which I elaborate in the methods section, but in a few words, it is a magazine that is consistent in its quality and longevity. Through a mixture of quantitative and qualitative approaches (Marshall & Rossman, 1989), the paper identifies and categorizes writing on medically related topics and themes, the different genres, and the types of contributors that make up *SCOPE* over the past twenty-two years (1994-2015). I also analyze several pieces selected for the way they articulate particular attributes of medical humanism.

Review of Literature Overview.

The origins of the medical humanities curriculum flow primarily from psychology, sociology, and anthropology (Hawkins, 2003). Many scholars think of medical humanities as a response to the fear in the 1980s and 1990s that medical education's increased incorporation of technological training would result in losing the art of medicine entirely to science. Scholars like Rita Charon, Ann Hawkins, and Katherine Hunter are a few of those who designed early medical humanities curricula and studied the effects on students and faculty. Rita Charon, an M.D. and PhD English scholar coined the term "narrative medicine," which she defines as the point when medicine and writing intersect for a greater experience of both healing and creativity (Charon, et al, 1995).

Students' writing connects to discussion of physician reflective writing and patients' writing about being ill. There is a long list of doctors who write as well as shelves of poems, plays, essays, and stories on illness by patients. Several prolific, well-known physician writers are Anton Chekov, William Carlos Williams, and Walker Percy. Virginia Woolf, Susan Sontag, and Reynolds Price also wrote compelling memoirs and essays about illness. Howard Brody, a scholar and M.D., wrote *Stories of Sickness* which analyzes depictions of illness in great literature in an interdisciplinary way and talks about how we are inwardly rearranged when we suffer. When it was first published in 1987 it spurred interest in narrative studies in health care (Kleinman, 1988; Frank, 1995; Brody, 2003).

To date, there is not a lot written about medical student creative writing, but the literature is growing. It includes references to studies by medical education scholars such as psychologist Johanna Shapiro and physicians such as Jack Coulehan and Rita Charon. All have looked at the impact of writing by medical students on academic performance, medical professionalism, and emotional well-being. There is still virtually nothing written on the medical school literary magazine, and this study intends to fill that gap.

Studying medical humanities education is important. A recent review of journal articles on medical humanities in undergraduate education divided up topics covered into the categories: "pleading the case," "course descriptions and evaluations," "seeking evidence of long-term impact," and "holding the horses" (Ousager and Johannessen, 2010). This study of *SCOPE* fits into the first two categories in that it argues for integrating humanities into undergraduate medical education, and it provides descriptive data of a humanities-related phenomenon occurring in an academic medical setting.

Methodology Overview.

In the initial stages of researching this topic, I spent a lot of time on the web looking at medical school home pages and browsing to see whether they had medical humanities programs, and if so, determining whether there was a literary magazine associated with the school. The Stanford Bioethics department page gives a good idea of the magazines in existence: http://bioethics.stanford.edu/arts/Journals.html. A handful of schools have magazines that publish exclusively student work. I identified the magazine I wanted to work with according to format: e.g. whether it was hard copy or electronic and the kinds of contributing writers. I evaluated the ratio of students to faculty and staff, alumni, and community members, such as patients.

Using a primarily qualitative approach with some quantitative components, I identify aspects of the magazine such as ratio of medically related and non-medically related pieces, genre types, and ratio of contributor types, depict the findings in tables, and discuss them. I identify the topics in the medically related works and summarize the findings. Along with those, I determine what medical humanities attributes, per the Gold Foundation I.E.C.A.R.E.S.[1] rubric, are expressed in the medically related pieces, and analyze my findings.

---

[1] According to the Arnold P. Gold Foundation, "Humanism in health care is characterized by a respectful and compassionate relationship between physicians, as well as all other members of the healthcare team, and their patients. It reflects attitudes and behaviors that are sensitive to the values and the cultural and ethnic backgrounds of others. The humanistic healthcare professional demonstrates the following attributes:

- Integrity: the congruence between expressed values and behavior
- Excellence: clinical expertise
- Compassion: the awareness and acknowledgement of the suffering of another and the desire to relieve it
- Altruism: the capacity to put the needs and interests of another before your own
- Respect: the regard for the autonomy and values of another person
- Empathy: the ability to put oneself in another's situation, e.g., physician as patient
- Service: the sharing of one's talent, time and resources with those in need; giving beyond what

For the qualitative part of the study, I picked several selections of poetry and prose and described in depth their expression, or lack of expression, of medical humanities attributes. I identified these pieces primarily by their literary strength and to what degree they convey medical humanities attributes. A close reading of those pieces shows the great depth of sensitivity that is both possible and necessary for the humanistic practice of medical professionalism.

---

is required."

CHAPTER 2

REVIEW OF THE LITERATURE

The first section of the review provides general background about how the modern American medical educational institution developed after the Revolutionary War until the beginning of the Flexner Era. The second one talks about the identity of the academic medical institution and the effects on education brought about by changes in social programs and economic decision-making in the latter part of the twentieth century. The third section shows the place of medical humanities and narrative medicine in medical education. The last one deals specifically with medical student writing and positions this study into the larger discussion.

History of Medical Education: Colonial Times to the Flexner Report.

If you were a white, 18th century colonial American and wanted to receive a medical education you would most likely apprentice yourself with an established physician. If you were wealthy, you might go to England or Europe for training at a renowned university or hospital. Even more common than these educational routes were the paths of individuals who became trustworthy doctors by reputation of helping the sick as medics or nurses or by selling reliable herbal and pharmaceutical medicines (Flexner, 1910).

In the mid-1700s, Americans began establishing their own medical schools, starting with Columbia University in 1767, the University of Pennsylvania in 1769, and

Harvard University in 1783. These schools offered a simple Bachelor's degree, but soon began offering Doctor of Medicine degrees. By 1820, there were thirteen schools offering degrees in medicine. Individuals seeking to become doctors through apprenticeship programs also had a standardized program to follow, consisting of both hands-on and theoretical instruction (Starr 1982, Rothstein, 1987).

Initial requirements for graduation from an American medical school in that era consisted of attending between 32 and 40 weeks of lecture and practicum courses. Toward the late 1800s, the curriculum became more rigorous as medical knowledge became more grounded in science (Ludmerer, 1985). A great deal of hands-on education had happened on the battlefields of the Civil War. Battlefield doctors learned that soldiers in the clinic did not die from their wounds as much as they did from disease often transmitted to them by their surgeons who had not cleaned their instruments or hands. It was no surprise that groundbreaking discoveries about bacteria were made after the Civil War. Later, the founding of Johns Hopkins University School of Medicine in 1893 set the standard for medical education that included laboratory instruction as well as clinical practice.

Although there were established medical schools at the end of the 19th century, this did not mean that there were consistent or well-reasoned educational standards. For example, some proprietary schools offered medical degrees to high-paying individuals without transmitting much medical knowledge. Groups of doctors owned these schools open to turn a profit. Some schools were simply diploma mills. Sometimes schools offered an imbalanced amount of lengthy lectures and written tests but little practical clinic experience. In the proprietary school that needed an amphitheater for its only

classroom (and maybe an upstairs room in the town drug store), hands-on experience was hard to find. There still were not many hospitals open in the United States in the mid 19th century that would allow students to help or learn. Despite the profit seekers, more medical schools and institutions emerged that were devoted to scientific research, largely influenced by European scholarship brought back to the U.S. and funded by rich industrialists. The desire for physicians to receive more training led to Johns Hopkins University's requirement that all students arrive with at least a four-year degree and then spend another four years becoming a medical doctor.

In 1910, the Carnegie Foundation hired Abraham Flexner, one of its own research staff members, to compile a report on the state of medical education in the United States and Canada. His inventory of the 155 medical schools showed low or questionable standards of admission, assessment, and graduation, and too many schools, including proprietary schools, that were not associated with a college or university. The suggestions in his report closed many schools and encouraged others to model their curriculum after Johns Hopkins'.

Flexner's report also recommended that every state establish a branch of the national organization the American Medical Association (AMA), founded in 1847, to oversee the 31 schools allowed to remain open. Physicians should receive at least six to eight years of post-secondary formal instruction. Classroom and laboratory training should adhere closely to scientific method and focus on physiology and biochemistry following standardized protocols of scientific research. Furthermore, there would be more prerequisites for admission into medical school, such as chemistry, taken at the undergraduate level. The first year curriculum would include lecture and laboratory

instruction in anatomy, embryology, and physiology. The second year would include instruction in pharmacology, pathology, and physical diagnosis. This is by and large the same pattern followed today. Salaried faculty in both basic and clinical sciences would be supported in their research. And very importantly, schools would have control of clinical instruction in hospitals so that students could receive supervised clinical experience.

Flexner encouraged the view that medical schools are public trusts and not private enterprises. Now that scientific discovery could lead to effective medical treatment, there was no reason for a physician to keep learning bloodletting, purging, and other heroic measures that had already been proven largely ineffective. The effort to align what was scientifically known with what was taught defined the Flexner revolution. Because the proprietary schools were closed, the successful, new system denied a medical career to some students who could have passed at a proprietary school. Rural areas now attracted fewer medical graduates who preferred to practice in cities where new hospitals were being built and which were likely to carry state of the art equipment. Questions arose about what role medical education should have in guiding physician behavior and in improving the overall health care system of the country in what was otherwise seen as a fee for service industry. No one paid much attention at first, but as the 20th century matured, these dilemmas proved troublesome to the educational philosophy of many professional education programs.

After the Flexner-inspired overhaul, graduation from an undergraduate medical program was sufficient; there was not a need for a graduate program like the kind we see today, which includes internships, residencies, and fellowships. These types of programs emerged after World War II when more focus was put on research and patient care. To

handle the explosion of new scientific information at the beginning of the 20th century, schools threw out the didactic method in favor of a procedural model. There was less emphasis on memorization and more emphasis on teaching evaluation and judgment skills. Students learned that what they observed and experienced themselves could be trusted (Ludmerer, 1999).

Medical Education in the Twentieth Century.

After the initial reform, students arrived at American medical schools with basic scientific knowledge they had received in intensive undergraduate premedical curricula. If one received his premedical education at an elite college like Harvard, Yale, or Princeton, his chances for being accepted to the medical school of his choice were higher (Ludmerer, 1999). Family influence and letters of recommendation also helped. Students who could pay full tuition were favored over students who might be distracted from their studies by having to work at the same time.

Since the Flexner Report at the beginning of the 20th century, little has changed in the actual structure of medical education programs, and standards remain consistent from school to school. The American Association of Medical Colleges (AAMC), founded in 1857, is the still main watchdog of curriculum content and required training hours. Schools vary little in how they deliver content and train students. This unified approach to admission standards, material covered, assessment, and graduation requirements means that the students who leave those schools have generally similar academic and practical exposure and are competitive in knowledge and skills for residency placements. This makes sense, because medicine is a standard language; the science is the same no matter where one studies.

Even if science is a language that speaks universal truths, our human response to those truths is varied and sometimes not easily communicated. The scientific reality of untreatable cancer and the certain demise it will cause a human body brings up for the ill person and the people around him all sorts of emotions that are often confusing, painful, and sometimes quite unmanageable. Turning to medical doctors and other treatment staff for help with decision-making is common and society hopes that they will all respond with compassion.

Practical experience has shown that good medical education usually taught the individual how to be a confident physician: someone reliable, thorough, devoted, and empathic. Good bedside manner was shown by example, not by preaching. No lecture could undo the damage if students witnessed their instructors not treating their patients with courtesy and care, or showing inordinate interest in lab results rather than in the patient's problems and worries (Ludmerer, 1999).

In any professional field, its education has to respond to the social needs and practical resources of the community. Most of the time, in the new America, doctors and patients shared the same culture and lived within a system of ethical mores that had been established by religious, intellectual, and social philosophies. Therefore, in 18th and 19th century, white, predominantly Protestant America, attitudes about illness, treatment, and dying were largely the same among the population. In that mostly paternalistic society, making decisions for the ill person, even decisions against their will (assuming some degree of incapacitation), was common practice, and a practice that was rarely questioned. Subsequently, little dialogue about its ethical value ever arose, and there was little need within the educational setting for sensitivity or cultural training.

We know today that ethics about personhood, autonomy, the body, and death vary between cultures and religions. Tension and even conflict can occur from potential misunderstanding and perceived insensitivity. The fields of bioethics, medical humanities, and most recently, narrative medicine that have found their way into medical education are responses to handling difficult situations and conversations about health issues that are not immediately evident. A simple medical procedure that can be life saving, such as giving a blood transfusion to an injured sixteen year old, is not so easy when the minor is an active Jehovah's Witness. What is good for the patient may not be best thing for the person, even if all medical logic screams out to save the youth with the simple transfusion (Bloodgood, 1995).

In the early days of reform post Flexner Report, medical schools did not have the student diversity profile that one sees today. African American students had few options for medical education, a problem that was seen even through World War II. Women also had a difficult time, however less so than black students. The 1920s was a time of tough immigration restriction. Prejudice was high against admitting Catholics, Italians, Jews, and other ethnic or religious minorities into the country, much less into fields of higher education.

A backlash to restrictions manifested as quotas began in the 1920s at the elite private colleges. Quotas appeared in medical and other graduate and professional schools. Jews faced the most rigid quotas. Between 1880 and 1925, the Jewish population in the United States grew from 200,000 to 4 million. In what was blatant anti-Semitism, discrimination was highest in New York at College of Physicians, Cornell, and City College of New York. Ultimately, rich Jewish students had the means to pay and would

not be kept away: otherwise they would seek education abroad (Ludmerer, 1999). The small minority had gained some power and brought with it a different outlook on sensitive ethical topics.

The main result of Flexner's call for reform was that medical schools became linked to universities and that both were linked to hospitals where the students could gain experience. With large public endowments, the university and the teaching hospital could support medical student instruction and clinical faculty research. Likewise, the hospital had a pool of qualified doctors to take care of patients. When once the hospital was loath to let medical students near patients, it soon discovered that it could not be competitive in the medical marketplace unless it allowed students responsible access to patients (Ludmerer, 2004).

By the end of the 20th century, the balance between academic and research interests and hospital patient care had shifted, but not in the favor of either faculty or patient. Already a difficult balance to maintain, the faculty member had to make sure that enough patient hours were covered for clinical instruction and to make sure that the university stayed on the academic funding map with breakthrough clinical research. Such a balance was most enjoyed in the years between World War I and World War II when most medical schools were not financially dependent upon faculty clinic practice. Fees from private patients helped make sure that faculty talent was not overly taxed by routine patient care. This was a time in which instruction was easy. Students and faculty were a closely aligned team and students were able to learn how to best care for patients effectively via the stable faculty model.

However, after WW II, millions of citizens were able to buy private medical insurance and could now seek treatment at any hospital they chose, including teaching institutions. Through the mid-1960s, education and research remained the focus since the hospitals were still not dependent on full-time faculty for revenue. This changed in 1965 with the passing of Medicare and Medicaid, which changed the status of charity patients to private paying patients and increased the patient load in the private and teaching hospitals (Starr, 1982). By the mid-1970s, clinical income accounted for more than half of the medical school's revenue, and this would increase through the 1980s and 1990s.

This also meant that a large percentage of clinical faculty was spending more time with patients and less time teaching or conducting research while the medical school loosely retained its academic mission because enough dollars were coming in from third party payers to underwrite the medical school's academic programs. In this era of fee-for-service, third party payers did not question the medical decisions of the treatment staff and patients stayed at the hospital as long as doctors determined was necessary. At that time students could follow a patient through all stages of care, but now, students are not able to follow the stages of testing, diagnosis, and treatment because none of it happens at the same facility.

In the late 1980s when third party payers began to refuse to pay for services that its medical review members did not deem appropriate or necessary for patient care, academic programs and hospitals suffered. Since that time, academic medical centers have increasingly found themselves needing to take on more patients in order to make up for lower payments from insurers. Because clinical faculty have to see more patients, they are less able to serve as teachers and mentors for students. While the institution may

be successful in that it is surviving the changing market place, it does so at the expense of its educational quality. The main teachers of students on the hospital floor are the chief residents who are mostly there as accountability agents to oversee the access students have to patients. It almost seems as if the era of the proprietary school has returned. There is a trend among universities to distance themselves from medical schools, thus devaluing the education and research aspect and returning medicine to vocational training (Ludmerer, 2004).

Medical Humanities Education and Literature and Medicine.

How then would it be possible to teach skills in humanism and medicine in such a changed environment? One response to the changing academic climate after the rise of managed care was for medical schools to offer classes in humanities. Until the decades of educational reforms that started in the 1960s, medical students could learn the skills and nuances of good bedside manner from watching their mentors. But as education in all aspects of medicine became more fragmented, there had to be another way to model this training if not directly at the bedside. Social and behavioral sciences had already been introduced into the medical school curriculum after World War II, first in the form of psychology. There was a need for psychiatry students to understand the complex issues that faced WW II veterans who were struggling with combat fatigue, or what we would now include in the posttraumatic stress disorder (PTSD) diagnosis. Likewise, after the initiation of Medicare and Medicaid, as the demographic of patients seeking care in hospitals changed, the need to understand how disease affects different populations led researchers to incorporate sociology into medical education. Other topics such as anthropology, ethnic, and gender studies were also introduced (Ludmerer, 1999, 2004).

In fact, when the M. S. Hershey Foundation wanted the Pennsylvania State University to build a medical school to serve the population of Hershey, PA in 1963, one of the requirements was that there be a medical humanities department. The medical humanities department at Pennsylvania State University College of Medicine, Hershey, Pennsylvania, was the first medical humanities department in the country. In 1967 the school opened its doors with a faculty consisting of scholars in sociology, anthropology, philosophy, history, and literature alongside the clinical faculty. Several of the notable voices in the medical humanities subset of literature and medicine began their careers in Hershey (Hawkins, 2003).

Medical humanities was appealing because, when there was not a clinical opportunity for direct modeling of how to ask patients difficult questions or how to break bad news, those topics could be introduced in a seminar embedded in the curriculum. Literature was brought in not so much to infuse culture into an otherwise totally technical training, but rather to "enrich a narrow curriculum that was focused, almost exclusively, on the value-neutral transfer of scientific fact" (Hunter et al, 1995).

In 1994, approximately one third of the U.S. medical schools taught literature to their students (Charon et al, 1995). Literature is one of the ways that we learn about the world, and it is an art form that reveals personal experience. There is a wide array of works through which both doctors and patients can learn about illness and treatment and about the experiences of being a doctor or a patient. Novels, stories, poems, and essays from ancient to modern times have connected readers to the human element of what it means to be ill or to be a practitioner trying to treat disease. Just as medicine has excelled in amassing scientific knowledge to assist in diagnosis and treatment, it is through literary

arts specifically that physicians have been able to gain valuable skills in understanding their patients' suffering and be more effective caregivers (Montgomery, K. 1991).

Literature helps medical students and doctors listen more carefully to patient narratives of illness, which is an important dimension of the patient interview. The narrative is often the first part of the clinical workup. The patient comes to the doctor in a distressed state with a set of symptoms that he may or may not understand or be able to describe very well. Most of us have been to the doctor and hear, "What brings you to the clinic today?" Then medical personnel ask us to relay a timeline of physical symptoms or significant changes in our well-being that we have noticed. We were feeling such-and-such a way and then something happened or changed and we started to feel a different way. We are narrating a subjective story. It may be imperfect and sequencing may be confused, but it is the starting point. The physician becomes our partner in the narrative when he brings scientific knowledge and diagnostic tools to the story. Both the patient and the doctor rely on physical evidence combined with personal narrative to begin the healing process (Brody, 2003).

According to the authors of "Literature and Medicine: Contributions to Clinical Practice," an article in *Annals of Internal Medicine*, from April 1995, the study of literature can make better physicians who understand more about their patients' lives, can appreciate how paying close attention to illness narratives strengthens diagnostic accuracy and therapeutic outcomes, are more ethically grounded, and are more aware of the implications of their profession. Scenes portrayed through literature capture the reader's imagination in ways that clinical, historical, or sociological treatments do not. The same feelings of fear and worry that fictional characters express are similar to

feelings that real patients experience. One of the main elements of fiction is a central conflict and its attendant uncomfortable feelings that the conflict causes. Illness is conflict affecting the status quo and carrying with it many uncomfortable uncertainties.

A few of the many standard fictional works about illness and dying used to reveal medical humanities values to medical students and physicians are: Leo Tolstoy's short novel *The Death of Ivan Ilych* (1886), Tillie Olsen's short story "Tell Me a Riddle" (1961), and Franz Kafka's story "The Metamorphosis" (1915). Each of these works shows the experience of illness from a different point of view. Ivan Ilych is dying of cancer and comes clean about his selfish life in a kind of prolonged deathbed confession. The family of the Russian Jewish immigrant, Eva, in Tillie Olsen's story, keeps the news about her cancer from her in a traditionally Eastern European paternalistic way. The chaos that illness brings to families is one of the many themes that can be gleaned from the pages of "The Metamorphosis." There are many texts that could fill a curriculum expressing a variety of cultures, points of view, and clinical scenarios.

In addition to stories about illness are works by patients themselves, often called pathographies (Hardman, Hawkins, & Mcentyre, 1993). These case histories are stories are written from the patients' points of view. A few of these include: William Styron's memoir of depression called *Darkness Visible* (1992); Reynolds Price's *A Whole New Life* (2003) in which he describes his spinal cancer, paralysis, and chronic pain; and a short essay by Virginia Woolf called *On Being Ill* (1930). Each of these shows different cultural, intellectual, and spiritual understandings of what it means to suffer. Since people are not the same, it is naïve to assume that people experience being ill in the same way. Sometimes the doctor meets patients who are from different cultures, and their outlook on

illness differs from the doctor's. If the doctor has studied some literature, he has a bigger base of knowledge besides his own experience to draw from.

Additionally, there is a large body of works by physicians who write with great insight about medicine from different cultural backgrounds. Mainstream readers and medical students could know the fiction, plays, poetry, and essays of Anton Chekov, William Carlos Williams, and contemporary writers such as Oliver Sacks and Abraham Verghese. Their works and others like them help doctors understand the complex relationships that exist between them and their profession and them and their patients. When medical students study such works, they see the importance of medical practice and the effect it has upon them (Charon et al, 1995). For example, students can see how compassion and conflict can exist at the same time, or how a flippant attitude can affect prognosis, or how to approach a treatment when healing is not possible. In a sense, these works are case histories of the professional life.

At the same time, the educational process can be seen as a narrative. In the way that the plot of a story and that of an illness develops, education too unfolds in a certain logical way. Students must master scientific knowledge before they can acquire diagnostic skills. As the student becomes more clinically competent and develops confidence in reading and listening to narratives, the technical and scientific aspects of medicine begin to exist alongside the skills of interpretation and contemplation. In medicine, one's internal literary critic, anthropologist, and philosopher can combine their insights with the doctor's knowledge for the benefit of the patient (Charon et al, 1995).

Some narrative medicine scholars think that in order to make sense of clinical information, doctors must rely on narrative skills (Hunter, Coulehan, & Charon, 1995;

Charon, 2001). In fact, it is natural for physicians to be immersed in narrative whether they are listening to patients, attending rounds, or writing up scientific data. It would follow that, if doctors were exposed or often involved in literary activities, they would strengthen their own narrative and analytical skills. Additionally, if physicians and medical students were to participate in reflective writing, they would know themselves as well as their patients better (Coles, 1989). Reading and writing reflectively can help doctors see patterns and meaning in clinical evaluations that might otherwise go unnoticed. This is important, especially in cases of a patient who is a "chaotic narrator," when the doctor has to pay even closer attention in order to glean the information necessary to build a testable hypothesis (Charon, 1993; Frank, 1995).

Focusing on narrative affects medical ethics. As we already know, literature, allows us to encounter fictional lives rich with moral complexity. A simple clinical approach can tend to reduce ethical dilemmas to rational conflicts that can be easily analyzed and solved. Real life is not so simple, even if medical solutions sometimes are (Groopman, 2007). Using the moral and clinical imagination together, doctors can more effectively understand the experience of the sick person, communicate with him or her, and therefore better see how the individual patient's biographical and cultural framework affect ethical dilemmas (Charon et al, 1995). Understanding the patient's values, beliefs, and will about disease and wellness, details of which can be obtained by using narrative skills, can assist in treating the patient. Literary narratives provide excellent test cases and are better able to capture the ambiguities and subtleties that arise in moral life.

One might not think that there would be a useful intersection of literary theory and medicine, but scholars of literature and medicine believe that the purpose of theory is

to help readers understand that the work of medicine is like a literary texts (Charon et al, 1995). For example, reader-response critics look at texts not as static objects, but as participants in a relationship with the reader. This approach makes sense for medicine too, since both the doctor and the patient are in a relationship with the other. The complexities of the patient are presented to the doctor as a narrative is presented to the reader. Likewise, other literary theory methods such as deconstructionism and feminism can assist in the close reading of medical cases. For example, deconstructionism looks in the spaces between the texts of the case for information, whereas feminism focuses on understanding the worries of disenfranchised populations.

Writing and the Medical Student Experience.

Some medical students believe that they receive their qualifications to become doctors simply by learning all of the biomedical material in the curriculum and by being able to perform medical procedures correctly. Some believe that the diplomas they receive at the end of a four-year process of completing all requirements determine that they are physicians (Draper & Louw, 2007). These same students may acknowledge that elements of humanism are important, but not necessary for mastering the curriculum (Shapiro et al, 2009). Others believe that humanistic attributes are central to what it means to be a doctor, whether these are learned in the hidden curriculum or within the main curriculum (Ozolins, 2008).

The majority of scholars in medical humanities contend that medical education could do more to promote medical humanism as an important professional value (Wear & Castellani, 2000; Cohen, 2007). The format of problem-based learning (PBL), billed as an integrated curriculum in which students learn on their own and in small groups, relies

on fictional written cases that link basic and clinical sciences with specific learning objectives (Cooke, 2010). The case structure can deliver important information relating to the patient's problem, including history, lab reports, and physical exam. In both self-directed learning and collaborative small group environments, students can explore multiple treatment options for that patient.

Problem-based learning offers an opportunity for faculty to demonstrate humanistic values, something that seems less likely to happen in traditional, or, non-PBL curriculum settings (Maheux, 2000). However, PBL still primarily focuses on formal knowledge acquisition and clinical reasoning and does not sufficiently integrate them with clinical experiences or professionalism (Hoffman, 2006). Sometimes PBL small groups discuss professionalism.

Writing is one vehicle that can convey and teach medical humanities values. It can allow the medical student to articulate feelings and impressions that may otherwise remain hidden. When students give themselves permission to write about a patient beyond the present illness, they are able to make imaginative connections that can potentially reveal testable hypotheses (Charon, 2001; Karnieli-Miller et al, 2010). First year students at SUNY Stony Brook and Northwestern have the opportunity to imagine the lives of their "first" patients, the cadavers they meet upon entering medical school (Coulehan et al, 1995). Columbia University School of Medicine requires second year students are required to keep journals and write about illness from the perspective of their patients, and has expanded required writing to third-year clerkship students (Charon, 2006).

So far, studies on evaluating the teaching of literature and medicine and writing seem to be done on a course-by-course basis. Pre and post seminar questionnaires along with faculty and student interviews tend to show that literature courses improve students' ability to understand and grasp the experience of illness and ethical dilemmas. Significant longitudinal studies would be ideal to help determine the influence of such courses on professional identity and medical practice.

While there is not a lot of evidence about the long-term impact of medical humanities in education physicians, educators, and social scientists are discussing the topic actively. In a recent literature review of over 245 journal articles published from 2000 to 2008, Ousager and Johannessen (2010) determined that the majority of articles fall into a category called "course descriptions and evaluations." These are publications that describe specific course work and objectives which may or may not have evaluations attached to them. Evaluations could include student or instructor self-reporting or some other kind of measurement usually related to the students' acquisition of knowledge, skills, or attitudes (Hatem & Ferrara, 2001; Rucker & Shapiro, 2003).

The second highest incidence of articles are what Ousager and Johannessen call "pleading the case:" publications that argue in favor of including medical humanities in the curriculum along with ideas for how to overcome obstacles to inclusion. They categorized the remaining articles as "seeking evidence of long-term impact" (empirical evidence about the impact of humanities on students or doctors) or "holding the horses" (questioning the reasoning and evaluative methods for medical humanities).

It is important to understand a little about what is happening to students as they undergo the transition from layperson to professional. It is an intense time of academic

rigor and personal change. There is cause for much celebration, but also much humiliation. Where students may have been exceptional in their hometowns, they are now lumped together with superior achievers from many hometowns and have to prove themselves again. Memorization is stressed from the beginning, and there is little time for self-care or socializing. While mostly idealistic in the first year, by the second year, the students begin to identify with the patients. Students perceive that doctors are not listening to or treating to the patients well. This identification of powerlessness is significant, and conflicts inspired by this identification fuel a lot of narratives. By the third or fourth year of training, students have likely overcome their hurdles and are feeling more hopeful as they look forward to attaining the status of full professional (Shapiro, 2009).

Suzanne Poirier, a retired professor of medical education and literature at the University of Illinois at Chicago College of Medicine (UICCOM) wrote an illuminating article in response to the intense emotional demands of medical education and how best to attend to them. She and her colleagues who co-wrote the article show that poetry proves successful in helping some students manage the difficult transitions they undergo as they move from medical student to the liminal state of quasi-professional to professional. Similar to this dissertation's work, Poirier selected poems from *Body Electric*, a student-run medical school literary journal at the University of Illinois at Chicago College of Medicine, to show the progression from student to professional (Poirier, Ahrens, & Brauner 1998).

In 2012, Therese Jones, Felicia Cohn, and Johanna Shapiro wrote about the tones of narratives that third-year gynecology and obstetrics students use in response to

conflicts. The authors borrowed definitions from Arthur Frank's system of defining types of narratives that patients tell in his book *The Wounded Storyteller* (1995) to apply to student narratives. Frank categorizes patient pathographies as "Chaos Narratives," "Restitution Narratives," and "Journey (Quest) Narratives". Jones and her colleagues determined that the stories the third year students told could fall into similar categories. Therefore, for example, a student may write a "Chaos Narrative" about a situation loaded with calamities. The situation resulted in confusion and the student's inability to maintain control for any number of reasons including patient incapacitation or hierarchical constraints. This leaves the student discouraged, ambivalent, or even demoralized, like the patient of the chaos narrative.

Likewise, in an account of a clinical encounter told as a "Quest Narrative", the student accepts a difficult mission, encounters incredible conflict and hardship along the way, and finally accomplishes the quest, being changed in the process. Often an idealized form of storytelling, the "Quest Narrative" says more about the student than about the clinical details. The form of student story that Jones cites with most incidences is the "Restitution Narrative." In this type of story, the problem is identified and a competent, fix-it approach is taken. In the case of an ethical dilemma, the student usually invokes a standard principle like patient autonomy (Beauchamps & Childress, 2001) to restore the narrator to the pre-conflict state. The "Restitution Narrative" relies on restoring stability as its primary goal. Unfortunately, this stability often recovers at the expense of the personal values of compassion and altruism. It is significant that identifying with the powerful doctor and less with the powerless patient decreases student anxiety (Jones et al, 2012; Shapiro 2009).

These two articles are revealing because they outline some of the conflicts that medical students experience and attempt to analyze them using the students' own writing. The liminal nature of transformation is part and parcel of medical education. In comparison, an often-consulted early study on medical education, *Boys in White* (Becker, 1961), tells the story of what being a white male medical student was like in the early 1960s at a Kansas medical school, but offers no analysis about the liabilities of that training program. Taking a different tone, the young physician Perri Klass's memoir, *A Not Entirely Benign Procedure*, from 1987 asks many challenging questions of her profession and her mentors. A major part of her story was the difficulties she faced from her superiors for being pregnant while enrolled in medical school. What we may see in a medical school literary magazine such as *SCOPE* is the effort of medical students striving to sustain their personal idealism about medicine throughout their education.

Johanna Shapiro's book, *The Inner World of Medical Students: Listening to Their Voices in Poetry* (2009), uses a modified format of Arthur Frank's narrative typologies to discuss in depth the socialization process that medical students undergo to become physicians. She collected hundreds of poems by medical students and used qualitative tools of content analysis, literary analysis, and grounded theory to analyze them, not so much to verify a single truth, but to inquire into socially constructed meanings.

If this study of *SCOPE* were to appear among the journal articles evaluated by Ousager and Johannessen, it would fit into the first two categories, because it makes another case in favor of including medical humanities in undergraduate medical education and studying it. It also describes and evaluates not a course, but a student-

generated and managed phenomenon. Using literary theory and content analysis, my study will most closely resemble Dr. Poirier's and Dr. Shapiro's works cited.

CHAPTER 3

METHODOLOGY

This research study is a content analysis with both quantitative and qualitative components (Colton & Covert, 2007). The first part of this chapter talks about evaluating and selecting the population for the study: the works of medically related poetry and prose in the twenty-two issues of *SCOPE*. I also discuss how I identified the eighteen pieces for close analysis. After identifying the sample I needed to name the theoretical frameworks upon which the larger discussion would rest. In this dissertation, I base my findings on two frameworks: a set of standardized medical humanities attributes (Gold Foundation) and a style of literary criticism, close reading, which is the most commonly cited theoretical approach to reading literature in medical education (Trautman,1982; Hawkins, 2000).

I collected quantitative data by determining ratios of genres, medically related and non-medically related works, and contributor types. Determining the types of topics written about and the incidence of medical humanities-related themes comprise other sets of data. I recoded and presented quantitative data primarily in a series of tables with summaries of findings.

I presented qualitative data primarily as narratives of close readings of the eighteen pieces chosen from the larger sample. The qualitative section looks at the Gold Foundation medical humanism attributes as they appear or do not appear across the short

stories and poems. Following that discussion, I show the vertical relationships between the works and the medical humanism attributes. Finally, I close this chapter with a person as instrument statement telling about my background, interest in the topic, and qualifications.

Choosing *SCOPE*.

I visited the Association of American Medical Colleges (AAMC) website and searched for medical humanities departments or curriculum programs within US medical schools. If there were a medical humanities presence of some kind, I would continue to browse on the school's site to see if I could find a link to a literary magazine. Of the 129 AAMC medical schools, about half of them have a medical humanities program or department. While fewer than half of those schools have literary magazines, if there is such a magazine, it is connected to a medical humanities program.

I began this project with a few criteria in mind. First, I looked for paper literary magazines, as opposed to online-only magazines. Secondly, I looked for magazines in which medical students are the primary decision makers and do the majority of the work: soliciting and selecting pieces, performing edits and lay out, plus all other duties necessary to producing and promoting a literary journal. Every issue of *SCOPE* is assembled, edited, and produced by students at the Southern Illinois University School of Medicine (SIUSOM). Another quality I looked for was that the majority of the magazine's contents contain works by enrolled medical students. Like *SCOPE,* the magazines I looked at featured works by students, but also they may have included more pieces by medical school or hospital faculty and staff, and even sometimes even by patients. I also sought a magazine that had longevity and consistency of format. *SCOPE*

was the oldest of the top five magazines I seriously considered. Spring 2015 marked 22 years of production and the magazine has maintained a consistent format. All issues are available as PDF files to view or download via the web. This study concentrates on the first twenty years of the magazine, from 1994-2013.

Twenty-two years is a long time for a publication. The majority of medical school magazines have only appeared within the last ten years. Some schools have magazines that run for a few years, then stop, maybe to resume when factors like funding, manpower, and mission all align again. Some magazines have dead web links so one cannot view any content. This may mean that the student editors loaded the issue they assembled to a personal web host and not to a dedicated school server. Due to the transient nature of medical residency, once the student graduates, there is little chance of finding him or her, with much less chance of asking them to follow up and make the literary magazine visible again.

Another feature of the consistency I sought relates to format. Again, a magazine might run several years, but its presence and format might change over the years. For example, one year may produce a paper copy but have no web presence. Another year may produce a paper version in which content is reduced and the art plates are printed in black and white while its corresponding web presence contains full text and shows the artwork in color.

All *SCOPE* files are easily accessible on the SIUSOM website as PDFs. The content on the web is an exact copy of the print version. Since these magazines tend to have to raise their own funds, the amount of money available affects many things, including black and white versus color printing, paper quality, and number of copies per

print run. Generally, advertising, private donations, and medical school money fund these magazines (personal interview, 2010).

Selecting Pieces from *SCOPE*.

Of the 118 medically related pieces in the first 20 years of *SCOPE*, I wanted to showcase a few of the exemplary ones in order to convey how a study about the voice of the medical school literary magazine could impact medical education. I believe that most medical student writing is important for the authors, but in terms of literary merit, not all pieces are equal. As almost all of the *SCOPE* editors write in their introductions, more pieces are submitted than can be accepted and picking the best is difficult. This is a great problem for any literary magazine to have, and it shows a positive trend for *SCOPE.* This means that the reviewers have to make hard decisions about what is selected for the magazine.

In making my selection of what to analyze, I chose well-written, interesting examples. The subject matter need not be unique, like that of a rare disease, but could be a well-crafted piece on one of the more popular topics, like the cadaver lab or professional life. What I think qualifies as good writing includes imagery that is fresh and without cliché. It contains well-constructed language and images which enlarges my perception of the world. I look for a rich and playful sound pattern or rhyme scheme in the poems, rhythmic but not singsong-y. In prose I look for threads of parallel imagery that advance the story and how complex characters develop over the course of the story.

Some of the elements common to creative writing are character, plot, setting, conflict, structure, action, voice, language, imagery, metaphor, dialogue, and style or genre. These vary depending the genre: poetry, fiction, or script. All creative writing

relies on structure, simply, a beginning, middle, and end. Metrical and rhyme patterns structure traditional poems, whereas free verse poems have other kinds of structures operating within them. Structure does not have to be linear. In fiction, plot and setting are the bare bones of what happens and the place or places through which the plot moves. Characters provide the human element that allows readers to engage in the story. Characters participate in the story through action and dialogue.

Just about every kind of creative writing has some form of conflict, strife, tension, or potentially difficult issue central to it. Conflict drives plots forward and makes characters take action. In poetry, a conflict may involve ideas or concepts, and the author asks the reader to be a participant-observer who interacts with the poetic images. Voice refers to who is speaking from the narrator to the other characters. Poems may have an abstract voice. Speaker and narrator are not the same as author. The target audience should determine the language used. For example, shorter, simpler words are appropriate for younger readers, whereas a more complex vocabulary and multiple plot intersections are suitable for a more advanced reader (Burroway, 2011).

In general terms, character and plot are the basis of short stories, and language and structure are the building blocks of poetry. Therefore, the fiction pieces in *SCOPE* that struck me the most had strong characters and interesting plots. There may be plots that are not told in the stories, but the characters are deep enough that you can imagine their lives before and after the written scenes. Also, there were compelling conflicts that the reader could contemplate that were both related to medical problems and to the characters of the stories. The poems that I found most compelling had strong language with fresh imagery, and their unique structure helped to reveal something significant

about the larger issues of medicine and humanism. I identified eighteen pieces, eleven poems and seven stories spanning twenty years that I thought represented the best of the medically related poems and stories. They amount to fifteen percent of the 118 total sample and were chosen for the reasons explained above.

Theoretical Framework 1: Gold Foundation Medical Humanism Attributes.

For the purpose of this study, we can assume that in the medically related pieces in *SCOPE*, the authors want to make a point about the human experience with illness, patient care, recovery, disease, injury, and death, among other topics. Professionalism reappears frequently as a theme. There is also an overwhelming realization in the majority of pieces which medical students wrote that the physician witnesses and even shepherds the individual through crises, while trying his best to treat and cure illness.

In order to objectively talk about the medically related pieces, I needed to find a framework in which to consider at the writing. Therefore, I began asking whether or not the pieces reflected any of the Arnold P. Gold Foundation's I.E.C.A.R.E.S. medical humanism attributes (http://humanism-in-medicine.org/about-us/faqs/). While researching definitions of medical humanism, I found this list of attributes that medical professionals should ideally display during clinical encounters. It contains the most common terms that one sees in the literature on medical humanities. Most of the seven attributes of **integrity, excellence, compassion, altruism, respect, empathy, and service** repeat throughout the medically related works in *SCOPE*.

To gain a preliminary idea about how often these attributes appear, I conducted the following inquiry: beginning with the first year, 1994, I counted every tenth medically related piece of writing through 2013. Of the 118 total pieces, there were six

poems and six pieces of fiction. Next, I determined what kind of contributors wrote the pieces and what the major themes were. In the sample, medical students wrote most of the pieces. I looked at the pieces to see if any Gold Foundation attributes were applicable. These results are summarized in tables 1 and 2 on pp. 41-42.

Theoretical Framework 2: Close Reading.

Close reading is a type of criticism that interprets passages of the text directly in front of the reader. It goes beyond the common sense notion of learning to pay attention to words and particular patterns as is taught in the common core secondary education system. Rather, it focuses on making observations about syntax, imagery, form, and how ideas are ordered within a work in order to interpret it. This type of criticism does not base interpretation on generalized assumptions about context (Lentricchia, 2003). The technique was pioneered in the 1930s by critics I. A. Richardson and William Empson, and later developed by the founders of New Criticism. Richardson's philosophy held that the words on the page contained all the information a reader would need to fully understand the meaning of the text (Richards, 1929).

This type of framework works well for discussion of the exemplary pieces I have identified. Close reading allows me to describe the pieces and connect the salient language and imagery to meaning. The medical school literary journal provides the context and the expected topics of the works. Combined with the additional framework of the Gold Foundation medical humanism attributes, close reading provides a simple and enriching approach to examining the literary works.

Quantitative Approach.

There are a lot of relevant data to analyze in *SCOPE*. What follows is an

assessment of the breakdown of type of submission (e.g. prose, poetry, or visual art), and the types of contributors (e.g. medical students, alumni, and other categories). To expand on the findings in Tables 1 and 2 at the end of this chapter, Chapter 4 includes a broader catalog of data such as incidence of topics in the 118 medically related pieces. Such a tally tells us which medical humanities attributes are most important to the contributors. Besides tables that show this data, there are written summaries of the findings. Tables include:

- Preliminary findings of incidence of Gold Foundation attributes based on random selection;
- Breakdown of submission by genre for all pieces in *SCOPE* (prose, poetry, visual art) by year;
- Breakdown by year of medically related and non medically related pieces in *SCOPE* and the ratio of them in short stories and poems;
- Breakdown by year of contributor types in *SCOPE* (medical student, alum, SIUSOM staff, and community);
- Breakdown of medically related topics by year;
- List of topics in medically related pieces ranked by incidence;
- Breakdown of Gold Foundation medical humanism attributes in the eighteen pieces selected for close reading;
- Cross analysis of medical humanism attributes from *SCOPE* sample.

Qualitative Approach.

This section of the dissertation describes the sample works chosen for analysis in the identified theoretical frameworks of medical humanities attributes and literary

criticism. This collection of data presented in narrative form comprises a significant part of Chapter 5.

Going through each poem and story and giving what is essentially a line-by-line analysis lies at the heart of close reading. The next part of this strategy is to make observations about how the individual elements work together to construct the larger whole and greater meaning, thus determining the overall effectiveness of the piece.

Person as Instrument Statement.

My primary and earliest academic and professional work is in creative writing, literary studies, and teaching. I hold a BA in humanities and an MFA in poetry. Personal interests directed me to bioethics and medical humanities. Subsequently I was drawn to the subfield of narrative medicine. Upon receiving an MA in Bioethics, I investigated pairing it with a Doctorate in Education.

My employment history includes many years of teaching, with three positions worth highlighting: I taught a unit on poetry for a medical humanities course at the University of Virginia, and I was invited to teach a humanities unit in the Engineering School, UVA. While working on my coursework for this degree, I proposed teaching an upper level writing course in English on the topic of narrative medicine and was granted permission. This class met a final writing requirement in the BA and BS degrees, and pre-med students were the largest enrolled group.

End of the semester student evaluations showed that this was the first humanities class many of the students had taken in college. Comments revealed that the class made a difference about how some students determined where they wanted to go to medical school. For most of the twelve students, it helped bridge the gap between all of the hard

science they had been studying and the reality of the patient they would soon meet. Seminar discussions encouraged the students to think in ways that they never had about their future in patient care. One of the units we covered was about the "theoretical lens," which they agreed would be helpful to them in their studies and in their practice. We discussed how the physician and patient have different points of view. These points of view may at times overlap and mesh, but may also conflict, and the physician can learn to "read" the patient correctly while providing outstanding care.

I am also qualified to perform this study because of my long experience with literary magazines. From being the editor of a magazine at a small high school, to working as a poetry selector and reviewer for two major magazines at the University of Virginia, *IRIS: a Journal for Women,* and *Virginia Quarterly Review,* to working on two exclusively online magazines, *Archipelago*, and as a founder of *Hospital Drive*, a medical related arts journal at the University of Virginia, I know about the selection process. As I writer, I am familiar the other side of the editor's desk, when my poems don't make the cut, and I receive a rejection letter or the rare acceptance letter.

Next Chapters.

Following the analyses in Chapters 4 and 5, Chapter 6 discusses the quantitative and qualitative findings in relationship to the literature. It includes implications for further research. For example, this study shows that *SCOPE* is a forum for student writers to manage intense emotional experiences and enhance their education during their professional training to become doctors. In turn, a further study could ask former SIUSOM graduates in what ways creative writing has informed their medical practice. This study could become the basis for someone to look at several medical student literary

magazines together, analyzing the potential medical humanities themes. I hope that the combination of qualitative analysis and quantitative data in this study illuminates the ways a student-run literary magazine like *SCOPE* can be a reliable resource for medical humanities education and evaluation.

Table 1: *SCOPE* Preliminary findings A

Year / **Gold Attribute**	**1995**	**1996**	**1997**	**1998**	**1999**	**2002**	**2003**	**2006**	**2008**	**2009**	**2011**	**2013**	**Totals**
Integrity						x				x			2
Excellence			x			x				x			3
Compassion	x			x		x	x			x			5
Altruism				x		x				x			3
Respect				x		x				x			3
Empathy	x			x		x	x	x		x	x		7
Service										x			1
TOTAL	**2**	**0**	**1**	**4**	**0**	**6**	**2**	**1**	**0**	**7**	**1**	**0**	**24**

Table 2: *SCOPE* Preliminary findings B

Year	**1995**	**1996**	**1997**	**1998**	**1999**	**2002**	**2003**	**2006**	**2008**	**2009**	**2011**	**2013**
Genre	Prose	Poem	Poem	Poem	Prose	Prose	Prose	Prose	Poem	Prose	Poem	Poem
Contributor Type	Student	Student	Alum	Student	Staff	MD	Alum	Student	Staff	Staff	MD	MD
Theme	Patient Experience	Cancer	Prof Life	Dying	Patient Experience	Prof Life	Aging	Diagnosis	Health Care	Prof Life	Coma	Side Effects
Gold Attribute Total	2	0	1	4	0	6	2	1	0	7	1	0

CHAPTER 4

QUANTITATIVE RESULTS

Chapter 4 provides data about several features in *SCOPE* that are important to my study. Data are represented in tables and there are brief narratives following the tables to further describe, explain, and provide observations about the numbers. Results in the tables follow a path from general to targeted, from basic page count to incidence of topics written about in each magazine. The goal of these tables is to provide an overview of the contents of the magazine and to help illuminate the link between contributor type and medical humanism topic. The majority of these tables show totals for five-year increments over a period of twenty years (1994-2013). The full breakdown of data by year can be found in corresponding tables in Appendix A.

Table 3: *SCOPE* Years, Pages, and Genres shows the total number of content pages content in each magazine over five year stretches, with a breakdown of the three main genres that appear in each issue. A full count per issue can be found in Table 3.a in Appendix A.

Table 3: *SCOPE* Years, Pages, and Genres

YEARS / PAGES / GENRES	**1994-1998**	**1999-2003**	**2004-2008**	**2009-2013**	**TOTAL**
PAGES	215	227	245	244	931
PROSE PIECES	23	22	23	28	**96 (16%)**
POETRY PIECES	79	68	72	61	**280 (47%)**
VISUAL ART PIECES	55	59	47	54	215 (36%) TOTAL PIECES = 591 |

					TOTAL FICTION & POETRY = 376

As you can see, there is little variation in page amounts among the periods. The total 931 pages are of actual creative work and does not include introductory or end material such as table of contents and author biographies. There is an average of about 45-50 pages of creative work per publication.

SCOPE publishes original works of prose, poetry, and reproductions of visual art. Prose is limited to fiction. *SCOPE* does not include personal essays, academic articles, or letters to the editor. Over the twenty-year period of issues included in this study, there were a total of 591 published pieces among three genres of prose, poetry, and visual art. The 96 pieces of fiction, totaling 16% of all contributions, means roughly about five pieces of prose were published per issue. Two hundred and eighty poems were published, making up 47% of the total works. An average of 14 poems were published per issue. The 215 pieces of visual art make up 36% of the total and an average of 11 pieces of visual art being printed in each issue.

There are more poems and pieces of visual art per magazine because by their nature they tend not to span multiple pages like fiction does. It would be rare for a work of visual art to take up more than a page, and if it did, it would cover two facing pages. While it is not uncommon for a longer poem to be printed on a couple of pages, most poems are shorter, fitting on one page. From this point visual art has been omitted from the results because my study is concerned only with the written works. In the next table, it is important to note that of the 591 pieces, 376 are literary works, or 64% percent of everything published. Of those 376, 26% is prose and 74% is poetry.

The next table shows the numbers of poetry and prose pieces that are medically related. Table 4: *SCOPE* Years, Genre, and Medically Related Pieces per Genre provides the breakdown of medically related pieces per genre and their ratio to all the works. Again, results in this table cover five-year increments with full, yearly totals available in Appendix A (Table 4.a).

Table 4: *SCOPE* Years, Genre, and Medically Related Pieces per Genre

YEARS / GENRE	**1994-1998**	**1999-2003**	**2004-2008**	**2009-2013**	**TOTAL**
PROSE	23	22	23	28	96
PROSE MED-RELATED	11	9	10	9	**39 (40%)**
POETRY	79	68	72	61	280
POETRY MED-RELATED	31	13	14	21	**79 (28%)**

This study is trying to find out to what extent and how the medical humanism attributes of **integrity, excellence, compassion, altruism, respect, empathy, and service** appear in the literary works of *SCOPE.* The total number of literary works included in a twenty-year period is 376. Of this 376, 118 are medically related or 31%. Of this 31%, 10% are medically related (39 fiction works). The remaining 21% are poems (79 total). Looking at numbers strictly within the genres, 40% of the 96 fiction works are medically related, and of the 280 total poems, 79, or 28%, are medically related.

Table 5: *SCOPE* Years and Contributor Type shows the number and types of contributors to the magazine in all three genres of prose, poetry, and visual art. One might expect the number of contributors to match the number of submissions (591 literary and visual art pieces), but it doesn't. This is because several contributors have more than one piece in the same issue. It was not uncommon for a contributor to have two photographs in an issue, or a poet to have work appear twice. Often one sees the

same author's name appear over the course of several issues. However, that contributor would be counted separately for each year in which his or her works appeared. Again, if there were multiple submissions in the same issue by the same author, the contributor type was counted once. Table 5.a in Appendix A shows a full breakdown per year of all contributors.

Table 5: *SCOPE* Years and Contributor Type

YEARS / CONTRIBUTOR TYPE	**1994-1998**	**1999-2003**	**2004-2008**	**2009-2013**	**TOTAL**
SIUSOM MED STUDENT	74	37	43	43	197 (35%)
SIUSOM ALUM	10	33	29	27	99 (18%)
SIUSOM FACULTY & STAFF	38	52	42	37	169 (30%)
COMMUNITY (OTHER)	21	18	25	27	91 (16%) | **TOTAL CONTRIBUTORS = 556**

What we see in this table is that the bulk of contributors, 197 or 35%, of the total 556 come from the student population enrolled at the time of the magazine's publication. Ninety-nine contributors or 18%, are SIU alumni. The next largest group of contributors draws from SIU faculty and staff and accounts for 30%, or 169 contributors. Finally, the category of community makes up the remaining 16%, with 91 contributors.

The data in Table 5 show that the highest percentage of contributing writers and artists per issue is students. In most issues there is a mix of all contributors: medical students, a sizeable number of alumni, people who are connected to the School of Medicine in some kind of professional capacity, and people from the community. The ratio of alumni to student contributions varies over the years, and it is difficult to detect any pattern. The first three years of the magazine have no alumni contributors, which

may mean that the editors at the time had enough material submitted by enrolled students. It may also mean that the editors had not yet opened submissions to alumni, or, if they had, that the word had not reached alumni.

The next highest group of contributors after current students and alumni is among people who are employed at the medical school: faculty or staff such as doctors and staff workers in the clinics, labs, and academic offices of the school. Some of the clinical faculty members are from the Departments of Surgery, Pediatrics, and Neurology. Other faculty and staff include people from administrative departments such as Medical Records or the Office of the Dean of Students.

The final category, labeled "Community" in the magazine, and called "Other" in subsequent tables, is the smallest group of contributors and might include patients, relatives of staff, visiting students, or friends not directly affiliated with the medical school.

As mentioned earlier, although every separate submission was counted in Table 1, there may be more than one submission by the same author per issue. In making the count, it was not uncommon to see the same names appear in multiple issues. Also, there were a few instances in which an enrolled student's name showed up in an issue years later with an M.D. and "Class of 19__ or 20__" following the name.

In Table 6: *SCOPE* Years, Medically Related Prose and Poetry Pieces, Topics, we begin to look at the incidence of topics in each magazine by genre. This table shows the number of medically related prose and poetry pieces and topics in five-year groups. A full table of all the years can be found in Appendix A, Table 6.a

Table 6: *SCOPE* Years, No. Medically Related Prose and Poetry Pieces, and Topics

GENRE/ YEAR	No.	Topics	GENRE/ YEAR	No.	Topics
Prose			**Poetry**		
1994-1998	11	Med Stu Experience Patient Experience Alzheimer's Disease Dying Professional Life Dementia	**1994-1998**	31	Kidney Disease Diagnosis Treatment AIDS Cadaver Stroke Dr./Pt. Relationship Cancer Suicide Addiction Anatomy Art Therapy Death Aging Dying Coma Mental Illness Med Stu Experience Brain Professional Life Genetics
1999-2003	9	Dying Patient Experience Mental Health Health Care Birth Defect Professional Life	**1999-2003**	13	Pain Dying Birth Med Student Experience Disease Prevention Memory Loss Aging Rehabilitation Professional Life Cadaver
2004-2008	10	Professional Life Diagnosis Caregiver Experience (non-clinician)	**2004-2008**	14	Lump Cancer Med Student Experience

		Med Student Experience			Death Dr./Pt. Relationship Diagnosis Celiac Disease Cancer Hospital Cadaver Morphine Health Care Professional Life
2009-2013		Med Student Experience Professional Life Patient Experience Suicide Futuristic Medicine Cadaver	**2009-2013**	21	Professional Life Dying Insurance Death Cancer Alzheimer's Disease Suffering Coma Paraplegia Mental Illness Med Student Experience Anatomy Side Effects Injury
	Total 39			**Total** 79	

In almost every issue "Professional Life," "Death," and "Medical Student Experience" appear repeatedly. In the full table in Appendix A, one can see exactly how many times topics appear per issue and within genre. Also in the full table, one can see overlap per issue and genre of topics. For example, in 1994, the topic of "Medical Student Experience" was represented in both prose and poetry. In the groupings by five-year increments, topics are listed in the order in which they appeared. In the Total column, topics are listed by how often they appear and are listed in alphabetical order, from highest to lowest

In the full table, we see that there are very few years that did not have medically related works in both genres. 1996 had no medically related fiction pieces and 2006 had no medically related poems. This is probably due to editorial decisions. There may have been medically related work submitted, but it may not have met the quality of editorial standards. Several years have only one story or poem that is medically related. The next table shows how often the topics actually occur over the 20-year period of *SCOPE.*

Table 7: *SCOPE* Topic, Incidence, Years, and Genres is arranged so that the reader can see the topics occurring most frequently in *SCOPE* in what years and genres. This table shows the topics about which contributors wrote most often.

TABLE 7: *SCOPE* Topic, Incidence, Years, and Genres

NO.	TOPIC	INCIDENCE	YEARS	GENRES
1	Professional Life	27	1994, 1997, 1998, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2013	Poetry (10) Prose (17)
2	Medical Student Experience	16	1994, 1997, 1998, 2001, 2002, 2003, 2005, 2007, 2009, 2011, 2012, 2013	Poetry (11) Prose (5)
3	Dying	7	1995, 1997, 1998, 1999, 2009	Poetry (4) Prose (3)
4	Cancer	6	1995, 1996, 2004, 2005, 2010, 2012	Poetry (6)
5	Death	5	1995, 1997, 2005, 2009, 2011	Poetry (5)
6	Cadaver	4	1995, 2003, 2008, 2013	Poetry (3) Prose (1)
7	Aging	3	1998, 2002, 2003	Poetry (3)
8	Alzheimer's Disease	3	1995, 2010	Poetry (1) Prose (2)
9	Diagnosis	3	1994, 2005, 2006	Poetry (2) Prose (1)
10	Mental Illness	3	1997, 1998, 2012	Poetry (3)
11	Patient Experience	3	1995, 1999, 2011	Prose (3)
12	Suicide	3	1995, 1997, 2012	Poetry (2) Prose (1)

13	Anatomy	2	1997, 2013	Poetry (2)
14	Coma	2	1998, 2011	Poetry (2)
15	Dr. / Pt. Relationship	2	1996, 2005	Poetry (2)
16	Health Care	2	2001, 2008	Poetry (1) Prose (1)
17	AIDS	1	1995	Poetry
18	Addiction	1	1997	Poetry
19	Art Therapy	1	1997	Poetry
20	Birth	1	2001	Poetry
21	Birth Defect	1	2002	Prose
22	Brain	1	1998	Poetry
23	Cancer Hospital	1	2007	Poetry
24	Caregiver Experience (non-clinician)	1	2006	Prose
25	Celiac Disease	1	2007	Poetry
26	Dementia	1	1997	Prose
27	Disease Prevention	1	2001	Poetry
28	Futuristic Medicine	1	2013	Prose
29	Genetics	1	1998	Poetry
30	Injury	1	2013	Poetry
30	Insurance	1	2009	Poetry
31	Kidney Disease	1	1994	Poetry
32	Lump	1	2004	Poetry
33	Memory Loss	1	2002	Poetry

34	Mental Health	1	2000	Prose
36	Morphine	1	2008	Poetry
37	Pain	1	1999	Poetry
38	Paraplegia	1	2012	Poetry
39	Rehabilitation	1	2002	Poetry
40	Side Effects	1	2013	Poetry
41	Stroke	1	1996	Poetry
42	Suffering	1	2010	Poetry
43	Treatment	1	1994	Poetry
TOPICS: 43			**PROSE: 39**	**POETRY: 79**

This table shows a list of 43 topics from the medically related prose and poetry, how often they occur, in what years, and in what genres. We see that the top topic is "Professional Life," followed by "Medical Student Experience." with twenty-seven and sixteen occurrences respectively. The topics "Dying" and "Cancer" are the third and fourth topics with seven and six incidences respectively. Next is "Death," with five occurrences. "Dying" and "Death" differ in that the stories and poems about dying show it as an active condition, whereas the poems and stories about death describe a person who has already passed away. Following is "Cadaver" with four occurrences. "Cadaver" is related to death, but these entries focus on the dead body as the primary teaching tool for first year medical students. Six topics have three occurrences and they are listed in the table alphabetically: "Aging," "Alzheimer's Disease," "Diagnosis," "Mental Illness," "Patient Experience" and "Suicide." Four subjects were represented by two entries, covering the topics "Anatomy," "Coma," "Dr. / Pt. Relationship," and "Health Care."

The remaining 27 of the total 43 topics listed occur only once: "AIDS," "Addiction," "Art Therapy," "Birth," "Birth Defect," "Brain," "Cancer Hospital," "Caregiver Experience" "Celiac Disease," "Dementia," "Disease Prevention," "Futuristic Medicine," "Genetics," "Injury," "Insurance," "Kidney Disease," "Lump," "Memory Loss," "Mental Health," "Morphine," "Pain," "Paraplegia," "Rehabilitation," "Side Effects," "Stroke," "Suffering," and "Treatment."

In the year column, the top-ranking topics are evenly placed throughout all twenty years of *SCOPE*. For example, "Professional Life," is well represented from year one, 1994, to 2013. Similarly, the next three topics appear evenly throughout the span of twenty years. While sometimes only appearing one or two times, the rest of the topics create a full picture of subjects important to a medical community that is treating and learning to treat.

In almost every American town the effects of cancer, Alzheimer's disease, and mental illness demand a lot of health care resources. There is a story for every patient and doctor. That is what a magazine like *SCOPE* is for: to tell the stories which we might not otherwise hear, stories that we might learn from as student, doctor, or patient.

For the most part, the many medically related topics in *SCOPE* are common issues in our times and experience. In other words, few pieces are about esoteric or outdated diseases or conditions. For example, in the 20 years I looked at, no one wrote about polio. Celiac Disease, written about in 2007, may not be known to many readers. Celiac Disease is an autoimmune disorder in which the ingestion of gluten damages the small intestine. The speaker in the poem describing it laments of all the foods that have to be removed from her diet. Nor are many of the stories and poems replete with medical

jargon that would be prohibitive to a general reader's understanding. An exception might be the poem about kidney disease from 1994 that contains technical language describing the function of the kidneys.

CHAPTER 5

QUALITATIVE RESULTS

This chapter briefly doubles back to the literature review and reminds us that most of the studies available on literature and medicine are largely qualitative. Since the nature of qualitative studies is flexible and emergent, it is important to determine what factors will be measured using what formal structures. The chapter describes the sample and then begins discussing each work within the sample in depth. At the end of a chapter is a table and discussion summarizing the findings.

Much of the literature review in this study describes qualitative studies of the emotional and psychological effects on medical students during courses on writing or literature and medicine. We have seen that effects vary but for the most part, students benefit from these courses and their own writing mirrors their experiences and helps them process them. We know that creative writing arouses empathy in readers, unarguably an important quality in care giving. The ability to understand and imagine what another person is undergoing in times of trial is innate to almost everyone. It is also a trait that can be fostered with practice.

How does one evaluate objectively a piece of art when its effect is intended to be subjective? It is not enough to know that a poem is good, but what are the elements that make it good? What components assemble to make the reader nod his head in deep agreement or scratch his head in puzzlement? While these are not the study's research

questions, they inform the qualitative portion of the analysis. The two primary evaluative frameworks used in the methodology are a form of literary criticism called close reading and a set of attributes of medical humanism found on a medical education reference website. Further discussion of medical humanism and a description of the specific medical humanities attributes appear below. Brief descriptions of the sample literary pieces follow with a close reading each work. I introduce each piece, describe it in terms of its literary merits, and then discuss its demonstration of the medical humanism attributes. At the end of the chapter, a table lists the titles of the works and the medical humanism attributes I identified in each work.

The strategies for close reading are simple. First, it is important to articulate an overall sense of the piece. What are the initial impressions? Do those early impressions compliment each other? What is the mood of the work and what images and words help convey this mood? It may seem elementary to look closely at vocabulary, but it is in the vocabulary that the writer establishes patterns of imagery, rhythm, and symbolism.

It is also important to examine, when possible, who is speaking in the work and determine if there are different forms of writing within the piece, such as narrative, dialogue, or description. Is it possible to determine why a subject is treated with poetry as opposed to prose? Is there something within one genre that is conducive to conveying meaning? While we cannot claim to know the author's every intention as he or she composed the piece, if it is strong, salient meanings will emerge from the pages.

Referring to the literature review, humanistic medicine or values-based medicine is an interdisciplinary field within the practice of medical care that focuses on addressing the problems that have arisen in contemporary health care. It is argued that medical

humanism evolved from George L. Engel's 1977 biospychosocial model of medicine, which posits that biological, psychological, and social factors contribute to human functioning and disease. This model was later to be co-opted as a popular term to describe the mind-body paradigm (Engel, 1977).

Humanistic medicine attempts to complement physical recovery by encouraging doctors to connect to patients with empathy, compassion, and patience. This is an effort to reduce patients' suffering and their feeling of isolation in their weakened state (Remen, 2001). Too often, the patient and his or her desires, the need for human comfort, and for adequate time to process important decisions are obscured by the chaos of lab results, technical procedures, patient chart checklists, and insurance regulations. According to the Arnold P. Gold Foundation website, medical humanism is also sometimes called "relationship-centered" or "patient-centered" care, in contrast to "case-centered" or "disease-centered" care. Fundamental principles of humanistic medicine are open communication, mutual respect, and emotional connection between physicians and their patients.

One approach used to encourage the practice of more humane medicine is called narrative medicine. Rita Charon describes narrative medicine as a way of educating physicians, nurses and other care providers by using storytelling and active listening to emphasize the humanity of both patient and provider. This enables the physician to practice medicine with empathy, reflection, professionalism, and trustworthiness. In a specific way, Charon encourages her students to be close readers of patients, texts, and their own responses to both (Charon, 2001).

A goal of humanistic medicine is to create ideal and balanced care that sacrifices neither cutting-edge science nor the gentle art of creating a caring relationship. As we've seen, several medical schools across the United States have begun to integrate humanistic teaching into their curricula in an effort to offset what some view as an over-emphasis on medical technology at the expense of patient care. One advocate in this effort is the Arnold P. Gold Foundation. Established in 1998 by several doctors at Columbia University College of Physicians & Surgeons in New York, the foundation works with healthcare professionals in training and in practice to instill a culture of respect, dignity, and compassion for patients and professionals. The foundation is a public, 501(c) 3, not-for-profit organization that provides an abundance of resources for professionals and lay people who are interested in humanism and medicine. On its many web pages, one will find studies, blogs, research articles, essays by doctors, scientists, scholars, medical students, and patients, all pointing to data and opinion supporting that the best practice of medicine is based on caring, trusting, and collaborative relationships between doctor and patient. As a result, studies show that better patient adherence with treatment plans and less costly healthcare are directly related to doctors and patients working together.

The Gold Foundation directly supports medical students in many ways including rewarding excellence in scholarship, providing research and grant fellowships, and by recognizing important milestones in their educational process. For example, in 1993, the White Coat Ceremony was designed as a way to welcome new students into the medical corps and to set clear expectations regarding their primary role as physicians by professing an oath. Today, the ceremony emphasizes the importance of compassionate care along with scientific proficiency. Several schools across the country have instituted

their own White Coat Ceremonies.

Since 1999, there is an annual essay contest that asks medical students to engage in a reflective writing exercise around a theme or quote related to humanism in medicine. Top medical humanities scholars all over the country judge the entries. Winners receive a monetary award and have their essays published in *Academic Medicine*, the journal of the Association of American Medical Colleges (AAMC). The theme for 2015 was: "A critical part of providing excellent patient care is getting to know your patient. Tell us a story about a time when learning a non-medical piece of information about a patient led to an improved healthcare outcome and/or patient experience. Use relevant examples from your experience."

We know that many scholars have determined writing to be important for instilling values of humanism in medical students. If medical school student run literary magazines in the U.S. can help teach students and faculty more about medical humanism, it would be wise to see to what extent and how the pieces of writing display these values. In order to determine how the medically related work from *SCOPE* does or doesn't address themes of humanism in medicine, it was necessary to find a rubric against which the topics, images, and implications of the written pieces could be analyzed.

According to the Gold Foundation website, "Humanism in health care is characterized by a respectful and compassionate relationship between physicians, as well as all other members of the healthcare team, and their patients. It reflects attitudes and behaviors that are sensitive to the values and the cultural and ethnic backgrounds of others. The humanistic healthcare professional demonstrates the following attributes: I.E.C.A.R.E.S."

- **Integrity:** the congruence between expressed values and behavior;
- **Excellence:** clinical expertise;
- **Compassion:** the awareness and acknowledgement of the suffering of another and the desire to relieve it;
- **Altruism:** the capacity to put the needs and interests of another before your own;
- **Respect:** the regard for the autonomy and values of another person;
- **Empathy:** the ability to put oneself in another's situation, e.g., physician as patient;
- **Service:** the sharing of one's talent, time and resources with those in need; giving beyond what is required. (http://humanism-in-medicine.org/about-us/faqs/)

This list of attributes from the Arnold P. Gold Foundation became a reliable framework to use for evaluating language in the medically related written works of *SCOPE*. Each writing sample does not have all seven qualities, nor would I have expected them to, but they resound with at least one and often more. I have chosen eighteen written pieces from *SCOPE* to provide an analysis that is both literary and that includes principles of medical humanism. In the analysis of the short stories and poems I intend to show practical examples of these attributes in order for physician students to see models of corresponding behaviors. When students and professionals read literature they can begin to ask how this relates to what they are learning and doing and what it means to be a physician.

Sample.

A full list of the 118 medically related pieces comprises Table 10 in the Appendix. The sample size of eighteen represents fifteen percent of the whole sample and includes eleven poems and seven short stories. The works have been organized into four groups. Group one contains four pieces about professional experience and includes three

stories and one poem all from the point of view of a professional interacting with a patient. Professional life is the most widely written about subject in *SCOPE,* reflected in Table 7, with 27 entries. The next most widely written about topic throughout the magazine is the medical student experience, and group two contains five poems on that theme. Group three could be seen as a subset of the medical student experience because the topic is cadavers, a common medical student preoccupation. In that group there are two poems and one prose piece. Cadaver is sixth among the overall topics recorded in Table 5. Group four contains the rest of the sample: three poems and three stories. This group presents the patient point of view, and covers various topics like death, cancer, or hospital stays.

Examples were chosen for literary merit, per qualifications discussed in Chapter 3. Quite coincidentally, I discovered that many of the pieces I was drawn to received prizes the editors awarded which further attests to their literary strength. In each of the four groups, there is at least one prize-winning entry. I also made sure that the sample evenly spanned the twenty years of publication, from 1994-2013. There are pieces from 1994, 1995, 1998, 1999, 2002, 2003, 2005, 2006, 2007, 2008, 2011, and 2013. Twelve issues of the magazine are represented, a little over ten percent. Some years are represented twice across the groups. Group one has two selections from the same year and both of those selections were prizewinners in prose. All pieces can be found in a PDF document in Appendix B.

Southern Illinois University School of Medicine has granted me permission to quote and reproduce the works from *SCOPE* I discuss in this section. I had no direct contact with any of the authors, hence the study did not involve human subjects. To

protect the authors' anonymity, I obscured their names on the pages in Appendix B. In the qualitative analysis of the written pieces, I refer to whether a student, alumnus, or faculty member wrote it. In most cases, the gender of the speaker of the piece generally may be assumed to be the gender of the author.

A brief note on quoting procedure: where passages are quoted within this document, page numbers are provided for prose and line numbers are provided for poetry. The standard format is (p. __) for prose quotes and (lines __-__) for the first line(s) quoted and then the line number for the rest of a poem's discussion. In poetry, a line break is signified by a single slash mark (/) and a stanza break is marked by two slash marks (//).

Group One – Professional Life.

In the preceding chapter, I explained that professional life is the most widely written about subject in *SCOPE.* Its authors draw from two groups of professionals: SIUSOM faculty and staff, and SIUSOM alumni. Three of the examples are prose and "A Gift," "Goliath," (both stories), and "Wishbones" were all prizewinners in the annual *SCOPE* contests for prose and poetry.

"The Velcro Bow," published in 1994 (pp. 6-7), is a two-page story by an author connected to the SIUSOM Department of Anatomy. It is interesting that the character narrating the is a female attorney with two healthy children whom she adores. Her clients' young child was disfigured in a fire, and the family needs legal help to address medical bills. During each meeting, the child was cheerful, despite having to wear protective covering over her skin. She was especially interested in pictures of the children on the attorney's desk. The injured child particularly liked the hair bow that the girl in the

picture wore. The speaker notes that the burned child's most prominent and unharmed feature was her big blue eyes. They were expressive in a way that the rest of her face could not be; she could hardly smile because her lips were burned off.

The attorney has an epiphany several months later when she thinks about the burned girl and imagines that she may never have enough hair grow back to wear a bow. Her religious faith taught her that "Man's extremity is God's opportunity," and to remove the word "never" from thought and speech (p. 6). The speaker then recounts two very significant times in her life when only a miracle could have reversed two medical crises. First, she had been told that she could never bear another child after the complicated birth of her son, but within nine months of her mother's death, she had her daughter. Second, the speaker was faced with a serious case of glaucoma that seemed completely untreatable and blindness inevitable. Again, her faith in the Lord was what sustained her and she was completely healed. Certainly, she thought, she could figure out a hair bow solution to brighten the life of one girl who had been injured accidentally. In this regard, the speaker demonstrates the medical humanities attributes of integrity, compassion, and empathy.

Later in the story, the attorney looks through the file on the girl's case and sees a picture of her before the accident. She was very pretty and had beautiful blond curls. Inspired, the speaker makes a hair bow for the girl and waits for the family to return, about a year after the first visit. The little girl was still covered up with protective cloth and the sensitive narrator wondered what the year had been like for her: "The pain. The stares" (p. 7). The little girl delights in the new pictures of the attorney's children on her desk and comments, "My Papaw says that I am goin' to go to heaven, 'cause I already

been burned up down here" (p. 7). Then the child smiles and the attorney cries and brings out of her desk a bag with the hair bow in it. Because it has Velcro on it, it will stick to the fabric of the protective covering the little girl must wear. The little girl's response is positive as she exclaims to her mother, "I feel pretty inside, like before" (p. 7). In this small gesture, the speaker shows the attribute of altruistic service.

This story stood out for me because though a member of the SIU medical school staff wrote it, the main character in the story was not a medical professional. Most of the stories and poems in the issues of *SCOPE* are written from the point of view of a character who is directly involved with medicine, either as patient or health care provider. The voices could be the patients', doctors', students', or other observer's, like a family member. This medically related story, written by someone in the Department of Anatomy, is told from the point of view of an unexpected professional: an attorney. Referring to the Gold Foundation list of medical humanism attributes, the story engages several that are valuable in any interpersonal interaction: respect, compassion, and empathy. The attorney goes above and beyond her duties as an officer of the court and creates a hair bow for the disfigured girl, making a difference in her life.

The little girl's medical issue is serious, and the narrator is sensitive enough to see the larger picture and makes a personal effort to provide relief beyond the services that her profession can offer. She chooses to help because she once faced health challenges which doctors considered incurable but her faith allowed her to overcome the impossible. Her resulting empathy and compassion drive the desire to help the girl. The attorney's solution would not address the clinical problem, rather, it would help to address how the little girl felt about herself. It might help reduce the internal pain caused by the external

disfigurement of her burned skin. The story shows that people who help heal do not have to hold M.D. degrees. Sensitivity from anyone helps the injured heal from the inside out.

Another story, "A Gift," from 2002 (pp. 10-15), written by a SIU physician in the Pediatrics Department and told from the point of view of a pediatrician, deals with a clinically hopeless case and exemplifies almost all of the medical humanism attributes in the Gold Foundation list. Not only must the narrator confirm the truth of the newborn infant's massive and life-ending defect, but must also share the bad news with the parents. Delivering bad news is one of the skills that medical students sometimes learn, but it is not given a lot of time in the curriculum since more time must be devoted to learning about the body's systems.

Everything that the main character in the story must do he does with integrity, respect, compassion, and excellence. For example, the speaker, a mature and experienced pediatrician, implies that delivering bad news is never easy and it never gets easier, but if he has at all become jaded, he does not betray this to the families. In the story the doctor quietly marvels over and over how physiological development can go very wrong, yet there is a strange beauty in nature's anomalies. In "A Gift," the newborn that the doctor is examining has no higher brain. The cranium looks large, but it is filled only with fluid. According to the story, in most cases, fetuses with this kind of gross abnormality would spontaneously abort. That the infant was carried to term was exceptional and this doctor was brought in for consultation. The infant demonstrated some normal reflex responses such as sucking on a pacifier and grabbing the physician's finger, but the doctor knows there is no treatment for this condition: "Whatever developmental monstrosity lurked beneath the skull, below the neck was a beautiful baby girl ready to live" (p. 11).

A short time after the doctor determined the diagnosis, he, a social worker, and a neonatologist met with the parents to deliver the prognosis. Throughout the story, the speaker remembers what it was like to first encounter such developmental anomalies, in textbooks and specimen jars, and later, as an intern, to deliver bad news to a family. Today the doctor still cannot disregard the fact that this little child had held his finger. He had experienced a personal and meaningful connection with the tiny human, a feeling that is amplified for the confused parents. Despite all the connection that the doctor may feel, it does not change the truth: that there would be little quality of life for the child, even though she looks mostly normal. The fact that the doctor felt that small connection makes it more difficult to remain detached while explaining that the child was missing the parts of the brain that form "thoughts, memories, personality – the brain that sees, hears, talks, interacts, or loves – all the things we take for granted" (p. 12).

This could be a good teaching story for students to learn about physician affect. The doctor is not sentimental, nor is he cold or overly detached. And he is not perfect. He is very matter of fact, but sometimes a sigh of exasperation will escape him when parents do not comprehend the reality of the situation. The language of the one of the lessons in the story is clear: "I've learned that the hardest thing is to start. From among all the possibilities that jump at you under the pressure of the moment choosing the right words – kind, sympathetic, yet accurate words – is the most difficult" (p. 12). He feels in his stomach the "same pang I felt on every occasion I had to greet perfect strangers as the messenger of devastating news" (p. 14). Another thing this story can teach is that while the situation is awful, it is a scene in a larger context that could become even more heartbreaking. For example, the speaker notes that most of the time, "Most fetuses with

severe brain malformations spontaneously abort" (p. 11), so not only is it tragic that the physiologic development went haywire, but the baby was carried to term without adequate prenatal care to indicate that there was something terribly wrong. The pathos is compounded in that the parents had tried several times unsuccessfully to have a child, and that "this was their last stand" (p. 14). Every other organ system had developed normally and was operational except the brain, the organ which makes a person a person. The doctor seemed to understand this couple and could empathize with how difficult this situation would be for them. He wouldn't have to understand them in order to do his job and do it effectively. His empathy helped him to do his job better.

The title of the story, "A Gift," may seem puzzling to the reader. Where is the gift in this tragedy? The father of the baby girl calls the child as "a gift from Heaven" (p. 14), but it is clear that the hopelessness of the situation has not hit home since he still sees a future with his daughter: "Well, of course, we want her around as long as possible" (p. 14). What the hospital team has been trying to tell the parents is that while they can expect some normal physical development in the child, because there is no higher brain, there will be no ability for the child to interact beyond simple reflexes, "…she will be blind, deaf, and completely vegetative" (p. 14). The physician predicted that the little girl would not live past a couple of months, but also said he had seen cases of children living several years. When the mother asked if her daughter would feel pain, which she would only as a reflex, the mother seemed to understand her daughter's future in a way that her husband had not yet grasped.

Before this, the neonatologist had asked the parents what their wishes were for the child should she stop breathing, eating, or become unresponsive. The questions had to be

overwhelming as they came in rapid-fire order. The doctor noted, “There was a hint of urgency in her voice” (p. 13). The father asked if inserting breathing and eating tubes would prolong their baby’s life, and the neonatologist said, “Yes, but be careful what you wish for…” (p. 13) as if to caution the parents against exposing the baby to what could be perceived as unnecessary and ultimately useless measures. The pediatrician also cautioned that it would be easier to not insert a breathing tube than to remove it, because “If the baby survives, you’ll be committed. This isn’t going to be like brain death where you can remove the tube later at will” (p. 14). Essentially the physician was intimating that to do so would be committing murder. The ethical lines could blur on this point, but the mother understands and indicates that she does not want such extraordinary measures taken for the life for the baby.

At the end of the story the doctor moves on from this sad situation and wonders about his work. It seems that these encounters have taken their toll on him. He asks if being older makes this work bother him more. Has he simply burned out? “Or did life just seem more precious?” (p. 15). This story is a good example of the really hard issues that doctors and patients face, issues with no easy answers and little positive conclusion. The story relates a situation in which issues of quality of life and personhood must be weighed with resource allocation and expected outcome. By looking at these types of stories through a medical humanism framework, students may be better able to respond to the messiness of life and death.

The doctor demonstrates excellence in his care and treatment of the child and empathy and compassion for the parents. He is respectful of the parents but honest when he delivers the news about their child. Altruism on the part of the doctor is not really a

factor in this story. The doctor's integrity is not challenged or featured in this story, but is assumed.

"Goliath" (2002, pp. 30-33) is told from the point of view of a seemingly cynical middle-aged physician working the graveyard shift in the emergency room. There are a couple of patients whom the doctor is monitoring when the story begins quietly. As if from experience, the doctor recognizes this quiet time as "the calm before the storm" (p. 30). Almost on cue, a very large man who is having seizures is brought in, and the doctor must think and react quickly to the situation. His initial responses reveal unedited judgments about the patient. First, the doctor describes the patient as "gigantic, like some freak of nature" (p. 30). He describes the man's head and arms and while astonished, admits he is a little afraid for the safety of himself and others in the clinic.

The way the doctor describes the patient makes him seem almost un-human, or subhuman and could be seen as derogatory. This says more about the doctor than his patient, whose giant limbs are "tentacles, blindly groping at the air" (p. 30-31). If there were a numerical scale of empathy and respect for patients, it would seem that this story shows deficits. Even the staff reacts to the "creature with the caution normally reserved for contagious and life-threatening bacteria and viruses" (p. 31). The truth is that a seizing patient is potentially quite dangerous to the clinicians who don't know what is causing the seizures or how treat them. "Jesus, this guy is huge mongous," says the ER clerk (p. 31), an observation that states the obvious and unnecessarily out loud, even if most of the staff was thinking it.

Without a past medical history, administering treatment to a seizing patient becomes more difficult. The doctor calls out to the waiting room if there is anyone

present who knows the man, and a petite woman comes forward to indicate that the patient had recently stopped taking his anticonvulsant medication, had been depressed, and had started drinking alcohol. The doctor assumes from woman's appearance that she is the patient's wife or girlfriend, the second in an "anatomically incongruous couple" (p. 31).

People make assumptions based on observations. Assumptions help us order our perceptions to aid in problem solving. In trying to master medical mysteries, assumptions can be useful, and at the same time, they can be misleading. Assumptions about a patient based on what he or she is wearing, for example, may be a helpful or may be a distraction. To base any conclusions on a limited set of assumptions would be dangerous and irresponsible and could almost be seen as stereotyping. This story deliberately suggests stereotypes and assumptions in the attitudes of the late night workers.

To take this one more level, when writers use certain modifiers in stories, we readers make our own assumptions. For example, the physical description of the man and the woman might make us think of biker culture and make some assumptions about behavior like drug use which could have been a factor causing the man's seizures. It seems that the doctor also might have wondered this as well. It would be a legitimate concern, since reversing the effects of an overdose may involve a different treatment approach. We find out that illegal drugs are most likely not part of the present picture when the female reveals the man stopped his seizure medication.

The doctor describes the woman who came in with the man as "haggard" and his eyes zero in on a tattoo located at the center of her chest, visible above her sports bra. In a moment of self-revelation, he admits to us that he is "gawking at the tattoo like some

kind of voyeur" (p. 31) and is obsessed with finding out what the tattoo is because it could hold the secret to "Goliath's life, her future, and possibly my own well-being" (p. 31). He discovers that it is an image of a small heart pierced with two arrows. In a transitional line of the narrative, the doctor muses, "If only all love was so easily identifiable and permanent, there would be much less suffering in the world and much less business in the ER" (p. 31).

Once the patient receives medications, he begins to calm down and become more human, though "his harsh snoring reverberated like a growl of a beast" (p. 32). The man, a physical Goliath, has been subdued, and the overt medical symptoms have been at least temporarily conquered. Now that the immediate danger was quieted, the doctor wants to speak more in depth to the woman he assumed to be the patient's wife, but she is gone. To his embarrassment, he finds out from a staff member that the woman was the man's mother. Suddenly the doctor's tone shifts and becomes more compassionate and empathetic. He sees love in the situation: the love a mother has for her son which is a love that demands nothing in return. We hear the cynical voice return near the end of the story when a nurse harshly remarks about the man leaving against medical advice, "Doesn't it make you angry that we spend so much time, effort, and money on some people and they just throw it away?" (p. 33). The doctor replies that there are some people who don't want to be helped, "But that doesn't mean you don't try anyway" (p. 33). The final image of the story is of the doctor "eagerly" entering an exam room containing a mother and her crying infant. The doctor seems to have gotten his empathy back.

This story, written by an alumnus, seems to be a believable account of what life is like for an experienced physician. Most people are rarely happy in their jobs all the time, and in the workplace a certain amount of cynicism and office short hand speech is normal. In the intense environment of the ER, where all kinds of tragedies are seen, it can be wearing on a staff who must take care of patients involved in sometimes preventable tragedies. The medical sociology literature tells us that one of the ways common for medical students to handle intense emotions and highly charged patient encounters is to blame the patients or make fun of them (Smith & Kleinman, 1989). This story shows that even experienced physicians are not caring all the time, especially when dealing with difficult patients. However, this doctor has both compassion and empathy: he wants to relieve the patient's suffering, and he shows us his insight into what the mother must go through repeatedly. He knows that the point of medicine is to treat, no matter what one thinks about the patient.

Other attributes such as service and clinical excellence can be seen in the way that the ER team is working together to help the gigantic seizing patient. The doctor is determined to try and find out what is wrong so he can administer the best course of treatment. He gains additional insight based on witnessing the mother's love for her son, and while it does not actually help the son a great deal, it does help the doctor with the next mother-child combination.

"Wishbones," from 2007 (p. 6), is a short poem dealing with the death of an individual in a sensitive but not overly sentimental way. What makes this poem unique is that from the beginning it relies heavily on sound to carry the meaning. A woman in SIU's Visiting Nurses Association program wrote the poem and uses the point of view of

the caregiver. It is reasonable to assume that the speaker is a female nurse. Right away, the single word title is evocative in both image and sound. We might immediately think of the traditional wishbone from a Thanksgiving turkey which makes a snapping sound upon breaking, and the person who holds the longer piece will have his wish granted.

However, the speaker is not talking about a bird but a female person dying of cancer and upon whose chest she starts to perform CPR. The nurse is doing her job, trying to resuscitate the woman. However, hearing the "Pop. Pop pop pop. Pop," (line 9) the speaker knows that she is breaking the patient's ribs with every thrusting attempt to stave off the inevitable. Although unnerving, the sounds are "Not the harsh snap the chicken breastbone makes / When my brother and I make a wish and pull // But a gentle staccato" (10-12). In hindsight, the speaker wished she had "made a wish for every rib: // For timely goodbyes / For freedom from pain / For a peaceful journey" (13-16). The reader can assume that the speaker meant these wishes for her patient, but the poem reminds us that these are wishes for everyone who suffers and faces the end. What more could this nurse really do, but perform the bone crushing CPR and make wishes for this patient, who had said at the beginning of the poem "Do everything for me"? (4). The nurse's professional integrity keeps her to her task.

The poem concludes with the speaker putting the dead woman's jewelry into "the muscular hand of her son" (19) and sitting with him "in silence / My hands still holding the popping of her ribs" (20-21). The simple but powerful picture of the woman's cancer-wasted body is contrasted with the muscular hand of the son. The author didn't need to write "muscular son," rather, the image of his hand is enough to contrast with the poem's first line, "Tiny she was, and dark / Within the white sheets / Frail and tired from the

cancer" (1-3). The poem's last line is an especially stunning image. The caregiver-nurse, who performs thousands of procedures for patients with her hands, is now holding her patient's death with that singular sound common to resuscitation. This is a spectacular physical manifestation of empathy.

The author chooses the word "holding" above any other word, like "carry" or even before any other tense of the verb to hold. Holding is intimate and secure. To hold someone is to know that person in a unique way. The present progressive case shows that the verb's duration is ongoing. One can imagine that this sensation will not be quick to leave the speaker. Such a sensation may get the attention of all who experience it, but it will mean something different to everyone. For some practitioners the popping sound will leave their hands at the end of the day. For others, they will never feel it. For still others, it may gradually go away over the years of practice. Encountering this poem may change readers and show them the values of medical humanism at work in powerful literature.

Group Two – Medical Student Experience.

The medical student experience is the second most widely written about subject on the pages of *SCOPE.* The majority of the contributors to the magazine in general are students (35%) and the high number of contributions on this topic shows that students are writing about what they are experiencing. All five pieces in this group are poems. "The Interview" and "Study Date" were both prizewinners.

One work that gives a peek into the humanistic and technical thinking required for good physician standards is "EMPaThY," a short poem written by and from the point of view of a medical student from *SCOPE* in 1998 (p. 30). Each stanza begins with a heading that is ascribed to the SOAP Note, a standardized form of documenting patient

status and the plan for patient care. It is as if the voice of the poem seeks to instruct both the reader and self, reminding them of procedures while staying connected to how the patient is feeling. SOAP headings stand for: Subjective, Objective, Assessment, and Plan. Each heading relates to the narrative of a patient's diagnosis and care. In this poem, the speaker is concerned with being empathetic and seeing the suffering patient as more than a collection of symptoms and diagnostic tests. The poem's quirky linguistic title shows that excellent technical skills are imbalanced, or, "empty" if not paired with values like empathy and respect.

The first section of a SOAP note usually identifies the chief complaint of the patient and describes the patient's condition in narrative form and when possible gives quotes from the patient. It may include a history and review of systems. There is no quote from the patient in the traditional SOAP note fashion in the first stanza. Rather, the "Subjective" voice is about the first impression the overtired medical student has upon looking at the chart of her patient: "her chart was depressing / Increasing respiratory failure after all those cigarettes" (lines 1-2). The patient had undergone a procedure that failed and the student is horrified when she catches herself thinking: "Why doesn't she just die? / QUICK curse the thought" (6-7). It is interesting that this 4th year student author already understands that in her chosen profession, "Empathy is now a luxury / To be contemplated under fluorescent lights / A cerebral conversation in a conference room" (10-12). Already we can see how this poem could serve as an excellent teaching model for the reality of how difficult it is sometimes to maintain compassion or respect for some patients.

The "Objective" themed stanza contains observations about the patient: "Her

voice is sweet / In obvious pain but yet polite" (13-14). In a typical SOAP note, this section contains findings from physical exams and results from laboratory and diagnostic tests. The woman is frightened about a procedure scheduled the next day and her pain doesn't seem to be under control. Upon a palpating exam, the medically observable action in the stanza, the student notes that the abdomen has severe tenderness, and it appears that the morphine is not effectively controlling the woman's pain. One part of the overall treatment plan would be to try to better manage the patient's pain.

The "Assessment" stanza seems to be the speaker's note to self to make sure she is polite and respectful of this patient who may die quite soon. The language does not seem like typical language in the assessment part of a SOAP note, which tends to focus on diagnostic information with patient progress and goals. The student sets goals for herself to, "Try not to cause her any more pain / Try not to regret the lack of thoroughness" (22-23). There is so much that is out of everyone's hands in this difficult situation, and it seems that the student borders on feeling responsible for it all. More strongly, the speaker struggles with integrity and fears failing at respect.

I included this poem because it was unlike most other poems in *SCOPE* in the way it deliberately blended medical terminology into its formal stanza organization. I do not believe this is intended to be a real SOAP note about the patient written in poetic form. Still, this poem was an attempt to meld educational material with the poetic voice. The poem doesn't demonstrate the values of medical humanism in action so much as it is a reminder to the student to try and keep these values at the forefront of providing patient care. Most physicians agree that it is hard to be empathetic toward a difficult patient when one is short on sleep. However, pushing through the need for sleep is an altruistic

effort.

The final section of the poem and SOAP note is “Plan” and should show what the health care provider plans to do to treat the patient’s concerns, such as ordering labs, performing procedures, or prescribing medications. We can predict this is going to be a plan for how the speaker is to behave: “round early tomorrow / Remember to check more than her labs” (25-26). The speaker wants to remember to be empathetic. After all, the patient is human, whose “heart still beats with regular rhythm” (27). To be empathetic is to have the ability to understand and share the feelings of another person, even if one has not had an exact shared experience. It is curious that the author spells the title word “EMPaThY” in such a way that the reader cannot help but see the word “EMPTY” standing out in the capital letters. Clearly the author wants to send the reader a message linking empathy and emptiness with the subjects of the poem: the helplessness of the student and the dying patient.

The student seems to understand that all she can offer this patient is kindness, which is an empathetic response. It may be that the author of this interesting poem is making a comment about the absence of empathy in the medical environment by contrasting the technical headings of the SOAP note with the emotional perspective of the student. In the end, all the student has is her empathetic responses, since little can be done medically, and long after the patient has died: “she teaches me that empathy remains” (28).

“The Circle,” from 2002 (p. 37), is a four-stanza poem written by a first year medical student. The poem describes the uncomfortable, liminal state that the medical student inhabits between learner and professional. The student in the poem knocks on a

hospital room door, and after it is not answered, cautiously enters the room and sees a circle of people gathered around a patient on a bed. The student has a self-conscious dialogue with herself about whether she should be there, “Are you intruding / Is this your place / Who are you / Professional, paid help, acquaintance / Family–no” (lines 6-10). She almost leaves, but the patient on the bed motions for her to come. Her role becomes more defined as “Professional, friend, supporter” (19). In this poem the medical student steps closer to that goal of doctor.

The word “professional” is used twice to describe the student. The first time is in the second stanza and the student is abstracted and distanced from the patient as “paid help” and “acquaintance” (9). It is true that a doctor is a professional acquaintance paid for services, but a doctor can be a professional who is close to the patient and displays an attitude like a caring friend. However, this relationship depends on how the patient feels about the doctor. The doctor may bring a caring demeanor to the clinical encounter, but the patient must feel cared for.

The poem brings up interesting questions about educational development: when **does** a medical student become a professional? Is it dependent simply on mastering material and test scores? Should there be a bedside manner rubric and if so, how would that be measured? This medical student crosses a significant threshold in this brief poem, from caring student to caring professional. The final line of the poem shows that this student doctor is connected to the patient in many ways including physically, “Her hand in yours” (20). In this poem, we can detect several attributes of medical humanism. The medical student is invited to the bedside because she exhibits empathy and compassion, as well as respect and excellence.

"Come Closer" (2003, pp. 36-37), is a longer poem written by an alumnus about the perceived need to maintain distance from overwhelming emotions, something the student learns is practically impossible. The first lines of the poem are spoken by a teaching doctor to new medical students, "We teach science here… not feelings, he said / We do not engage the dying… Stay distant" (lines 1-2, 5). These lines repeat like a refrain throughout the poem as if to remind the student to stay focused on science and not get bogged down in feelings or connect too much with dying patients. There are many adverse physical conditions that a doctor can reverse, but she can never master death.

The other refrain in the poem is the title's words "come closer." It seems as if the medical student speaker is being let in on important secrets about the body, death, and how to "shackle the impotence of your emotions" (20). The poem also refers to changes that a medical student undergoes in the process of professionalization: "A kaleidoscope of feelings stands in the shadows … / New patterns emerge" (27-28). The student learns to come closer to the mystery of death and accept the inevitable but is reminded to "stay distant" from the patient. In the poem, a patient will die while the young doctor is in the room, but before that he entreats her to help, to literally come closer, "You can do something young doctor" (50). Whether that is wishful thinking on the part of the dying patient, or whether it is a challenge to do something great in the future, it is a command that she continue to search for meaning.

The word "stranger" appears in the poem, used most often to modify the speaker, "…listen carefully / Listen lest you become a stranger" (14-15). It also is used to describe death, when the speaker wonders if death is a "strange season" (13) and later, "Is death the enemy … the stranger?" (32). Death is a normal yet mysterious occurrence; we are

not strangers to it. Presumably it is the dying man's voice that calls for the young doctor to "Come closer … come closer …" in the last line of the poem, which also says, "there are no strangers here" (51). Whether this is actually the speaker reimagining things, or the patient, the point is that we all meet death, that final and intimate stranger.

Few medical humanism attributes are overtly displayed in this poem. However, we can infer compassion and respect on the part of the medical student who wants to help and integrity in staying with the patient. There are no procedures being performed, so service and excellence are not applicable. The student is drawn to the suffering man and is reminded not to engage with him, but only the science. An almost anti-empathetic response is encouraged. The student is caught between mixed messages and at the end of the poem sits with the patient as he dies.

"The Interview" (2005, p. 7) is a poem written by an alumna that compares the experience of a young doctor with the speaker's reflections today. The poem begins with a medical school interview and the prospective candidate reminding herself, "A pigtailed bobblehead" (line 2) to "Appear earnest" (1) and to say, "I love science / I love working with people, / and medicine" (3-5). The speaker is desperate to get out of a rural, blue-collar, dead end life and wants "A career to engulf her" (11) and to become "Too busy to cry" (12).

Indeed this career does engulf her. Fast forward a few years and she is married with children and in the middle of a riveting surgical practice. The children have grown up and the husband has left. Her daughters are gone, shells "gutted, hollow" (20) while in the meantime, the speaker was "Reveling in the glow of another save" (25). No one can be prepared for what goes on in life when the practice of medicine tries to consume it. At

the end of the poem the speaker wonders what to do with the empty shells. Fill them "With newspapers? Like we do an autopsied carcass" (28-29). She seems to realize that she abandoned her children just like she had been abandoned. Very little in her life is neat and tidy and capable of being healed. The speaker asks at the very end, "Can we not tighten up this interview process?" (33).

On the surface, it seems that this doctor might fall short on empathy, as consumed as she is with her practice. However, it is not clear. Perhaps the family falls apart due to her work, but this doesn't necessarily mean that she does not display empathy to her patients. But, there is nothing in the poem to suggest that empathy is present or lacking. It would appear from the poem that the doctor does good work, displaying the attributes of service and excellence. One might think that this could imply that the doctor has some degree of respect and compassion for the patient. There is little in the poem to show that medical humanism attributes beyond excellence and service are in place. The poem is stark and generally describes a life devoid of meaningful human connection.

"Study Date" (2011, p. 18), is a short poem written by a third year medical student that describes a quintessential aspect of medical student life. Most academic literature shows that there is little time for a medical student to do anything but study. Family, friends, and romantic relationships are all but put on hold for the duration of the three or four years of training to become a doctor (Shapiro 2009). Keeping this in mind, we see that even from the title, there is a clever ambiguity working throughout the poem. Is the speaker meeting someone to study or is the study date simply a solo meeting with the books?

The deliberate, seductive language throughout the poem reinforces this ambiguity. The speaker is “Seduced by nightly study sessions” (line 1). Given what the literature says about medical school socialization, another person is probably not seducing the student to study. Rather the student is describing the relationship to the work itself as though it were an irresistible lover, a lover who has a body that the speaker is learning to navigate in studying physiology. The parts (“synapses and asymptotic potentialities”) (2) and the whole are “Undeniably entwined despite their attempts to maintain / The professionalism of colleagues and classmates” (3-4).

It appears that this student is in love with learning. She is someone for whom “Never had the imagery of physiology been so vivid. / Anatomical pursuit transcended to the ethereal. / Bringing clarity to concepts beyond the classroom” (6-8). By the third and final stanza, one begins to second guess and wonder if in fact there is another body there, and that perhaps this has been a date with a fellow student all along. What better way to really learn than through hands-on lessons, “Laying on the crimson sheets, pouring over biochemistry. / Tachycardia increasing with each turn of the page” (10-11). While there is no “we” in the poem specifically identifying another person, there is a textbook partner. As readers, we might decide that the book is the “other” being explored with excitement like a lover, “between the lines, beneath the sheets of text” (11) with a resulting “constant companionship flamed into palpable synergy” (12). This student knows which lover she must court.

This poem typifies the medical student experience, but like others, does not overtly display medical humanism attributes. The student may altruistically be placing the need to study over the building of social relationships. Nothing clinical happens, and

there is no doctor-patient relationship described. This poem is simply a study in a primordial aspect of medical student life. I believe that one reason that the poems in this group do not display a lot of medical humanism values in their lines is that students don't have experience with many of the medical humanism attributes at this point of their careers.

Group Three – Cadaver.

This group of writings, two poems and a short story, is linked to medical student experience because the cadaver is often thought of as the student's first patient (Coulehan, 1995). Reflecting about the person and the activities of dissection, students seem alternately amazed and horrified by what they are doing. They are both incredibly curious about the deceased's life and grateful for the ultimate donation of the body. Curiosity and wondering about the deceased's life is usually matched with respect for the deceased, and as imagination is the basis of empathy, the ability to empathize increases. One of the poems, "You Speak of Medical School Cadavers" was a prizewinner.

"Henry" is a short poem that a third year medical student addresses to a medical school cadaver (1995, p. 41). Many of the poem's observations are contradictions such as, "You were old but new, dead yet alive" (line 1) which implies that the cadaver belonged to an old person yet was new and also exciting ("alive") to the student. The speaker is very aware of the paradoxical and highly personal impersonality of the cadaver lab setting, "You rested, gift of yourself to strangers. / Strangers–we who would know more of your mortal coil than any other, / Yet would not know your name" (3-5). There is also some technical language in the poem. Terms like "celiac trunk, teres major," and

"sciatic nerve" (7) contrast with those things that the speaker imagines the cadaver could never leave behind to the students, such as memories, lessons, and values.

By the end of the poem, having been reduced to a shell of the full body (which was the shell for a once living person) the students met at the beginning of the school year, "Henry" has taught the speaker a lot. At the same time the student takes away the cadaver in bits and pieces, he comes to understand how the whole physical being works as an integration of systems. The speaker in this poem understands that the cadaver he is working on is a person who had hopes and dreams and feelings and is more than a collection of body parts. The student projects that "somewhere you are happy" (15), showing empathy.

A five-part poem by a member of the SIUSOM community "You Speak of Med School Cadavers" (2008, pp. 6-7), provides a more in-depth meditation on medical student cadaver studies. The main speaker of the poem appears to be a cadaver; the one who tells all to the student, but the one who no longer has a voice. At times, it is difficult to tell who the different pronouns represent. There seems to be at least one other speaker in the poem equally as omniscient as the cadaver. For example, in the first section and first stanza, a "you" tells "me" how cadavers are prepared ("…heads / are draped in gauze at first / face down…") (lines 2-3), for the first entry by the students. The students' response will be terror at first but then gratitude for "the intimate gift of the open body" (7). It seems that the speaker addresses the student in the second stanza of that first section, a young, idealistic person who responds that he will return the favor at his death, and then makes the first cut,

> Your hand below my shoulder blade
> you trace a right angle: the first cut,
> you say, a flap of the skin's tenting

into the human soliloquy." (10-13)

The second section also seems to be told from the point of view of the cadaver as omniscient speaker. The cadaver flesh is described as oily and "resembling Italian beef" (15). The student can't swallow his sandwich at lunchtime because he is nauseated by the stench of formaldehyde and by the sight of the sandwich meat. The student is less idealistic than he was in the first stanza. He now wears the same clothes to the lab because the smell is so bad and he doesn't want to stink up his other clothes. He must have had enough experiences with the trauma of this environment that he jokes he'll mark his body up with "NO CODE" on his chest, and "CUT HERE" on his back (22-23), to make it easier for future doctors.

The next section seems to be addressed to the new doctor and projects what he will become by the end of his practice. The theme links back to the tattoo imagery in the section before it. The speaker may still be the cadaver or perhaps the voice of the student speaking to his future self. Regarding the imagery, we might see an actual tattoo on the body of the cadaver that the student is working on, "Here for the skin of your back, a tattoo, / an indigo bio-script wreathed in trumpet vine" (24-25). What else is a tattoo but a "bio-script," or piece of text that helps tell the story of a person? Since medical students generally know few personal details about their cadavers, a tattoo could provide some interesting clues or at least discussion for the larger narrative that makes up the human life.

The tattoo is a narrative of the student-become-doctor's professional and personal life. To summarize, the doctor treats all kinds of patients and relieves suffering. He has a family and hobbies. The last stanza addresses the "reader" meaning the medical student and future doctor for whom the cadaver has become "your text now, / your legend, cover

to cover." There are a lot of different layers in this poem that create an interesting tapestry of overlapping speakers, selves, bodies, students, and professionals.

The fourth section ties back to the image in the first section about the faces of the cadavers kept hidden until near the end. However, it is not only the face that causes students discomfort, rather it is the hand and all that one imagines the hand doing, "its fingers curled around a thigh / or fisted in a rage. The corporeal totem / of the hand, angelic, monstrous" (45-47). The hand seems to communicate more emotion and is more personal than the face.

The fifth and final section is addressed to the student on behalf of the cadaver. The speaker could be the cadaver or someone related to the deceased who muses that the students can "search you, / muscle, nerve, artery, ligament, bone" (50-51) but never know "how you / slept beneath these three thin blankets, / your hand at the base of my head, / my hand at your spine's low arcing" (52-55). In this stanza, the intimacy of lovers seems to be winding down in a deathbed scene. The beloved's loss through death becomes a gain for the medical students who will learn from this cadaver and engage the body in a different kind of intimacy.

Empathy is the main medical humanism value displayed in this poem. The relationship described between student and cadaver seems more like a mishmash of relationships. The student is called to work hard and persevere through the disgust he experiences and to keep learning.

"Bare" is a short story published in *SCOPE*'s 20th anniversary issue in 2013 (pp. 36-40). The author is a medical student and the main characters are medical students in a typical educational setting: the anatomy, or cadaver lab. Several student groups are in

various stages of dissection and examination of their cadavers' bones and tissues. The main characters in the story are Jen and Todd. Jen and her group are extracting back muscles from the cadaver of an 89 year old woman and Todd's group is working to gain entry into the back of a 56 year old male cadaver. Jen is using a scalpel for delicate work and Todd is using a heavy bone saw to reach the spine. While not doctors yet, the medical humanities attributes of excellence and integrity are apparent in their attention to their work. They are taking their tasks seriously and are working out the best techniques.

The author conveys the atmosphere of the cadaver lab with vivid sensual imagery. She writes that "As he moved past her to get to his group's body Todd stirred up the air around her and Jen's nostrils stung from the preservative in every breath. The smell of it lingered in her hair, her clothes, and it stayed with her for hours after she left at night. It made her nauseous for days" (p. 36). This seems a particularly noxious environment where students gather for an important educational experience. The auditory sense is piqued with the description of the sound of the bone saw makes: a "high-pitched whining" that stopped conversations "until the blade sank into the muscles of his body's back, and the noise deepened" (p. 36). Evocative terms describe the body and alternate between commonplace and technical: "hunk of muscle," "thick muscle," and "thinner serratus posterior inferior muscle" (p. 36). An experience that the majority of us never experience is described in terms we can understand: "Jen peeled [the skin] off the lower ribs like an orange rind; it made the same satisfying noise" (p. 36).

The room is alive with noise and movement of her peers, and the irony that they are talking and consulting and arguing "over the cold hard limbs of people who once were" (p. 36) is not lost on Jen. There are several parallels and opposites throughout the

story that make the writing very intelligent and give the already intense subject matter more depth and clarity. From the Gold Foundation list of medical humanities attributes, one can also find evidence of empathy and respect. One can also find the opposites of these, as the students sometimes forget that the body lying on the slab is more than a body lying on a slab. If one thinks about it, the cadaver is the medical student's first patient. An inert and fallen victim of its pathology, it still is an individual who had a name and a life. The mortal remains in the cadaver tank remind the students of their mortality and lead them to develop a greater sense of respect for both the dead and the living.

In "Bare," Jen is particularly sensitive to the "waves of chemicals wafting up out of the body like spirits" (p. 37). "Spirits" is a nice, deliberately used word to help bridge the life and death connection in the cadaver lab. The chemicals and the strenuous work remind Jen that she needs to take it easy lest she have an asthma attack. Jen's lungs are compromised by a potentially life-threatening condition. Her physical limits help her develop empathy for her cadaver whose demise was brought on by congestive heart failure and chronic obstructive pulmonary disease (COPD). Jen remarked to Todd, working on the body of a younger man that when they removed the woman's lungs, they were "all tiny and shriveled up like raisins" (p. 38).

Todd and Jen differ in their views about their assigned cadavers. Todd, the other principle character in the story, works on the body of a 56 year old man who died of a brain aneurism. Todd does not mourn the fact that his man died relatively young, because he believes death spared the man many upcoming years of "the hardship of watching his body fail and get weak and sick" (p. 38). However, Jen counters with, "he only got half a

life" (p. 38). Both students may be right. The cadavers have similar and different lessons for the students. Different experiences foster compassion and empathy. Jen and Todd could both appreciate the benefits and limitations of the lives their cadavers had.

While Jen is resting to control her asthma attack, she and Todd do what could be seen as a flirtatious dance when talking about their cadavers. It is clear that Jen is self-conscious of the movements she and Todd make as they maneuver around the tanks and share the intimate space in the lab and the intimate spaces within the cadavers. Jen admits having been curious about Todd, and she blushes several times upon unintentionally brushing up against him, or making eye contact with him. Todd's question to Jen about why she is sad that his man died young, accompanied with a comrade-like gesture of his arm on her shoulder brings about two responses: Jen's realization of how much she misses human touch and her throat closing up again, making her uncomfortable enough that "Despite the background noise she felt exposed and naked" (p. 39).

There are several more moments like this in which both students realize that life and work are both about living and mortality. Jen thinks aloud a question about the bodies, "…would they tell us to stay and keep working or to go out and do…something?" (p. 39). Todd lightens the mood with "God – try and not make anatomy lab such a sober place next time, ok? It's hard enough to get through this without having to constantly contemplate our own mortality" (p. 40). When Todd puts on a new pair of gloves, he places his hand lightly on her back and says about the cadavers, "I think they would tell us to do both. Life and work can happen at the same time, you know" (p. 40).

Jen, now more comfortable with her colleague's physical presence, and feeling better physically, leans over Todd's cadaver. She sees the hacking work that Todd has

done with the bone saw and sees where his cut was off. In an altruistic way, she reaches into the cavity and lightly presses one vertebrae and the tension in the spine that the sawing had been trying to reach was released. Again, the description is very visceral, and the speaker shares her amazement with the reader:

> She pressed her thumb against the knobbly side of a vertebra, not very hard. She heard a sharp snap, like a knuckle cracking, and then the tension in the bone gave way. She almost felt horror rise up in her throat – she hadn't even been trying. Even this perfection of person was so very delicate… (39)

Successful encounters with dead and living humans put Jen in a better frame of mind by the end of the story. The bustle of work in the lab continues. Jen is much more comfortable in her skin, trading humorous remarks with Todd and other students and looking forward to the rest of the day. She feels hopeful and she notices physical sensations that only the living could know and perhaps the dead once appreciated: "She felt her toes in her shoes, and the felt the cotton of her scrub pants shift against her legs as she moved, and she felt the blood surge in her veins, and the sun was slanted in the windows to tell them how long the day was yet" (p. 40). A story like "Bare" gives a realistic portrayal of clinical activities and normal human emotions and allows the reader to imagine being a fellow student in this unique educational setting.

Group 4 – Patient Experience.

The next group of six works is about illness from the patient experience and may or may not have direct encounters with medical professionals. There are two pieces from the point of view of a dead person and a dying person. Two poems tell about incapacitated women who are in the hospital. Finally, two prose pieces recount receiving a diagnosis and a trip to the E.R. One of the prose pieces was a prizewinner.

The poem "Time of Death" (1995, p. 22), written by a second year medical

student, places an observer in the presence of a dead person in the middle of a highly charged instructional venue. The poem refers to clinical information and uses medical language. The details show that the experience is unfamiliar to the poem's speaker. The setting is a hospital at nine on a Sunday morning and the group of people is gathered in an ER or trauma center probably. The man in question has been the victim of a violent death. The author does not specify, but language like "Liver: 1800 grams / Spleen: 300 grams / Both severely lacerated" (lines 24-26) and "a crushed container of Skoal, the engraved pocket knife / that his wife gave him last Christmas / and … / his favorite gold Timex which read exactly / 'Three-thirty-five'" (14-18) are clues that the victim died suddenly, possibly from an automobile accident.

The speaker of the poem is the dead man who wonders why he is there: "9 o'clock Sunday morning …/ 'Shouldn't I be in church'" (1-2)? As an observer, he too, is one of many "People of sort … / Doctors, technicians, medical students, policemen, photographer…" (7-8) who are all trying to piece together what happened. There are no obvious displays of any of the medical humanism attributes, except perhaps empathy which is elicited from the reader.

The dead man seems to know that death brings with it a certain de-personification, since he can no longer speak for himself using words, gestures, or any other type of meaningful communication. He cannot say yes or no, set boundaries, or describe what happened. The narrator knows that all the details available to tell most of the story are in the room. He must rely on the medical team to put the pieces together. They are performing a "close reading," so to speak, of the deceased's body and effects. This close examination can be seen both to particularize the individual and depersonalize

him at the same time.

All of the deceased's clothing and personal items sit on a nearby table "while he lay there / still as the night" (22-23). He has been stripped and as items are examined, they are put to the side, devoid of the significance they had when the person was alive. Even his organs, vital parts of his life, are being removed, measured, and set aside in a routine way. That one very important object of measurement, the wristwatch, can conceivably reveal the most, factually and symbolically: "All his thoughts were frozen in time / the moment his Timex had struck / Three-thirty-five" (28-30). Time literally stopped. The man's gold Timex was precious, as was his life, and now they were both beyond repair.

"Does She Step Outside to Gaze Upon This Scene?" is a poem published in 1998 by a medical student (pp. 19-21). It is told from the point of view of a female patient who appears to be dying, is not conscious, and is unable to interact with her environment. Clinicians, doctors, nurses, techs, and medical students are around her. Despite their various opinions about her prognosis, this individual is very sick and unlikely ever to leave the hospital.

In the poem, the speaker describes the machines that keep her alive, the way her body has fallen apart versus how she used to feel and look in her youth, and the treatment by individuals on the clinical team. The machines are noisy and their printouts seem to have an authority which the medical team thinks important. The medical team is referred to as "troops" whose "bantering gets louder" (line 3). She wonders, "Do they think that I can't hear?" (4). One doctor or perhaps a student, "The young one with black hair pleads to the air: / 'Come on people, just let her die…'" (5-6). Perhaps "the young one" spoke in

exasperation, seeing the woman's recovery as beyond hope, or mercifully if heroic measures continued to be ineffective. Wouldn't the kind thing be to let her go? Regardless, the young man tasked with monitoring the lung function machine "cannot think of such things" (7) and "faithfully returns to the machine – turning, checking, writing, and suctioning" (8). This image displays clinical excellence, but seems meaningless given the hopelessness of situation.

Another doctor, who the patient can tell is not like the "old distinguished one" (10), visits her. The doctor she prefers is kind and "approaches my soul with soothing penetration" (12), hears her wishes, and holds her hand. This sense of care and intimacy through touch is repeated several times in the poem. The speaker recalls youthful intimacy with lovers and places them in stark contrast to the physical circumstances in which she finds herself.

It becomes clear in a later stanza that the young person we heard earlier advocates for the woman when she is standing at the nurses' station talking about DNR and advance directives. The nurses nod but don't necessarily act, "hardened from years of days with death" (20). A telephone rings with a long distance call from the woman's family and the determined young woman resolves to "handle it" (24).

Next, the speaker describes how machines manage her body's functions. There is a sling that circulates the blood in her lower limbs at the end of which are feet that "are full and ashen" (25). Beside her bed are "the noisemakers that sustain my state" (28). The ventilator is loud and condensation accumulates inside its tubing, "Drops of dew … / the only things around me that are truly mine" (31-32). This patient owns little anymore except her name and her dignity. Although it's unclear what the patient's brain function

is, the narrator would have us believe that she is conscious on some level and able to appreciate her memories, places in which her dignity still resides.

The dichotomy of a body once ravished by lovers now ravaged by illness and machines provides the central imagery of the poem: “These lips parted once with anticipation of caresses; / they are dried and cracked, bowing / to the blood-stained tube taped upon my face” (37-39). The woman’s hair is messy, not from passionate nights but from lack of attention in the hospital. No one except the vocal student expresses much interest in her. We could presume from the long-distance phone call earlier in the poem that the family is far away and not very engaged. Her “vibrant hands (with soft curves) which once held closely / the lips of lovers are moored at my side, / soaked with a blue bogginess from my failing heart (last night’s ‘valiant effort’)” (46-48).

Near the end of the section told from the woman’s point of view are two powerful stanzas with poignant lines about the speaker’s powerlessness, “Six tubes enter my body, / Six wires listen to my sorrow” (50-51). The wires that listen to her “sorrow” are presumably those attached to assess heart and brain functions in organs where sorrow metaphorically and literally resides. However, no one else is feeling sorrow over her plight, as indicated by “the box of tissue that remains / unopened” (53-54).

The final lines of the poem contain traditional memorial language from funeral liturgy that indicate that the woman has died. The speaker of these lines might be an omniscient narrator or is someone handling things after the woman’s death. There are also initials and dates at the end of the poem to further bring home the fact that the patient was a real person and not just another anonymous body.

The medical humanism attributes in this poem center around empathy, compassion, and respect. The clinical team does its best to monitor the woman's bodily functions and provide excellent clinical attention, but the poem shows that this care does little to relieve her suffering. The woman cannot communicate to the staff that she is suffering, but the poem's voice has communicated it to the reader. It's clear that the clinical staff is mostly clueless. Everyone, from the poem's speaker to staff to reader is waiting for the woman to die. It is natural for us to imagine ourselves in this woman's place and hope that this is not our fate.

"Creation (Piece by Piece)" (1999, pp. 4-5) reads like a prose poem with its short paragraphs and surreal imagery. While categorized as prose, it is short enough for quoted text to be followed by a line number. The main character is a dying man and his experience of it is shown by a shrinking world, but the speaker is an omniscient narrator. At the beginning of the work his sight is affected by a gray film covering his eyes, like a curtain coming down on "a show that had run too long" (line 2). In the meantime, his thought life is very active, "Things were being destroyed. Universes were falling" (3-4). Throughout the piece, objects and places keep disappearing from existence. In a blink of an eye, "the Atlantic Ocean was gone. It would never again exist in his universe. It would never be imagined, never thought of, never experienced" (5-8).

The man's wife remains a part of his world, even though most world geography has vanished. She wipes his face with a damp cloth and he thinks about his childhood home, a place that still exists, in reality and his imagination. His children are real to him as are the room in which he sleep and the bed. Cars no longer exist on the street or in his imagination. Perhaps he has already taken his last car ride, and in waiting for death to

arrive, he has no need of anything but family and the bed he lies on. This work gives the reader an idea of what death may be like: a gradual reduction of the world to nothing but the body laboring to exit.

He wanted to remember more things, but the "universe was closing and growing very small" (24). He said good-bye to his family forever. Even the touch of his wife's hand disappeared. There was a new kind of fullness that he had not experienced, "it was warm and friendly. It was not lonely and he was not scared" (42-43). A few lines earlier, it is clear that he is not afraid "since he filled everything, he made up everything that he knew… In fact, the universe was so small that it was crowded even though he was the only thing in it" (39-41). In the last section the mystery of the title becomes clear. The speaker imagines that a new life is born in a farm house not far away; the life of a baby with new eyes to see the world. The speaker also imagines that with this new life, a "mother was created" (46-47). Just as the dying person loses pieces of the world, so living is built up, piece by piece.

Unlike the poem discussed immediately before this one, there is no clinical language here, nor is there an encounter with any one or place involved in medicine. It is about the physiological process of shutting down before permanent suspension of consciousness. While there are few descriptions of bodily functions, the process of the world shrinking is similar between the two poems. Even though there is no overt medical connection in this piece, it expresses similar values of empathy.

"The Other Side of the Clipboard" (2006, pp. 6-7), by an SIU medical student, is a short story told from the point of view of an 84-year woman facing the recurrence of a life-ending illness. We meet her in the examination room while she waits to receive the

diagnosis. Four days earlier an admission of not feeling well, breathlessness, and the appearance of a handful of blood "Candy apple red like my first tube of lipstick" (p. 7), brought her to the doctor. During the time she waits, she reflects having been diagnosed with and treated for cancer six years ago. At that time she had the loving support of her husband, himself debilitated by heart attacks and stroke. He died during her final week of chemotherapy treatments. She reflects,

> "He must have thought I was going to be okay, and that he could finally go home. My family quietly celebrated my remission as we paid our last respects to my dear love, my soul mate, and tried to console me with thoughts of 'at least now you have your health.' Yes I suppose I did. But what good was my health without my heart? I had wept unrelentingly at my good fortune." (p. 6)

The woman strongly suspects that she is going to be told that her cancer has returned after four years. This time she won't have the support of her husband. All she has left of him is the "single, thin, gold band on my twisted and swollen left ring finger" (p. 6). She determines that she will refuse treatment because it was hard to re-grow her hair. She is old and it is safe to assume from how she feels about her husband that she will be glad to be reunited with him after death.

She notes the absurdity of the phone call she received four days ago from the nurse asking her to come back in, "Of course I could come in this afternoon. Her tone of voice was similar to that you would expect of an invitation to luncheon with the ladies or a friend's birthday party. Some party this was going to be" (p. 7). Still, it is difficult to face mortality on your own. The woman is in the exam room waiting, "Confused. Resigned. Proud." (p. 7). She has her dignity and integrity. She ponders that she has come full circle and is ready to face head-on the inevitable conclusion, but when the knock at the door comes, a single tear escapes her eye betraying her confidence.

This story includes some medical language and takes place in a clinical setting. The anxiety the woman feels is palpable in a situation with which most people can empathize. Most people have either experienced waiting for a diagnosis themselves or known someone who has experienced waiting for a diagnosis. That level of understanding is empathy.

An alumnus wrote "Pink Fluffy Slippers," a story which takes place in a hectic ER, and appeared in *SCOPE* 2011 (pp.12-14). The main characters are an elderly couple, Arnie and Hattie. Hattie is ill and needs to be seen for abdominal distress, and Arnie is fretting over her, trying to find out when she will be seen and when she will get a room. After being together for sixty years, he is acutely aware of how the situation is affecting her. In the story, Arnie daydreams on and off about their early days of courtship, marriage, and family life, but comes back to himself to attend to her needs. This activity is parallel to Hattie drifting in and out of consciousness.

The medical humanism values of empathy, compassion, altruism, and respect are all working together in this story, and the husband is the main caregiver displaying them. Arnie is empathetic and compassionate toward his wife and wants to do whatever he can to help alleviate her suffering. He is also afraid that she may be very sick, "…she was 77 and she hadn't been eating for the past two days. What if she was really sick, what if it was … no he couldn't think that. Lord God please, my Hattie he screamed, yet his lips uttered not a word" (p.13). Arnie does an admirable job at keeping himself together during this crisis. There is another reference to altruistically checking his emotions in the tears that he cries, while his face remains dry.

Hattie also tries to be strong and not show vulnerability. Attentive Arnie sees a sign that Hattie must be very cold, by her trembling lips, and wishes he had thought to ask the hospital worker for another blanket. Hattie had already told him that she was cold. Arnie said he would keep her warm and searches the bag of items they brought for a specific item: pink fluffy slippers. A smile comes across the faces of both Hattie and Arnie with this small comfort. We must hope that the clinical staff would treat Hattie with the same respect that Arnie does.

Finally, the poem "Hospital Room" also from 2011 (p. 54), is by a physician in the Department of Neurology. It describes a female patient who is in some kind of semi or totally unresponsive mental state. The patient is in bed and attached to an IV drip. We don't learn what happened to her to bring on this condition, but the first line locates us in a "strange town."

Another person, presumably a significant other, is the keeper of time and the vigil and sees her "naked on an ice float, / farther from the river banks" (lines 14-15). In this case, naked means vulnerable and the river banks are synonymous with shore, or safe ground. The man doesn't want to lose her and feels useless at her side as she drifts aimlessly. She seems to wake up once but fades away quickly.

We know nothing about this woman, how old she is, her family situation, or any medical history. Do we need to know these things or other details to fully appreciate the poem? Some readers might say yes and others would say no. In a way, the poem gives the reader a taste of the experience that a doctor could have of a patient who becomes incapacitated in a strange town. As in "Goliath," discussed earlier, the doctor must work with what is in front of him and whatever information he can get from people associated

with the patient, if they are available. Medicine is a type of close reading – we examine a body/text to glean important information or meaning.

In the poem, the notion of time is abstract, "A wall clock measures / time she is away / from herself … and him" (4-6). Time appears lengthy too, "The flowers empty their vase / before she answers/ to her name // or opens her pretty eyes / to a light kiss" (7-11). Even though we don't know how long the couple has been in this hospital, we can tell that time is measured in day long increments. A worker comes and mops under the man's feet and a food tray comes and goes, untouched. We also know that it is winter from the stunning visual image ending the poem, "winter sun makes its journey // on the off-white wall, / then, / nightfall" (24-27).

This woman is a medical mystery, and we meet few characters: the woman, the man, and the custodial worker. We may not be able to empathize with the woman's plight as much as we can empathize with the man who waits alone with her. Like him, we want her to be relieved of her undescribed suffering, but since we don't know what the cause is, our compassion is more abstract. We believe that she is suffering because the poem indicates her unavailability. Clearly her companion is suffering.

We could gain some insight into this patient's experience from the voice in "Does She Step Outside to Gaze Upon This Scene." The sense of powerlessness on the part of the sufferer and of those watching and waiting is similar in both of them. Whereas the earlier poem's speaker wants relief that death will presumably bring, we assume that the patient in "Hospital Room" will return to normal life. There are few biographical details in the second poem. It could be that the patient is old and at the end of life, but there is nothing in the description to indicate this. It is important to consider the title of the poem

and recognize that the poem may be less about the patient than it is about the place, the hospital room, and what happens there.

Table 8: Summary of Medical Humanism Attributes in *SCOPE* Sample

Year	Title	Genre	Topic	Contrib	Integrity	Excellence	Compassion	Altruism	Respect	Empathy	Service	Total
1994	The Velcro Bow	PR	Professional Life	Faculty			x	x	x	x	x	**5**
2002	A Gift	PR		Faculty	x	x	x		x	x	x	**6**
2002	Goliath	PR		Faculty		x	x			x	x	**4**
2007	Wishbones	PO		Other	x	x	x	x	x	x	x	**7**
1998	EMPaThY	PO	Medical Student Experience	Student			x	x		x		**3**
2002	The Circle	PO		Student	x		x		x	x		**4**
2003	Come Closer	PO		Alum	x		x		x	x		**4**
2005	The Interview	PO		Alum		x					x	**2**
2011	Study Date	PO		Student				x				**1**
1995	Henry	PO	Cadaver	Student						x		**1**
2008	You Speak of Med School Cadavers	PO		Other						x		**1**
2013	Bare	PR		Student	x	x		x	x	x		**5**
1995	Time of Death	PO	Patient Experience	Student						x		**1**
1998	Does She Step Outside to Gaze Upon This Scene	PO		Student		x	x		x	x		**4**
1999	Creation	PR		Student						x		**1**
2006	The Other Side of the Clipboard	PR		Student	x					x		**2**
2011	Pink Fluffy Slippers	PR		Alum			x	x	x	x		**4**
2011	Hospital Room	PO		Faculty			x			x		**2**
Totals					**6**	**6**	**10**	**6**	**8**	**16**	**5**	**57**

Table 8 Discussion.

After looking at the eighteen samples from *SCOPE* and referring to Table 7 on page 51, we see the authors express the seven Gold Foundation medical humanism attributes in various combinations 57 times. Works range from having one to all seven attributes. The poem “Wishbones” contains all seven. “A Gift,” with six attributes, “The Velcro Bow” and “Bare” follow with five attributes each. “Goliath,” “The Circle,” “Come Closer,” “Does She Step Outside to Gaze Upon This Scene” and “Pink Fluffy Slippers” each have four. “EMPaThy,” show three and “The Other Side of the Clipboard,” “The Interview,” and “Hospital Room” each have two. Finally, “Study Date,” “Henry,” “You Speak of Med School Cadavers,” “Time of Death,” and “Creation” reveal only single attribute per piece.

We should never presume that the *SCOPE* authors would have written their medically related works with the Gold Foundation medical humanism attributes in mind. It is therefore interesting to see what principles emerged from the stories and poems as I applied an organizational rubric. In the six poems and stories reflecting one attribute, empathy appeared in four of them. The other two had different foci altogether, excellence or altruism. In the poems and stories in which two attributes surfaced, both had empathy and one other different attribute, integrity or compassion.

We can see from the table that empathy appears most often, in 16 of 18 or 89% of the works. Next in frequency is compassion, appearing ten times or 56%, followed by respect, appearing eight times or 45%. Other attributes like service and excellence tend to be situational and are defined in the moment. Medical students would not have experience performing procedures: therefore their writing would not have a basis for

excellence, for example. Of the six times that excellence appears (33%) and the five times that service appears (28%), those stories and poems were mostly written by alumni and SIU faculty. Empathy, the ability to imagine what another person is going through, and compassion, the desire to relieve someone's suffering are often linked, and in most pieces where one finds empathy, one finds compassion. In the stories and poems about death or cadavers, however, one finds empathy but not compassion. Table 11 on p. 137 in Appendix A gives an example of each medical humanism attribute with a quote from the texts.

CHAPTER 6

DISCUSSION & CONCLUSION

In general, this study has shown how written works elicit both tragic and tender aspects of learning to heal and of being a caregiver by considering attributes of medical humanism. Details specific to each story or poem make it unique, but emotions of joy, sadness, or helplessness are universal. Whether the story or poem is well written or not, the reader and the writer alike are moved by the creative power to communicate strong inner emotions (Campo, 2003). The contents of *SCOPE* tell important truths about the doctor-patient relationship and about the experience of medical education.

In this chapter I first relate the data collected to the research questions. Next, I look at possibilities for using *SCOPE* as a tool for medical humanities education and propose ideas for future research. At the end, we will better be able to see how this study fills an important gap in the literature on creative writing and medical humanities education.

Answers to Research Questions.

This dissertation sought to answer to the following question: "To what extent and how does creative writing in *SCOPE* reflect the medical humanities attributes of **empathy, compassion, integrity, respect, altruism, excellence, and service**?" The study reviewed the contents of twenty years of *SCOPE* magazines and calculated data pertinent to this question. The study also analyzed source materials from *SCOPE* to

determine in a qualitative way what were its significant patterns. Tables and narratives presented the results from this combined methodological approach.

The study posed two additional supportive questions: “In what ways do authors in *SCOPE* articulate their relationship to medical humanities attributes?” and “How frequently do authors in *SCOPE* discuss medical humanities attributes?” These two questions drove the data collection strategies, and addressing them first informs the larger concern.

We can see in the data and discussion that since 1994, authors in *SCOPE* have articulated their relationship to medical humanities attributes through poems and fictional stories. About 64% of all the written work over the twenty-year span of the study is medically related, and we can see that there are medically related poems and stories in every issue of the magazine. There are about twice as many poems as stories, which is not surprising since fiction pieces are generally longer than poems. In a sample of 18 taken from the 118 medically related pieces looked at within a framework of medical humanities attributes, there are 57 instances of the seven Arnold P. Gold Foundation medical humanism attributes (**integrity, excellence, compassion, altruism, respect, empathy, service**) expressed.

From the tables in Chapter 4 and the close readings of the 18 pieces in Chapter 5, we can see that the most common topic is “Professional Life.” Authors from the groups SIU Alumni and SIU Faculty & Staff are the primary contributors to this topic since these individuals have professional experience about which to write. Together, these two groups make up the largest percentage of contributors (48%), but separately they are not larger than the biggest single group, SIU Medical Students (35%). It also makes sense

that medical school students' work would take most of the print space in a medical school literary magazine operated by medical students. The results also show that enrolled medical students write about the second most common topic, "Medical Student Experience." One reliable observation is that the contributors write about what they know and experience.

Where does imagination fit in? Why poetry or fiction? One can write about what one knows in a report, a letter, or in other expository ways. I believe that the reason empathy is the highest scoring medical humanism attribute in the sample from *SCOPE* is that empathy requires the ability to imagine what someone else is experiencing, and creative writing is an imaginative act. Stories and poems allow the reader to react empathetically (Blackie & Wear, 2015). To speak figuratively, if empathy were a muscle, both the writer and reader would strengthen it by engaging the imagination. Increasing empathy can strengthen our physicians (Shapiro, Kasman, & Shafer, 2006).

Compassion is the next most frequently noted attribute. Healers want to help those who suffer and relieve their pain and distress. They could not be successful healers if they did not have some compassion. In order to understand the suffering to be relieved, empathy has to come first because one must be able to imagine the suffering and its effects on a person's life. Many people confuse empathy and compassion, which is understandable because they are related. The writing in *SCOPE* and the analysis in this study show that empathy comes before compassion. The stories and poems about cadavers are good examples. The story "Bare" and the poem "Henry," both written by medical students, contain empathetic reflections about the lives of these patients and

show that the students appreciate and can imagine that the dead persons lived full lives (Boker, Shapiro, & Morrison, 2004).

The third most frequent attribute is respect, as it relates to experiences with patients. Whether or not the patient can make a decision or communicate what he or she wants, the patient still deserves respect. From the sample, we can see the cautious student waiting to be invited to the patient's bedside in "The Circle," and another student ready to advocate for the unresponsive woman in "Does She Step Outside to Gaze Upon This Scene?"

In the medical humanism attribute table (Table 9, p. 110), integrity, excellence, and altruism all appear with equal frequency. None of these specifically stood out as the main theme in the stories or poems of the sample, but rather were part of the background of the pieces. For example, the student in "Come Closer," was advised that medical school was about science, but instinctively knew that the patient came first, before one mastered the science to treat him. This student stayed with the dying man, and such an act could be seen as a demonstration of integrity and compassion. However, this integrity would only be present if empathy were already in play. Similarly, altruism and excellence are not where the imaginative focus lies, but are factual details that support the overall piece. The exception to this from the sample is in "The Interview," in which excellence and service (the attribute with the least number of instances) are the only noticeable attributes. This is a powerful poem in which the tragedy is that empathy and compassion seem to be missing from the doctor's life. These poems raise points about how professionalism is interpreted and experienced. Medical education literature shows that

lessons on professionalism often use literature and writing as a base to help students foster professional identity (Shapiro, et al, 2015).

Cross Analysis.

Table 9 below, which provides another way of looking at the frequency of medical humanism attributes in the *SCOPE* sample, helps to continue this discussion about the extent to which medical humanism attributes appear.

Table 9: Cross Analysis of Medical Humanism Attributes from *SCOPE* Sample

Incidence/ Topic	Professional Life	Medical Student Experience	Cadaver	Patient Experience	Total Incidence of Attributes
Integrity	2	2	1	1	**6**
Excellence	3	1	1	1	**6**
Compassion	4	3	0	3	**10**
Altruism	2	2	1	1	**6**
Respect	3	2	1	2	**8**
Empathy	4	3	3	6	**16**
Service	4	1	0	0	**5**
Total Attributes Per Topic	**22**	**14**	**7**	**14**	**57**

In the table, we can see that the four pieces in which the subject is “Professional Life,” all seven attributes are included 22 times. The contributors are established in their professions and have had time to experience situations in which these attributes would emerge. The authors allude to attributes like service and excellence because these are part of their professional activities. In contrast, a medical student, who may be an empathetic person, is not yet ready to perform clinical procedures or to give bad news to a family. Therefore, the student’s literary work will not reveal the same understanding and attributes. Even though the poem “The Circle” is about the medical student experience, it

describes who a professional is in lines where the difference between “Professional, paid help, acquaintance” (9) and “Professional, friend, supporter” (19) are separated only by commas.

The five pieces about “Medical Student Experience” reveal 14 total occurrences of all seven attributes. Compassion and empathy each appear three times, suggesting that this is the level at which the students are most engaged and are the attributes with which they have the most experience. Even the girl in “The Interview” attests that what brings people into medicine is a desire to help people and relieve suffering. Later, as we see in the poem “EMPaThY,” impatience and lack of sleep strained and compromised empathy and compassion. The final line of this poem reminds the student and the reader that the patient “teaches me that empathy remains” (28).

In the three pieces on the topic “Cadaver,” empathy is the most common attribute with seven incidences. Not all seven medical humanism attributes are present; both compassion and service have none in these works. Reasons for this have already been expressed, with the most notable being that one cannot show cadavers compassion, since the cadaver is not alive. However, as we see in the sample and in the table, the empathy that the speakers feel for the lives of those who are now cadavers is remarkable. Jen and Todd express feelings for their cadavers in “Bare” which reveal insight into their own mortality.

The pieces in “Patient Experience” show six medical humanism attributes over 14 instances. Empathy appears in each of the six pieces. This is not surprising since the patient is the primary beneficiary of the humanistic attributes, and the authors of these pieces have infused their pieces with concern for the patient. In this way they have

invited the reader to be concerned. The disease or condition of the patient is an objective circumstance, but the life and feelings of the patient are always subjective (Terry & Gogel, 1987).

The sense of not being at home in the poems and stories in this group show that illness is a disordered state. In “Pink Fluffy Slippers,” Arnie tries to find the slippers for his wife which “always give her a sense of being home” (p. 18). The patients in “Hospital Room” and “Does She Step Outside and Gaze Upon the Scene” are strangers in a home away from home. The woman in “The Other Side of the Clipboard” looks forward to being reunited with her lifetime love who predeceased her. And one could interpret that the dying man in “Creation” becomes the baby born in a farmhouse miles away. We see too that there are several more liminal states described in the works of *SCOPE:* the state of being ill before getting better or dying, and the state of dying before being deceased.

SCOPE as a Medical Education Tool.

Scholarly literature shows again and again the connection between increased empathy and the practice of reflective writing in medical education (Shapiro et al, 2006). Among its many intents, reflective writing helps medical students order chaotic experiences, and it helps physicians not to succumb to burnout. On the pages of *SCOPE,* medical students attempt to make sense of overwhelming experiences and impressions. In the stories and poems which medical students write about cadavers, most portray a sense that the act of dissection is at once profane and sacred. Likewise, stories and poems by the established physician-authors in *SCOPE* show the balance between the heartbreaks and redemptive rewards of being a healer.

SCOPE has the potential to be a vital reflective tool for medical students. At first exposure the attributes of medical humanism look like abstract concepts. Ideally one should experience them to internalize them. The stories and poems in *SCOPE* give flesh to the theoretical. Attributes are not so vague for students when they read stories by their peers and mentors. What students have only encountered conceptually becomes more real, and their reading prepares them to engage those attributes when situations arise for them.

This magazine is potentially a great resource for both students and physicians who can find themselves in the pages. It can be a tool for students and physicians not to feel so isolated in their stations, since isolation can breed discouragement and despair. It can also help students find voices of models and mentors in the works of those ahead of them professionally. Since the medical school experience is a process of initiation as well as training, the stories and poems in *SCOPE* can show the students what awaits them once they walk their own wards.

This study adds to the literature on the needs for and uses of reflective writing in medical education. Writing is shown to be a strong pedagogical tool that helps physicians in training develop professionalism, core humanistic values, respect for self and others, and the ability to handle complex situations (Shapiro, Kasman, & Shafer, 2006). In an educational field that still heavily relies on precise, logical, and systematic methods of analysis, imaginative thinking and problem solving can be overlooked. Listening to or reading peers' creative writing fosters mindfulness and narrative competence on the part of the listener and reader. Writer and reader are able to step back from the immediate

pressures of training to look at the bigger picture. Readers' assumptions, expectations, and values are challenged during close reading (Gallop, 2000).

Writing is a solitary activity, but authors can find community in a literary magazine. Whether writers create alone, in a classroom, or for a literary magazine, sharing writing becomes analogous to the vulnerability, risk-taking, and self-disclosure that patients face. This study did not ask in what setting the student submissions to *SCOPE* were created, but if writing took place in a class, the literary magazine provides a rewarding forum at semester's end.

In terms of curriculum evaluation, one can find important learning benchmarks expressed on the pages of *SCOPE*. Should an educator choose to do so, he or she could examine the poems and stories written by enrolled students and alumni and identify details that correspond to lessons and expectations within the curriculum. Rita Charon's "Reading Guide for Reflective Writing" could help train the educator to look for narrative competence and empathic engagement (Charon, Hermann, & Devlin, 2015).

A word of caution here about the reality of the writing in a magazine like *SCOPE:* we should not consider all of the works as truths. Rather, the works are representations that need to be examined critically depending on the audience who is seeing them. Relying on literary magazine literature to illustrate preselected points can be a disservice to an audience who wants to gather poems about patient experiences and can't separate out the flawed details from a batch of emotionally charged works (Terry & Williams 1988). For example, in *SCOPE,* medical students have brilliantly imagined what dying and that period of time shortly after death could be like in "Does She Step Outside to Gaze Upon the Scene," "Creation," and "Time of Death." At face value, the pieces are

imaginative, insightful, questioning, and in some instances, clinically grounded. However, they should be taken as examples of this: imaginative musings about abstract experiences.

Ideas for Future Research.

This study of a student-run medical school literary magazine is the first of its kind and could launch future studies. For example, another study could replicate this one using a different magazine from another medical school. Or one could look several magazines at different institutions to see to what extent and how writers include the Gold Foundation medical humanism attributes.

Instead of tracing a group of attributes through twenty years in a single magazine like this study did, one could trace a single or a couple of attributes through one magazine or through several different magazines. For example, do medical students at different medical schools uniformly express empathy in their writing about patients? If so, in what genres does it appear and in what kinds of narratives (e.g. “Chaos,” “Restitution,” “Journey” p. 27 in literature review above)? How much do results vary if medical students do not run the institutional magazine primarily, or if it has a different contributor profile? If medical students are writing about x, y, and z, about what are their nursing student colleagues writing? Do institutions have separate or combined medical and nursing student magazines? Are there predictors that could determine whether or not a student writer becomes a physician writer? Could a longitudinal study confirm the benefits or effects of medically related writing over the course of a physician’s career? More research into this line of inquiry could be very beneficial to those planning medical

education curricula. In the way that handling a scalpel is central to the surgeon's trade, could handling a pen be considered so as well?

Another line of study could focus on the *SCOPE* contributors themselves. One naturally wonders if former students keep writing after they graduate. Several of the contributors to *SCOPE* were alumni, so this question has somewhat been answered. However, do others continue but not seek publication? What about the magazines like *Veritas* at UVA, which only allows current medical students and house staff to contribute? Are those graduated students working elsewhere still writing? If so, what place in their lives as physicians does writing have? Does it fill both a therapeutic need and pleasurable interest, and if both, which factor is dominant? The literature shows that physicians who write have less burnout. Could a former or present involvement with a medical school magazine like *SCOPE* reduce physician burnout?

I first discovered *SCOPE* five years ago, at which point it was already over ten years old. The magazine's longevity and stable format is part of what drew me to study it. Regarding its existence as a physical object, what other ways could we consider using *SCOPE*? For example, what are people's responses to the magazine? To what extent and how do the students and faculty at SIUSOM use it? For development and fund raising? Recruitment? To help assess that curriculum goals are met? How do alumni interact with the magazine? Do students who worked on the magazine recall how it affected them?

To answer these questions and many more like them, I would recommend a mixed method approach, like the one in this study. Depending on the question, data can be examined and interpreted in quantitative, qualitative, or both ways. In a study like this, with a high percentage of qualitative analysis, the person as instrument variable will

affect outcome. For example, a literature student with no background in magazine editing will make observations about a magazine's structure and content differently than someone with a scientific background.

Conclusion.

In summary: *SCOPE* is a literary magazine founded in 1994 by the School of Medicine at Southern Illinois University. Its contents consist of poems, stories, and reproductions of visual art. Issues average about 45 pages, and *SCOPE* staff produces the magazine annually in hard copy and posts it to a web server as a PDF. In an attempt to analyze the contents of *SCOPE* in relation to commonly accepted medical humanities attributes, this study catalogued pertinent data such as the percentage of medically related poems and stories over the first 20 years of the magazine's history. The study included other quantifiable data: breakdown of pieces by genre, breakdown by contributor type, and breakdown by topic.

The qualitative component of the study consisted of a close reading of a sample of 18 stories and poems to highlight their literary strengths and to determine the incidence of medical humanities attributes. Through this method, the study answered the research question: to what extent and how does creative writing in *SCOPE* reflect medical humanities attributes of **empathy, compassion, integrity, respect, altruism, excellence, and service** was answered. I hope that this study and its insights will promote more interest in the genre of the medical school literary magazine and its potential uses as a medical education tool, will encourage additional use of creative writing in the medical curriculum, and will help all who read it understand more about medical humanities and its importance to patient treatment.

REFERENCES

Beauchamp, T., & Childress, J. (2001). *Principles of biomedical ethics* (5th ed.). New York, N.Y.: Oxford University Press.

Becker, H. S. (1977). *Boys in white.* New Brunswick, NJ: Transaction Books.

Blackie, M., & Wear, D. (2015). Three Things to Do With Stories. Academic Medicine, 1309-1313.

Boker, J. R., Shapiro, J., & Morrison, E. H. (2004). Teaching empathy to first year medical students: Evaluation of an elective literature and medicine course. *Education for health*, *17*(1), 73-84.

Brody, H. (2003). *Stories of sickness* (2nd ed.). Oxford: Oxford University Press.

Burroway, J. (2011). *Imaginative writing: The elements of craft* (3rd ed.). Boston: Longman.

Campo, R. (2003). *The healing art: A doctor's black bag of poetry*. New York: W.W. Norton.

Charon, R. (1993). The narrative road to empathy. *Empathy and the practice of medicine,* 147–159.

Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA: The Journal of the American Medical Association,* 1897-1902.

Charon, R. (2006). *Narrative medicine honoring the stories of illness*. Oxford: Oxford University Press.

Charon, R., Trautmann Banks, J., Connelly, J. E., Hunsaker Hawkins, A., Montgomery Hunter, K., Hudson Jones, A., et al. (1995). Literature and medicine: Contributions to clinical practice. *Annals of Internal Medicine, 122*(8), 599-606.

Charon, R., Hermann, N., & Devlin, M. (2015). Close reading and creative writing in clinical education. Academic Medicine, 1-1.

Cohen, J. (2007). Viewpoint: Linking professionalism to humanism: What it means, why it matters. *Academic Medicine,* 1029-1032.

Chen, D., Lew, R., Hershman, W., & Orlander, J. (2007). A Cross-sectional measurement of medical student empathy. Journal of General Internal Medicine, 1434-1438.

Coles, R. (1989). *The call of stories: Teaching and the moral imagination*. Boston: Houghton Mifflin.

Colton, D., & Covert, R. (2007). *Designing and constructing instruments for social research and evaluation*. San Francisco, CA: Jossey-Bass.

Cooke, M., & Irby, D. (2010). *Educating physicians a call for reform of medical school and residency*. San Francisco, CA: Jossey-Bass.

Coulehan, J., Williams, P., Landis, D., & Naser, C. (1995). The first patient: Reflections and stories about the anatomy cadaver. *Teaching and Learning in Medicine,* 61-66.

Das Gupta, S., & Charon, R. (2004). Personal illness narratives: Using reflective writing to teach empathy. *Academic Medicine: Journal of the Association of American Medical Colleges,79*(4), 351-356.

Draper, C., & Louw, G. (2007). What is medicine and what is a doctor? Medical students' perceptions and expectations of their academic and professional career. *Medical Teacher,* E100-107.

Flexner, A., & Updike, D. (1910). *Medical education in the United States and Canada: A report to the Carnegie Foundation for the advancement of teaching*. 576 Fifth Avenue, New York City: Carnegie Mellon.

Frank, A. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago: University of Chicago Press.

Gallop, J. (2000). The ethics of reading: Close encounters. *Journal of Curriculum Theorizing, 16*(3), 7-17.

About us/FAQs- The Arnold P. Gold Foundation. (2015). Retrieved February 12, 2015, from http://humanism-in-medicine.org/about-us/faqs/.

Groopman, J. (2007). *How doctors think*. Boston: Houghton Mifflin.

Hardman, M., Hawkins, A., & Mcentyre, M. (1993). Teaching literature and medicine. *The Modern Language Review,* 789-789.

Hatem, D., & Ferrara, E. (2001). Becoming a doctor: Fostering humane caregivers through creative writing. *Patient Education and Counseling,* 13-22.

Hawkins, A. (2000). *Teaching literature and medicine*. New York: Modern Language Association.

Hawkins, A. H., Ballard, J. O., & Hufford, D. J. (2003). Humanities education at Pennsylvania State University College of Medicine, Hershey, Pennsylvania. *Academic Medicine: Journal of the Association of American Medical Colleges,* 78(10), 1001-1005.

Hoffman, K., Hosokawa, M., Blake, R., Headrick, L., & Johnson, G. (2006). Problem-Based learning outcomes: Ten years of experience at the University Of Missouri Columbia School Of Medicine. *Academic Medicine,* 617-625.

Hunter, K., Charon, R., & Coulehan, J. (1995). The study of literature in medical education *Academic Medicine,* 787-94.

Jones, T., Cohn, F., & Shapiro, J. (2012). Minding the gap(s): Narrativity and liminality in medical student writing. *Literature and Medicine,* 103-123.

Kafka, F., & Corngold, S. (1996). *The metamorphosis: Translation, backgrounds and contexts, criticism*. New York: W.W. Norton.

Karnieli-Miller, O., Vu, T., Holtman, M., Clyman, S., & Inui, T. (2010). Medical students' professionalism narratives: A window on the informal and hidden curriculum. *Academic Medicine,* 124-133.

Klass, P. (1987). *A not entirely benign procedure: Four years as a medical student*. New York: Putnam.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.

Lentricchia, F. (2003). *Close reading: The reader*. Durham, N.C.: Duke University Press.

Ludmerer, K. (1985). *Learning to heal: The development of American medical education*. New York: Basic Books.

Ludmerer, K. (1999). *Time to heal: American medical education from the turn of the century to the era of managed care*. Oxford: Oxford University Press.

Ludmerer, K. (2004). The development of American medical education from the turn of the century to the era of managed care. *Clinical Orthopedics and Related Research,* 256-262.

Maheux, B., Beaudoin, C., Berkson, L., Cote, L., Marchais, J., & Jean, P. (2000). Medical faculty as humanistic physicians and teachers: The perceptions of students at innovative and traditional medical schools. *Medical Education,* 630 634.

Marcus, E. (1999). Empathy, humanism, and the professionalization process of medical education. *Academic Medicine,* 1211-5.

Marshall, C., & Rossman, G. (1989). *Designing qualitative research*. Newbury Park, Calif.: Sage Publications.

Medicine & the Muse Program Medical Humanities and the Arts. (2015). Retrieved March 3, 2015, from http://bioethics.stanford.edu/arts/Journals.html

Montgomery, K. (1991). *Doctors' stories: The narrative structure of medical knowledge*. Princeton, N.J.: Princeton University Press.

Olsen, T. (1995). *Tell me a riddle*. New Brunswick, N.J.: Rutgers University Press.

O'Malley, W. J. (1999). Teaching Empathy. *America,* 18(12), 22-26.

Ousager, J., & Johannessen, H. (2010). Humanities in undergraduate medical education: A literature review. *Academic Medicine,* 988-998.

Ozolins, I., Hall, H., & Peterson, R. (2008). The student voice: recognizing the hidden and informal curriculum in medicine. *Medical Teacher,* 606-611.

Personal Interview. (2010). *Interview with Marcia Childress.* UVA, Department of Medical Humanism.

Poirier, S., Ahrens, W., & Brauner, D. (1998). Songs of innocence and experience. *Academic Medicine,* 473-8.

Price, R. (1994). *A whole new life*. New York: Atheneum.

Remen, R. (1996). *Kitchen table wisdom: Stories that heal*. New York: Riverhead Books.

Richards, I. (1929). *Practical criticism: A study of literary judgment*. London: K. Paul, Trench, Trubner.

Rucker, L., & Shapiro, J. (2003). Becoming a physician. *Academic Medicine,* 391-397.

Shapiro, J., & Rucker, L. (2003). Can poetry make better doctors? Teaching the humanities and arts to medical students and residents at the university of California, Irvine, College Of Medicine. *Academic Medicine,* 953-957.

Shapiro, J., Kasman, D., Shafer, A. (2006). Words and wards: A model of reflective writing and its uses in medical education. *Journal of Medical Humanities* 231-244.

Shapiro, J. (2009). *The inner world of medical students: Listening to their voices in poetry*. Oxford: Radcliffe.

Shapiro, J., Coulehan, J., Wear, D., & Montello, M. (2009). Medical humanities and their discontents: Definitions, critiques, and implications. *Academic Medicine,* 192-198.

Shapiro, J., Nixon, L. L., Wear, S. E., & Doukas, D. J. (2015). Medical professionalism: What the study of literature can contribute to the conversation. *Philosophy, Ethics, and Humanities in Medicine : PEHM, 10*, 10.

Smith, A. & Kelinman, S. (1989). Managing emotions in medical school: Students' contacts with the living and the dead. *Social Psychology Quarterly*. 56-59

Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.

Stepien, K., & Baernstein, A. (2006). Educating for empathy. *Journal of General Internal Medicine*, 524-530.

Stratton, T., Saunders, J., & Elam, C. (2008). Changes in medical students' emotional intelligence: An exploratory study. *Teaching and Learning in Medicine*, 279 284.

Styron, W. (1990). *Darkness visible: A memoir of madness*. New York: Random House.

Terry, J. S., & Gogel, E. L. (1987). Poems and patients: the balance of interpretation. *Literature and medicine*, *6*(1), 43-53.

Terry, J. S. & Williams, P. C. (1988). Literature and Bioethics: The Tension in goals and styles. *Literature and Medicine* 7(1), 1-21. The Johns Hopkins University Press.

Tolstoy, L., & Wettlin, M. (1963). *Short masterpieces by Tolstoy*. New York: Dell.

Trautmann, J. (1982). The wonders of literature in medical education. Möbius: A Journal for Continuing Education Professionals in Health Sciences J. Contin. Educ. Health Prof., 23-31.

Wear, D., & Castellani, B. (2000). The Development of Professionalism. *Academic Medicine*, 602-611.

Woolf, V., & Lee, H. (2012). *On being ill*. Ashfield, Mass.: Paris Press.

APPENDIX A: TABLES

Table 3.a: *SCOPE* Years, Pages, and Genres

YEAR	**1994**	**1995**	**1996**	**1997**	**1998**	**TOTAL**
PAGES	41	45	33	47	49	215
PROSE	5	6	3	4	5	23
POETRY	16	9	16	19	19	79
VISUAL ART	9	16	10	11	9	55

YEAR	**1999**	**2000**	**2001**	**2002**	**2003**	**TOTAL**
PAGES	45	40	44	44	54	227
PROSE	5	4	5	4	4	22
POETRY	15	8	11	17	17	68
VISUAL ART	15	10	11	10	13	59

YEAR	**2004**	**2005**	**2006**	**2007**	**2008**	**TOTAL**
PAGES	64	46	39	44	52	245
PROSE	3	5	5	5	5	23
POETRY	15	12	11	15	19	72
VISUAL ART	11	11	7	9	9	47

YEAR	**2009**	**2010**	**2011**	**2012**	**2013**	**TOTAL**	**GRAND TOTAL**	
PAGES	40	44	60	48	52	244	931 pages	
PROSE	4	4	7	7	6	28	96 prose pieces	
POETRY	12	15	14	9	11	61	280 poetry pieces	
VISUAL ART	8	12	12	10	12	54	215 visual art pieces	**TOTAL PIECES = 591**

Table 4.a: *SCOPE* Years, Genre, and Medically Related Pieces per Genre

YEAR	1994	1995	1996	1997	1998	TOTAL
PROSE	5	6	3	4	5	23
PR MED-RELATED	2	4	0	3	2	11
POETRY	16	9	16	19	19	79
PO MED-RELATED	5	5	3	9	9	31

YEAR	1999	2000	2001	2002	2003	TOTAL
PROSE	5	4	5	4	4	22
PR MED-RELATED	2	1	1	2	3	9
POETRY	15	8	11	17	17	68
PO MED-RELATED	2	0	3	4	4	13

YEAR	2004	2005	2006	2007	2008	TOTAL
PROSE	3	5	5	5	5	23
PR MED-RELATED	2	1	3	1	3	10
POETRY	15	12	11	15	19	72
PO MED-RELATED	2	5	0	4	3	14

YEAR	2009	2010	2011	2012	2013	TOTAL	GRAND TOTAL
PROSE	4	4	7	7	6	28	**96**
PR MED-RELATED	3	0	1	2	3	9	**39 (40%)**
POETRY	12	15	14	9	11	61	**280**
PO MED-RELATED	4	5	4	3	5	21	**79 (28%)**

Table 5.a: *SCOPE* Years and Contributor Type

YEAR	1994	1995	1996	1997	1998	TOTAL
SIU MED STUDENT	13	14	18	12	17	74
SUI ALUM	0	0	0	8	2	10
SIU FAC & STAFF	9	7	7	5	10	38
OTHER	5	6	5	3	2	21

YEAR	1999	2000	2001	2002	2003	TOTAL
SIU MED STUDENT	13	6	4	10	4	37
SUI ALUM	9	0	6	9	9	33
SIU FAC & STAFF	8	13	9	10	12	52
OTHER	4	3	3	1	7	18

YEAR	2004	2005	2006	2007	2008	TOTAL
SIU MED STUDENT	8	10	5	10	10	43
SUI ALUM	9	7	3	3	7	29
SIU FAC & STAFF	8	8	9	11	6	42
OTHER	4	1	5	5	10	25

YEAR	2009	2010	2011	2012	2013	TOTAL	GRAND TOTAL	
SUI MED STUDENT	8	15	5	9	6	43	197	
SUI ALUM	3	2	10	6	6	27	99	
SIU FAC & STAFF	8	9	10	5	5	37	169	
OTHER	4	3	6	5	9	27	91	**TOTAL Submissions = 556**

Table 6.a: *SCOPE* Years, Medically Related Prose and Poetry Pieces, and Topics

YEAR	1994	TOPICS	1995	TOPICS
PR MED-RELATED	2	• Professional Life • Medical Student Experience	4	• Patient Experience • Alzheimer's Disease (2) • Dying
PO MED-RELATED	5	• Kidney Disease • Medical Student Experience (2) • Diagnosis • Treatment	5	• AIDS • Death • Cancer • Cadaver • Suicide

YEAR	1996	TOPIC	1997	TOPIC
PR MED-RELATED	0		3	• Dementia • Dying • Medical Student Experience
PO MED-RELATED	3	• Dr./Pt. Relationship • Stroke • Cancer	9	• Dying • Mental Illness • Professional Life (2) • Anatomy • Art Therapy • Addiction • Suicide • Death

YEAR	1998	TOPIC	1999	TOPIC
PR MED-RELATED	2	• Professional Life (2)	2	• Dying • Patient Experience
PO MED-RELATED	9	• Aging • Dying • Brain • Mental Illness • Coma • Genetics • Medical Student Experience (2) • Professional Life	2	• Pain • Dying

YEAR	2000	TOPIC	2001	TOPIC
PR MED-RELATED	1	Mental Health	1	Health Care
PO MED-RELATED	0		3	• Birth • Medical Student Experience • Disease Prevention

YEAR	2002	TOPIC	2003	TOPIC
PR MED-RELATED	2	• Birth Defect • Professional Life	3	Professional Life (3)
PO MED-RELATED	4	• Memory Loss • Aging • Rehabilitation • Medical Student Experience	4	• Professional Life • Cadaver • Aging • Medical Student Experience

YEAR	2004	TOPIC	2005	TOPIC
PR MED-RELATED	2	Professional Life (2)	1	Professional Life
PO MED-RELATED	2	• Cancer • Lump	5	• Medical Student Experience • Diagnosis • Death • Cancer • Dr./Pt. Relationship

YEAR	2006	TOPIC	2007	TOPIC
PR MED-RELATED	3	• Diagnosis • Caregiver Experience • Professional Life	1	Medical Student Experience
PO MED-RELATED	0		4	• Cancer Hospital • Professional Life (2) • Celiac Disease

YEAR	2008	TOPIC	2009	TOPIC
PR MED-RELATED	3	Professional Life (3)	3	• Medical Student Experience • Professional Life (2)

PO MED-RELATED	3	• Cadaver • Morphine • Health Care	4	• Professional Life • Death • Dying • Insurance

YEAR	**2010**	**TOPIC**	**2011**	**TOPIC**
PR MED-RELATED	0		1	Patient Experience
PO MED-RELATED	5	• Cancer • Professional Life (2) • Alzheimer's Disease • Suffering	4	• Medical Student Experience (2) • Coma • Death

YEAR	**2012**	**TOPIC**	**2013**	**TOPIC**
PR MED-RELATED	2	• Suicide • Medical Student Experience	3	• Professional Life • Cadaver • Futuristic Medicine
PO MED-RELATED	3	• Cancer • Paraplegia • Mental Illness	5	• Professional Life • Medical Student Experience • Anatomy • Injury • Side Effects

Table 10. *SCOPE* Year, Title, Genre, Topic, and Contributor Type

Year	Page	Title	Genre	Topic	Contributor Type	Total pieces/ year	Total Prose/ Poetry
1994	6	The Velcro Bow	Prose	Professional Life	Faculty		
	16	Ode to a Hyper Malady	Poetry Mixed	Kidney Disease	Faculty		
	28	Diary of Life	Poetry	Med St. Exp.	Student		
	30	First Day in Gross Laboratory	Prose	Med St. Exp.	Student		
	32	Lamp Light	Poetry	Med St. Exp.	Student		
	36	Untitled	Poetry	Diagnosis	Other		
	40	A Very Technically .. Medical Haiku	Poetry	Treatment	Student	7	2 / 5
1995	4	La Tormenta	Prose	Pt. Exp.	Student		
	11	For My Brother	Poetry	AIDS	Student		
	22	Time of Death	Poetry	Death	Student		
	24	To the Oncologist	Poetry	Cancer	Student		
	27	Alone with Ben	Prose	Alzheimer's	Other		
	37	Memories	Prose	Alzheimer's	Faculty		
	41	Henry	Poetry	Cadaver	Student		
	43	Rhythm	Prose	Dying	Faculty		
	44	Forwarding Address Unknown	Poetry	Suicide	Student	9	4 / 5
1996	24	The Silence of June	Poetry	Stroke	Student		
	26	Wendy	Poetry	Cancer	Student		
	30	They Say	Poetry	Dr./Pt	Faculty	3	0 /3

				Relationship			
1997	7	Diagnosis	Poetry	Suicide	Student		
	11	Armageddon and Black Holes	Poetry	Addiction	Alum		
	13	Housecalls	Poetry	Prof. Life	Alum		
	17	Desert Rains	Prose	Dementia	Faculty		
	21	The Navicular, in Particular	Poetry	Anatomy	Alum		
	26	The Therapist	Poetry	Art Therapy	Faculty		
	27	A Heart Revealed	Poetry	Death	Student		
	28	Stella	Poetry	Dying	Student		
	31	A Remaining Two	Prose	Dying	Student		
	33	Voices	Poetry	Mental Illness (Disturbance)	Student		
	37	Looking Back	Poetry	Prof. Life (comment on med)	Student		
	41	A Moment of Peace in the Storm	Prose	Med St. Exp.	Student	12	3 / 9
1998	4	The Handshake	Poetry	Aging (stroke)	Student		
	15	Town	Prose	Prof. Life (memory prob)	Student		
	19	Does She Step Outside	Poetry	Dying	Student		
	22	No	Poetry	Coma	Other		
	28	Severe Depression	Poetry	Mental Illness	Student		
	30	Empathy	Poetry	Med St. Exp.	Student		
	34	Clathrin Coats	Poetry	Med St. Exp.	Student		

	35	Letter From Tibet	Prose	Prof. Life	Faculty		
	43	Poem	Poetry	Brain	Student		
	44	The Hospice Evaluation	Poetry	Prof. Life	Student		
	49	Unanticipated Consequences	Poetry	Genetics	Alum	11	2 / 9
1999	4	Creation	Prose	Dying	Student		
	19	The Doctor Will See You Now	Prose	Pt. Exp.	Faculty		
	22	12	Poetry	Pain	Student		
	44	Dying on a Spring Day	Poetry	Dying	Alum	4	2 / 2
2000	36	Wally Blew	Prose	Mental Health	Student	1	1 / 0
2001	2	Red	Poetry	Birth	Other		
	3	Immunology Lecture	Poetry	Med St. Exp.	Student		
	17	The Ban on Health Care Act	Prose	Health Care	Alum		
	25	Dangerous Words	Poetry	Disease Prevention	Alum	4	1 / 3
2002	3	Untitled	Poetry	Memory Loss	Student		
	6	Thanksgiving	Poetry	Aging	Faculty		
	10	A Gift	Prose	Birth Defect	Faculty		
	18	Rehab	Poetry	Rehabilitation	Alum		
	30	Goliath	Prose	Prof. Life	Alum		
	37	The Circle	Poetry	Med St. Exp.	Student	6	2 / 4
2003	10	Ode to My Dear Melena	Poetry	Prof. Life	Alum		
	12	Instructors All	Poetry	Cadaver	Faculty		
	30	I Hate the Person I've Become	Prose	Prof. Life	Faculty		

	35	Nursing Home Visit	Poetry	Aging	Faculty		
	36	Come Closer	Poetry	Med St. Exp.	Alum		
	42	The Crow As Muse	Prose	Prof. Life	Faculty		
	46	Peetee Came Back to Me	Prose	Prof. Life	Faculty	7	3 / 4
2004	14	Leon	Prose	Prof. Life	Faculty		
	44	Raining Stethoscopes	Prose	Prof. Life	Alum		
	58	You Are Not Welcome Here	Poetry	Lump	Other		
	63	Malignancy	Poetry	Cancer	Faculty	4	2 / 2
2005	6	The Interview	Poetry	Med St. Exp.	Alum		
	20	In Memoriam	Poetry	Death	Student		
	35	Turn Left at the Horizon	Poetry	Cancer	Faculty		
	40	The Abortionist	Prose	Prof. Life	Faculty		
	44	You Were Welcome In	Poetry	Dr. Pt. Relationship	Student		
	45	They	Poetry	Diagnosis	Student	6	1 / 5
2006	6	The Other Side of the Clipboard	Prose	Diagnosis	Student		
	10	Instinct	Prose	Caregiver Exp.	Student		
	30	Celebrants	Prose	Prof. Life	Faculty	3	3 / 0
2007	6	Wishbones	Poetry	Prof. Life	Other		
	7	Nurses	Poetry	Prof. Life	Student		
	20	A Mournful Disease from the Heart of a Mourner	Poetry	Celiac Disease	Faculty		
	32	Unfinished Cancer	Poetry	Cancer Hospital	Student		

		Hospital					
	42	11th Floor	Prose	Med St. Exp.	Student	5	1 / 4
2008	6	You Speak of Med School Cadavers	Poetry	Cadaver	Other		
	15	Naked	Poetry	Morphine	Student		
	18	Detachment	Prose	Prof. Life	Alum		
	26	Clinging	Poetry	Health Care	Faculty		
	28	All Hallow's Eve	Prose	Prof. Life	Other		
	41	Dueling Diagnoses	Prose	Prof. Life	Other	6	3 / 3
2009	6	Sonata No 8 in C Minor	Poetry	Prof. Life	Faculty		
	18	A Hard Day for Me	Prose	Med St. Exp.	Student		
	21	D. Thomas	Poetry	Dying	Alum		
	22	There Are Times I Don't Like to Write	Poetry	Insurance	Faculty		
	27	Mortal Pain	Prose	Prof. Life	Faculty		
	31	Rolling Up the Rug	Poetry	Death	Alum		
	35	Promises Made, Promises Kept	Prose	Prof. Life	Faculty	7	3 / 4
2010	6	Amazons	Poetry	Cancer	Other		
	10	Saving Lives in Style	Poetry	Prof. Life	Faculty		
	28	A Cure for Alzheimer's	Poetry	Alzheimer's	Faculty		
	29	In the Lab	Poetry	Prof. Life (audiology)	Faculty		
	34	Triptych on Medicine and Art	Poetry	Suffering	Faculty	5	0 / 5
2011	12	Pink Fluffy	Prose	Pt. Exp.	Alum		

		Slippers					
	16	Just a Typical Day for a Med Student	Poetry	Med St. Exp.	Student		
	20	Study Date	Poetry	Med St. Exp.	Student		
	54	Hospital Room	Poetry	Coma	Faculty		
	57	A Tribute	Poetry	Death	Alum	5	1 / 4
2012	12	How Did It Happen?	Poetry	Cancer	Other		
	22	Tom	Poetry	Paraplegia	Alum		
	26	In Memory of Dave	Prose	Suicide	Alum		
	28	'The Quicks' and 'The Slows'	Poetry	Mental Illness	Alum		
	36	Crack Ride	Prose	Med St. Exp.	Alum	5	2 / 3
2013	6	Anatomy Lesson: The Body Part We All Hate	Poetry	Anatomy	Faculty		
	12	Two Dozen Walkers	Prose	Futuristic Medicine	Alum		
	28	Catching up on Zs	Poetry	Side Effects	Faculty		
	30	What Lies Within	Prose	Prof. Life	Alum		
	34	Cicatrization	Poetry	Med St. Exp.	Student		
	34	Somnicillorum	Poetry	Prof. Life	Student		
	34	21yo M NDH IF LF	Poetry	Injury	Student		
	36	Bare	Prose	Cadaver	Student	8	3 / 5

Table 11. Sample Quotes from *SCOPE* Characterizing Medical Humanism Attributes

Medical Humanism Attribute	Quote
Integrity	No. I will not fall. I will clutch my light blue cardigan tighter around my 94 pound frame and defiantly refuse any further treatment. – The Other Side of the Clipboard (2006, p. 6)
Excellence	Jim, a group mate, standing across the body, sliced along the back as confident as a butcher, but Jen worked slow. She didn't want to hurt anything. – Bare (2013, p. 36)
Compassion	"A word of caution," I added. "It is much easier not to go with the breathing tube in the first place than to remove it. If the baby survives, you'll be committed. This isn't going to be like brain death where you can remove the tube later at will." – A Gift (2002, p. 14)
Altruism	His brow wrinkles again, ever so slightly. He doesn't want her to see his concern, she might get worried, even more so than she already was, he didn't want that for her. He looked into her eyes and gave a smile. – Pink Fluffy Slippers (2011, p.12)
Respect	Even this perfection of person was so very delicate… – Bare (2013, p. 39)
Empathy	I tried to imagine what she must have gone through the past year. The pain. The stares. – The Velcro Bow (1994, p. 6)
Service	Their conversation builds, and no one notices the telephone. "Family of Room D, long distance, line 4." They quiet and air of hesitancy and embarrassment ensues. The young one rises, determined. "Let me handle it," she says. – Does She Step Outside to Gaze Upon This Scene (1998, lines 21-24)

(Note: While medical humanism attributes are embedded in the stories and poems, exemplar quotable lines from them are difficult to identify out of context.)

APPENDIX B: SOURCE DOCUMENTS

fantastic stories weren't good for him, they warped his own sense of reality. And they were probably all lies anyway. In her radiant good-bye at the corner where she got out, in the foolish tremulous wave of her hand, he could see now the dumb, blind cunning of her class, the years of certainty and the dreamy lack of consequence.

The Velcro Bow

by [redacted] - Department of Anatomy

Sugar and spice and everything nice. It wasn't until the birth of our daughter that I realized what little girls are made of. Fluff, lace, ribbon and curls all remind me of a precious little girl with a special little hair bow.

"About knee-high to a grasshopper" would describe that little girl the first time she walked into my life. I worked for a law firm, and her parents were clients of ours. The little girl had been terribly burned and disfigured in an accidental fire at her grandmother's house a few years before. With legalities regarding insurance coverage to pay for the medical bills, her parents needed an attorney.

The little girl walked slowly over to my desk. She wore a hooded face cap on her head, similar to that of a ski mask, to shield her fragile body from germs. Her big blue eyes looked at me. With her lips gone and her mouth horribly twisted, she managed a smile.

On my desk were pictures of my son in his baseball uniform and my daughter in her birthday dress. As the little girl pointed to the pictures, her hands covered in protective gloves, she asked, "Who are they?"

I told her their names, "Hriston and Karissa."

She turned to look for her mother and father sitting in the conference room, and I secretly prayed she'd return to them. Instead, she turned around to me again and said of my daughter's picture, "She's pretty. She has long, long hair. I really like her hair bow."

And that was that. Papers signed, notarized and copied, and out the front door she went.

One Saturday, several months later, as I held one of my daughter's hair bows in the palm of my hand, I wondered what that little girl would do with a hair bow. She didn't even have any hair. She'd never be able to wear such a bow.

Just as I spoke the word *never*, I felt such a grieving within my soul. It was as though I had spoken a word of profanity.

I'd always heard in Sunday School class and church that we should take the word *never* out of our vocabulary. We were told, "Man's extremity is God's opportunity." And I had said the word *never*. Lord, forgive me!

Hadn't I been told after the complicated birth of our son that I could never have another child? For eight years, surgery and medications had failed. Wasn't it nine months from the very day my mother went home to be with Jesus that

the good Lord gave us a baby daughter?

Hadn't I been diagnosed with glaucoma and told I would be blind within three years? Neither laser surgery nor medications had helped, and I would never get better. Wasn't it this same loving and able God who heard all the prayers and stretched down His healing hands? I not only regained the lost eyesight but was completely healed. How could I doubt my Lord?

That week I found the little girl's folder in my desk. There in the middle section of the file was an envelope marked "Evidence Photographs/Do Not Bend." I slowly opened the envelope and pulled out a 5 x 7 picture taken at Sears of a little girl with big blue eyes and brown banana curls. She was beautiful.

That evening I made the little girl a hair bow. Lots of lace, white beads, pearl strands, a little peach butterfly, a couple of tiny flowers all hot-glued together with long ribbons hanging down. So what if she wore a mask? I prayed the bow could be secured with Velcro. All done, I put the bow in a sandwich bag, took it to work and placed it in my bottom desk drawer.

A year after her first visit, the little girl came into the law office again. Her flesh still covered to guard against infection, she waved a gloved hand and I waved back. I tried to imagine what she must have gone through the past year. The pain. The stares.

I had added new pictures on my desk and she noticed. I told her that one picture was of Hriston, and the other was of Karissa in the Easter dress in front of the Church.

Those big blue eyes. The same blue eyes I had seen in that lovely photograph from Sears.

She said, "My Papaw says that I am goin' to go to heaven, 'cause I already been burned up down here."

She smiled and I cried. As I cleared my throat, I told the little girl I had something in my desk just for her. I pulled out the bag containing the Velcro bow.

"It's so pretty! Put it on me!" she pleaded.

Her mother nodded and I placed the bow on her scalp hood. The Velcro held. No skin nor hair, but this little girl was wearing a fancy hair bow just like my daughter's. I gave her a small mirror from my purse.

"I feel pretty inside, like before," she said. "Remember, Momma?"

And to me she whispered, "Thank you."

Hugs, tears and smiles. Blessings never to be forgotten. And then, just as suddenly as she had come into my life, she was gone again. She and the Velcro bow.

A Gift

As I hovered over the isolette, just when evening had begun to feel like the middle of the night, I wondered why the task had befallen me to damn the soft, warm, fresh life in my hands. Grasping the coiled tubing, I pressed its blunt silver tip to the infant's head.

"Throw the switch," I said.

From across the narrow bed, the nurse nodded.

Suddenly the infant's skull glowed, the focused light beam finding no resistance to its path. I slid the transilluminator over the scalp, side-to-side, front to back. Except for the stark, blood-red sprig of an occasional vessel, there was nothing but homogeneous, yellow-pink haze from above the eyes to the base of the skull, from ear to ear.

So it was true. The ultrasound at the outside hospital had glimpsed a dreadful mistake of nature, a freak mishap.

The nurse shook her head. She had seen it before, too.

"You can turn off the light," I said.

I slipped a pacifier into the baby's mouth. She sucked. She grasped my index finger, wrapping her translucent little fingers, tiny nails and all, around mine. Still too new to have a first name, she peered at me through narrow eyelid slits, as if to query who dared disturb her tranquil sleep.

One could still hope for a rim of cerebral cortex, no matter how thin, one which might be missed by transillumination. That would mean hydrocephalus—something at least treatable. Any other cause for her large head would offer a slightly better prognosis. But I could not convince myself to hope.

When I left the NICU, memories flooded my weary mind from a distant hospital and much forgotten time. They rushed to the surface from beneath the sediment of swift river time that long ago carried me deep into life's choices. Now the smell of the hand soap, the lemon-yellow gowns, pulsations and bleeps of monitors, even the snap and swoosh of the automatic doors as I left the nursery, reminded me of years spent caring for sick babies in the wee hours.

As I passed the empty cafeteria, the few workers seemed as dreary as the people in Van Gogh's "Night Cafe." I recalled how I used to stand at the grill where I trained as a resident. Midnight was last call. Getting that grilled cheese with a slice of bacon seemed to give me the energy I thought I needed to survive the night. Now I regret the bacon.

Downstairs, entombed in the catacombs beneath the hospital, I finally arrived at the radiology viewing room. As soon as I snapped the baby's films onto the one lit view box, the MRI confirmed my suspicions: no higher brain. Midbrain, pons, medulla, even a rudimentary diencephalon and vestige of frontal cortex showed up white in the dark void; however, no cerebellum, no basal ganglia, no cerbral hemispheres. Like a vast gray ocean, the abundant space the "thinking brain" should have occupied was filled instead with fluid.

On the long walk back to the NICU, I wondered how things had gone so dreadfully wrong. I could envision primordial cells dividing and migrating, totally dependent on genes and chemical signals to guide them. Then the growth messages stopped. Early in the pregnancy, perhaps even when the parents were planning the baby's room or cuddling in bed and giggling over its first kicks, developmental order succumbed to chaos. Most fetuses with severe brain malformations spontaneously abort, but at a tertiary hospital, one has to expect to see the ones that don't. The real question is how most infants all over the world for millennia have turned out so well.

The next day, one of the nurses noted brief jerking of the arms and legs. Reconsulted over the possibility of seizures, I returned to the nursery. Phenobarbital had been given. The examination revealed brisk deep tendon reflexes, but no seizure activity. I suggested an EEG. The irony struck me: not enough brain to be a human being in any real sense, but enough to mount a seizure.

On the way out, I mentally glimpsed the parents in the delivery room. They must have been told something was wrong, but were they prepared for the seriousness? Sure, in medical school I had seen grotesque specimens floating in formaldehyde-filled jars. I had studied photographs of malformed fetuses in books. I had even taken care of anencephalics, who lacked a skull overlying the empty brain cavity. It was easy to detach from them—they looked subhuman. But this infant had clasped my finger. Whatever developmental monstrosity lurked beneath the skull, below the neck was a beautiful baby girl ready to live.

Two days later, I received a call to participate in a conference with the baby's parents. The mother, still recovering from her Caesarian section, was well enough to travel to our hospital. I arrived early to find the parents at the bedside in the nursery holding the infant like the other proud

parents, who were surrounded by family or friends. They showed no signs of the gravity I felt.

We convened in a nearby small, utilitarian conference room. The social worker, a nurse, and the neonatologist flanked the parents as they sat at the table.

The mother looked plain. Her dyed brown hair was very gray at the roots—probably too much of a burden to maintain as the delivery day drew nearer. Fatigue registered in her demeanor. The husband was a large man, whose forearms and shoulders suggested a manual laborer. His features were coarse and his hair was streaked with gray.

The neonatologist introduced me and asked that I speak to the diagnosis and prognosis. I've learned the hardest thing is to start. From among all the possibilities that jump at you under the pressure of the moment choosing the right words—kind, sympathetic, yet accurate words—is the most difficult. Everyone's eyes were on me. I felt a twinge of the feeling I used to get as an intern when I had to tell parents in the middle of the night that their child had died.

"Your baby has hydranencephaly."

The father began to take notes. "Could you spell that?" he asked calmly, as though he were at a board meeting.

His wife watched him scrawl the letters on a small yellow pad.

"That means the brain did not form normally, I'm sorry to say. The part that maintains heart rate, blood pressure, and respiration is okay, so the baby still breathes, sucks, and swallows."

"Isn't that what normal babies do?" the mother asked. Her face was expressionless.

"Yes—." I paused. Before I knew it, I had sighed. "I guess what I'm trying to say is that's all the baby is capable of. What's missing are the parts that form thoughts, memories, personality—the brain that sees, hears, talks, interacts, or loves—all the things we take for granted. What normal babies do in the first few months of life doesn't require much brain." I made a helpless gesture.

They looked incredulous.

I held up one film from the MRI scan overhead in front of the ceiling light and explained what they were looking at. Both parents fell silent.

"Why did this happen?" the father asked.

"No one knows for sure. During brain development, blood vessels that would have nourished the upper brain never formed or closed off. Many genes control brain development—we're only starting to understand that—and something could have gone wrong with them. Or an infection is sometimes the cause."

They looked over at me. It was *that* look. I knew she would begin racking her brain for the one incident during the pregnancy that might have caused the anomaly.

"Whatever the reason, it's not your fault. There's nothing you could have done differently."

Secretly I wondered what role parental age could have played. Nature can be cruel to older parents.

"How long will she live?" the father asked.

"Odds are, not more than a couple of months." I raised my eyebrows and cocked my head to the side. "Some children *do* survive for years—I've seen it happen—but that's rare."

"So what can we expect?"

"Well, she may develop seizures. The baby's EEG—that's a brain wave test—showed lots of abnormal electrical activity that can cause seizures. Normally the higher brain would suppress that, but there is no higher brain. Muscle tone also will increase until the arms and legs become fixed in position. Her head may become much larger, too. The children often die of infection, or the brain seems to run out of some vital energy."

"Would it help to drain fluid from the brain?" the father asked.

"Putting in a shunt to drain the fluid might help cosmetically as the head expands, but it won't prevent the inevitable."

The neonatologist spoke up. There was a hint of urgency in her voice. "We need to make some important decisions for the baby. We need to know what your wishes are. Do you want us to put a breathing tube into her throat if she stops breathing? Do you want us to put a feeding tube into her stomach if she doesn't eat? Do you want us to resuscitate her if her heart stops or her blood pressure falls?"

"Would she live longer if we did that?" the father asked.

"Yes, but be careful what you wish for," the neonatologist said. "You may prolong her life, but you will have to feed her through a stomach tube. She will need a hole in her throat, called a tracheostomy, where a breathing machine will be attached. She will need constant care because she won't be able to care for herself."

"Will she grow?"

"She'll grow, but not at the normal rate."

"So all her other organs are normal."

"Yes."

Oddly, he seemed relieved. Did he not understand?

"Can you tell if she will feel pain?" Everyone turned to the mother, who broke her long silence. Then they looked back at me.

"She will withdraw from pain, but only as a reflex. She will cry out of hunger, maybe even move to a bright light or loud sound, but she will be blind, deaf, and completely vegetative."

The couple was quiet for a few long moments.

"I know it must be difficult," I said. "She looks so normal on the outside except for her large head."

The mother nodded. This time her eyes were moist. "We've been trying *so* hard to have this baby," she said.

"It's a lot to hear all at once. I'm sure this isn't what you expected," I added.

Her husband looked up. "Well, of course, we want her around as long as possible. She's our baby. She's a gift from heaven."

We all must have glanced down at the same time. What I felt in the pit of my stomach was the same pang I felt on every such occasion. I had to greet perfect strangers as the messenger of devastating news. It never got any easier. No matter how badly I felt, it must have been so much worse for the parents.

When I peered up again, the whole medical team still seemed uncomfortable.

The couple looked at each other. Tears rolled down the mother's cheeks. I got the feeling this was their last stand. From the chart, I knew how many previous attempts to have a child were unsuccessful.

"A word of caution," I added. "It is much easier not to go with the breathing tube in the first place than to remove it. If the baby survives, you'll be committed. This isn't going to be like brain death where you can remove the tube later at will."

The mother studied me. That point registered. Her face contorted and her mouth drew up, exposing the gaps between her side teeth. "I don't want her to live like this."

"Are you in agreement?" the neonatologist asked the husband. "We are talking about a do-not-resuscitate order."

He met her gaze without answering. His demeanor said *no*, but when he viewed his wife's agonized face, slowly he pursed his lips and placed his hand on her shoulder. "Okay." A long pause. "Whatever she wants."

"You can talk this over between yourselves, if you'd like," the neonatologist said. "We'll leave the room."

The mother shook her head adamantly. "I don't want any breathing machine or anything like that." Her voice was strong and resolute. Then she began to sob.

After a moment, the social worker asked, "Do you have the moral support of family and friends?"

She nodded. "My family lives here."

"Good."

When the meeting disbanded, I left the NICU to see other hospital consults. It wasn't a day I was glad to be a child neurologist. I'm used to being called upon to give unpleasant news and to try and explain what doesn't make sense. Was it my getting older that made things bother me more? Without knowing it, had I attended one too many of these terrible sessions?

Or did life just seem more precious?

[redacted] M.D.
Pediatrics
Third Place, Prose

Goliath

It is two o'clock in the morning and the emergency room is unusually quiet. A chest pain in search of a diagnosis occupies Bed 1 and a low back pain is waiting in Bed 4. My gut feeling is esophageal reflux or maybe anxiety in #1 and a need for a work excuse plus or minus a script for Tylenol with codeine in #4. I don't think I've grown especially cynical in my middle age, but in the early morning hours a person gets to be a pretty good judge of human nature. In the emergency room, instinct is as valuable as knowledge.

Bed 1's EKG looks better than my own. Bed 4 seems pacified by a pain injection. While cardiac enzymes and other labs are cooking for Bed 1 and X-rays are being processed for Bed 4, the nurses and I make small talk while sipping bitter coffee. We always enjoy a few minutes of peace and quiet, more commonly known as the calm before the storm.

And as if right on schedule, the ER is assaulted not by a cloudburst but a human earthquake. Two paramedics along with the hospital security guard struggle with a large man strapped to a stretcher who is flailing and thrashing about so violently that not only are the restraints in danger of being torn off but very possibly the heads of the attendants as well. My first thoughts are drug abuse, seizure, or possibly both. My next thought is that if I don't do something quickly, someone is going to get hurt. And I don't mean the patient.

This guy is gigantic like some freak of nature. He is easily the largest human being I have ever seen face to face. He is the equivalent of two men. Weighing at least 400 pounds, his arms alone are each the size of a child's entire body. Like Greek columns, they are decorated with intricate carvings and markings. Yet his inscriptions and garnishments are not mythical beasts and heroes but rather tattoos of daggers, barbed wire, and a skull. He will not remain still long enough for me to inspect these engravings more closely and read the story of his life scrolled on his skin. Besides, I'm beginning to fear for my own.

His head appears almost comically small for his gargantuan body. His perfectly round face is framed by short curly brown hair and a ragged beard. His eyes are closed but a small trickle of drool bubbles from the right corner of his mouth. His face seems to depict a grimace. His massive limbs hang over the hospital cart like tentacles, blindly groping at the air. I simultaneously examine him and avoid his arms and legs. The man is so large that he seems to be wearing the hospital cart strapped to him as if it were a backpack. If he flips it over, I doubt we'll ever turn him right side up. The entire staff approaches this creature with the caution normally reserved for contagious and life-threatening bacteria and viruses. They sense what I already know. In truth, he is even more dangerous than his appearance suggests.

"Jesus, this guy is huge mongous," Stephanie, our ER clerk, announces the obvious to everyone. She sometimes speaks English as if it were a second language for her.

Our Goliath is unable to provide any medical history in his present condition. If he has a voice, it is hidden deep within his massive body. Treatment will be tricky, even dangerous, without knowledge of his current medications, drug allergies, and previous illnesses, but I can't wait for answers.

"Does anyone know anything about this guy?" I ask everyone around me.

Almost on cue, an apprehensive woman approaches the commotion. She is careful to keep her distance from the vortex created by the agitated behemoth and those of us caring for him. Intuition tells me it is Goliath's wife or more likely his girlfriend. She is little more than one-quarter the size of her man. They are an anatomically incongruous couple. Her pale blond hair is limp and slowly being overtaken by dark brown roots. Her face appears haggard. The woman looks fortyish but dresses as if she were half that age.

She wears a low cut, black top that might actually be a sports bra. Peeking just above the garment is a small tattoo that seemingly floats on the center of her chest. I realize that I'm gawking at the tattoo like some kind of voyeur, but it suddenly becomes essential that I learn what it is. Goliath's life, her future, and possibly my own well-being depend on deciphering that small symbol. I squint hard and discover that her skin is indelibly marked with a little heart pierced not by one, but two tiny arrows. It is as if her body is a map, and this small tattoo marks the spot of its treasure. If only all love was so easily identifiable and permanent, there would be much less suffering in the world and much less business in the ER.

"He's going to be okay, isn't he?" she asks of no one in particular. Her voice sounds tired. She looks at Goliath with an expression of concern and then maybe disappointment. She touches his arm and for

an instant I imagine his seismic activity quelled. Immediately, his shaking resumes and the force of it disconnects them.

"Yes, I think so," is all I can stammer. "We need some more information."

"He's been drinking...again," she says without remorse. "When he gets depressed, he drinks heavily and has a seizure. Like this. They're hard to stop."

I learned he had quit taking his anticonvulsant medication six months ago even though he still had an entire bottle of pills at home. Now Goliath's bulging veins greedily accepted our medicine, but it might as well have been water. He received more intravenous drugs in the emergency room than I have ever prescribed for a convulsion but still he quaked. This was no mere seizure. Seizures are not communicable, but I felt myself trembling. Goliath looked like a man possessed. Despite enough medication to stop a charging rhino in its tracks, he continued to shake violently.

"He may need general anesthesia," I thought out loud, "but lets try some Haldol first."

Within twenty minutes of the injection, I convinced myself that our juggernaut was settling down. The floor was no longer vibrating. Another dose of Haldol was administered, and soon Goliath was sound asleep. His harsh snoring reverberated like a growl of a beast. No one dared disturb him. His vital signs were stable and all his tests, including a CT scan of the head, turned out normal except for a blood alcohol level confirming his reverence for spirits.

It occured to me that Goliath's woman had vanished. I could understand that she might be upset or tired and perhaps went home to rest. I wondered if she might just be frightened that we would send this wild man home before she was ready to deal with him again.

"Where did this guy's wife go?" I asked Stephanie. "I need to speak to her. I'm admitting him to the ICU, and I don't even know his name."

"Wife?" she looked puzzled. "He's not married. Do you mean the thin blond woman that was here earlier? She's his mother."

The look on my face surely betrayed my embarrassment. Of course, it had to be his mother. Who else would wear their love so openly for everyone to see? Who would tolerate behavior so adolescent, dangerous, and disconcerting? Who would always be there to take him home? I wanted to say something to this woman before her sleeping child was transported to the ICU. I wished to reassure her, console her, or maybe advise her about the future. Perhaps that is why she disappeared without a trace. Too often wounded by words and promises, she did not desire my counsel or commiseration.

When I returned to work the following day, I learned that Goliath had already left the hospital against medical advice. And when you think about it, who in their right mind was going to stop him?

"I'm amazed that guy was even able to wake up in less than 24 hours considering his alcohol level and all the drugs we gave him on top of that," an experienced nurse pointed out. "Doesn't it make you angry that we spend so much time, effort, and money on some people, and they just throw it away?"

"You can't help people who don't want to be helped," I replied. "But that doesn't mean you don't try anyway. I'm betting he'll be back."

"Well then, let's go save the world," the nurse mocked me. "You've got an otitis media in Room 2."

I quickly forgot about seizures, tattoos, and rescuing the world. I sipped my coffee and savored the rich taste and smell of a new day's fresh brew. I eagerly entered the small exam room and greeted a mother who was cradling her crying infant. Immediately, I felt warmed by the power of a mother's love.

[redacted]
Class of 1980
Second Place, Prose

Wishbones

Tiny she was, and dark
Within the white sheets
Frail and tired from the cancer.

Do everything for me she said.

So when her heart stopped
I climbed into her bed
Put my hands on her chest
And pushed.

Pop. Pop pop pop. Pop.

Not the harsh snap the chicken breastbone makes
When my brother and I make a wish and pull

But a gentle staccato.

Oh, that I had made a wish for every rib:

For timely goodbyes
For freedom from pain
For a peaceful journey.

When we were done with her
I removed her rings
And passed them to the muscular hand of her son.

I sat with him in silence
My hands still holding the popping of her ribs.

[redacted]
Visiting Nurses Association
1st place

EMPaThY

Subjective: her chart was depressing
Increasing respiratory failure after all those cigarettes
Chronic extended care
And now an anastomosis fails
A med student wonders
Why doesn't she just die?
QUICK curse the thought
But not quite quick enough
A life becomes less important than sleep not slept?
Empathy is now a luxury
To be contemplated under fluorescent lights
A cerebral conversation in a conference room.

Objective: her voice is sweet
In obvious pain but yet polite
She must be so tired of suffering
Yet she tries to smile
And admits she is scared of tomorrow
Abdominal exam with severe tenderness
Morphine doesn't seem to be enough.

Assessment: she may die soon
Alone on a cold narrow table
Try not to cause her more pain
Try not to regret the lack of thoroughness.
Your politeness matching hers.

Plan: round early tomorrow
Remember to check more than her labs.
For her heart still beats with regular rhythm
And she teaches me that empathy remains.

[redacted] MSIV

Untitled

How can I learn what they know?
I study and read and strive to aquire
The knowledge they have, the wisdom they show.
Their level of love, fear, and desire.

Why do they cry when I ask of such things?
Do they not understand the joy that it brings?
For what they possess, there is no other source
To hear of mistakes, and their life's chosen course.

For the knowledge they give, I will never forget.
As long as I live, that I owe a debt
To give what I learn to those who desire,
And ignore the pain it took to acquire.

[redacted]
MS I

The Circle

You quietly knock
No response
The door opens some
You step in and see
The circle around the bed

Are you intruding
Is this your place
Who are you
Professional, paid help, acquaintance
Family—no

Hesitation, should you leave
This circle is closed
She looks up
Smiles to see you there
Despite the pain

A hand help up
Invitation
You are welcome
Professional, friend, supporter
Her hand in yours

[redacted]
MS I

Come Closer

We teach science here . . . not feelings, he said
We do not engage the dying . . .
Arm yourself well young lady
We teach science here . . . not feelings
Stay distant . . .

Searching for meaning
Looking beyond self . . . with some degree of quietness
I reflect upon those words
Thoughts of dying reverberate somewhere deep within my consciousness
Dying and death . . . pain and suffering . . . surrender and fight
All consuming . . .
Why can't I help?
Are we true strangers . . . is death a strange season?

Listen people . . . listen carefully
Listen lest you become a stranger
Come closer . . .
do not tread more lightly
do not whisper empty platitudes
engage the dying
shackle the impotence of your emotions

Death . . .
Reciprocal reflections branch out like tentacles
Rituals abound
Transcend your scientific posture
Breakdown the frameworks of your personal boundaries
Come closer . . .

A kaleidoscope of feelings stands in the shadows . . .
New patterns emerge
Revitalizing . . . Not death denying
Rejuvenating . . . not recoiling
Liberating us from the fingers of science . . .
Is death the enemy . . . the stranger?
Or have we anointed death with this strange title
Come closer . . .

They said there was nothing to do
Even as I stood at his bedside . . .
he looked so terrified
his face racked with pain
I patted him on the shoulder
I said something inane . . .
We teach science here young doctor
Stay distant

As the dawn of day settles over the room . . . as he lay dying
. . . in a room filled with starched white aprons
. . . in a room of seeming strangers
I hold his shaking hand . . .
I see the lines smooth over his face
I see his body relax
I hear the whisper in the morning air
You can do something young doctor
Come closer . . . come closer . . . there are no strangers here

[redacted]
Class of 1989

The Interview

She remembers the interview. Appear earnest.
A pigtailed bobblehead.
I love science,
I love working with people,
and medicine
Running, she was running
A blue-collar upbringing complete with 2-carbon chain sucking parents
A vacuum.
Say community and rural, alot, and Smile
She wanted, no, needed a career.
A career to engulf her.
Too busy to cry.

And then she was engulfed.
Surgery.
The comfort of control.
And while she was away
Her children grew. What did happen to her husband anyway?
Is that genetic or was it his vacuum?

Her daughters were gone,
The shells were there—gutted, hollow.
For one it had gone on almost half a decade.
Where had she been, where had
the bobblehead been—
Cross-clamping somebody's fuckin' aorta.
Reveling in the glow of another save.

Now, left with the damages, the damaged
The justice system.
How do you fill a shell?
With newspapers? Like we do with an autopsied carcass.
What do you do with hollowed little souls
With innocence not ripped away but
coaxed and teased?

Can we not tighten up this interview process?

[redacted]
Class of 1983
Second Place, Poetry

Study Date

[redacted]
Class of 2012
3rd Place, Poetry

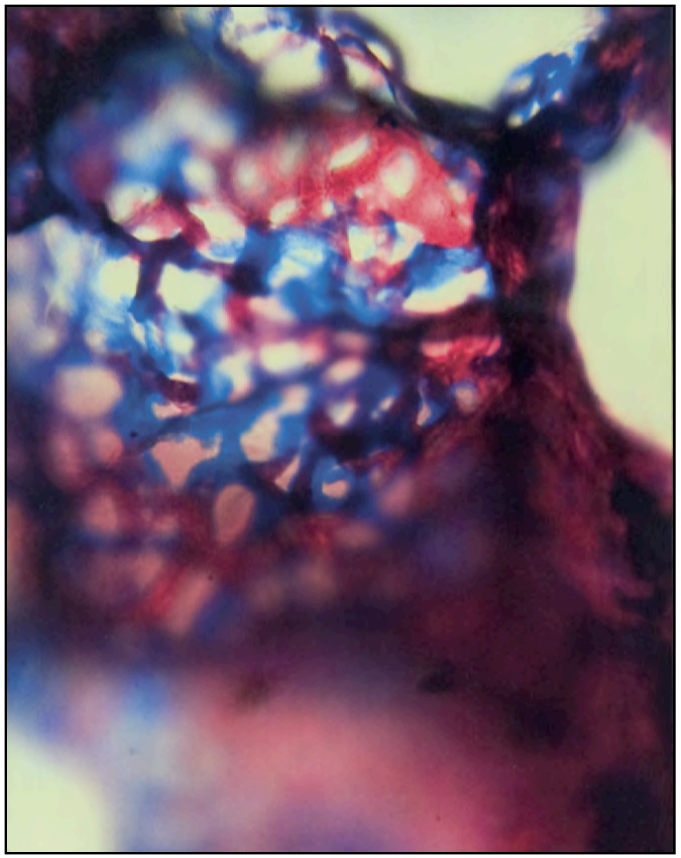
Seduced by nightly study sessions.
Exploring synapses and asymptotic potentialities.
Undeniably entwined despite their attempts to maintain
The professionalism of colleagues and classmates.

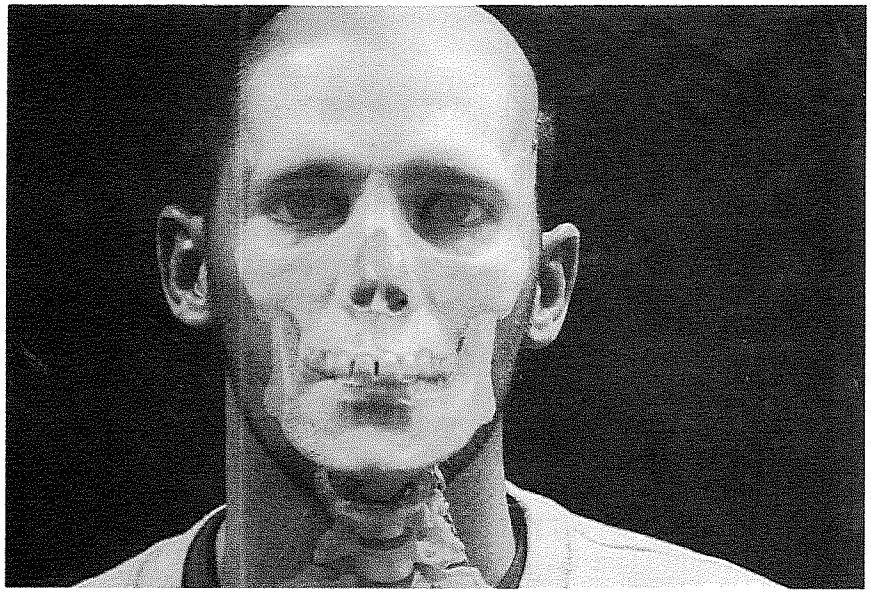
Taking small, justifiable liberties in the name of medicine.
Never had the imagery of physiology been so vivid.
Anatomical pursuit transcended to the ethereal.
Bringing clarity to concepts beyond the classroom.

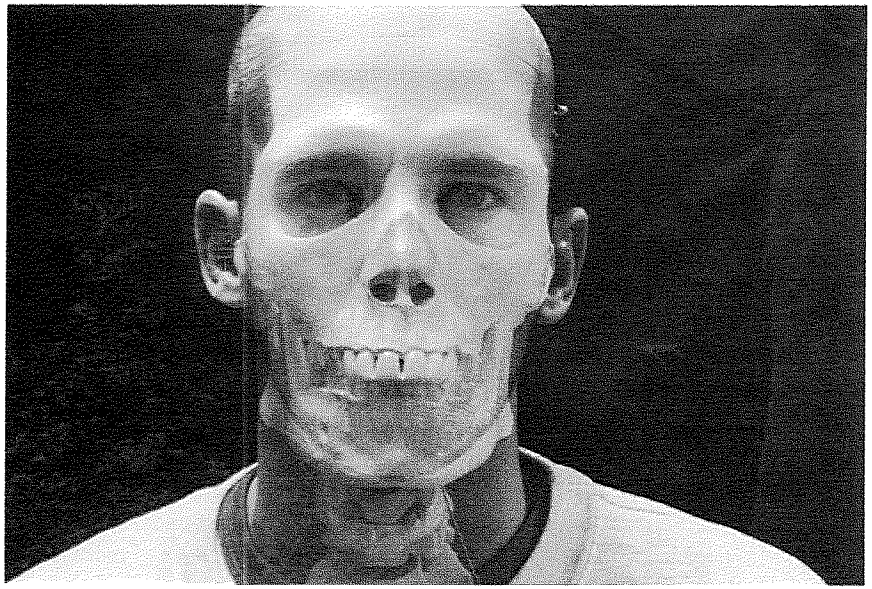
Laying on crimson sheets, pouring over biochemistry.
Tachycardia increasing with each turn of the page.
Behind the books, between the lines, beneath the sheets of text,
The constant companionship flamed into palpable synergy.

Perfusion

[redacted]
Department of Anatomy







Bailey's Bones [redacted] MS I

Henry

You were old but new, dead yet alive.
On the shiny metal cart, in the clean, white bag,
You rested, gift of your self to strangers.
Strangers—we who would know more of your mortal coil than any other,
Yet would not know your name.

Months pass...system by system, part by part,
We learned to find your celiac trunk, teres major, sciatic nerve;
I always felt a little sad
That you would leave us without things I'm sure you felt important.

Today, while looking at the shell that bears little resemblance
To that fellow I met in August,
I decided that no matter how hard it becomes to take away
Bits and pieces of what you once were,
I've learned much from you, Henry, my teacher—

And I think somewhere you are happy.

[redacted] MS III

You Speak of Med School Cadavers

1

You tell me the heads
are draped in gauze at first,
face down, for easier entry of student blades
into the backs of those they'll love
before the whole thing's over. What begins
as terror cloaked in banter, ends in gratitude,
the intimate gift of the open body.

You tell how you'll return the favor at death,
your body a lesson beneath somebody's pry.
Your hand below my shoulder blade
you trace a right angle: the first cut,
you say, a flap of the skin's tenting
into the human soliloquy.

2

Cadavers are oily to touch,
the flesh resembling Italian beef.

Once you left the lab for lunch
and ordered a sandwich;
formaldehyde stench on your hands,
the beef damp and gray—you couldn't choke it down.
Each day at the lab you wore the same clothes,
stink so persistent you torched them at year's end.

You joke, you'll tattoo your chest NO CODE,
and on your back a dotted line, CUT HERE.

3

Here, for the skin of your back, a tattoo,
an indigo bio-script wreathed in trumpet vine:

I treated the poor and the old,
sat at the silent deathbeds
of penniless women,
listened to ancient men
exhume childhood grief.

Taught my daughter
to drive in bad weather.
Grew orchids, shot targets, made lists, stacked books,
I hated to be interrupted.
I was a good kisser.

I once looked into a patient's throat.
Surprised at what grew there I said, Oh shit.
Dear Reader, I'm your text now,
your legend, cover to cover.

4

When the head is at last unwrapped from its gauze
and the face appears, the skull waits for the saw.
But worse than the face, you say, the hand,
that cut a shard from the ball of a foot,
or poured cheap vodka down;
its fingers curled around a thigh
or fisted in rage. The corporeal totem
of the hand, angelic, monstrous.
If not proof the body cages the Soul,
then proof the Body's obstinate grist will do.

5

So they will search you,
muscle, nerve, artery, ligament, bone,
not knowing how you
slept beneath these three thin blankets,
your hand at the base of my head,
my hand at your spine's low arcing,

how we drowsed, dream-moving
to the ceiling fan's whir,
Death at the window on its dogged watch,

beneath my hand
your blood and breath counting you down.

[redacted]
Community
1st place poetry

Bare

[redacted]
Class of 2013

The harsh chemicals landed on every surface in the room as light as mist. Jen felt, uncomfortably, as if they settled on her like dew and she itched to be rid of them.

"Coming through," announced Todd, clutching one of the bone saws like a father holding his baby for the first time, awkward. As he moved past her to get to his group's body Todd stirred up the air around her and Jen's nostrils stung from the preservative in every breath. The smell of it lingered in her hair, her clothes, and it stayed with her for hours after she left at night. It made her nauseous for days. She wondered if it mixed in with the paint on the bare white walls, or if it sunk into her pores to mingle with the oil on her skin.

At the next tank over Todd plugged in the bone saw and high-pitched whining drowned out any chance of conversation throughout the room until the blade sank into the muscles of his body's back, and the noise deepened. A scalpel – delicate as frost – rested on top of Jen's body's meaty hip and she picked it up, started to cut. Sighing with discontent she used tweezers to grab a bit of purple and yellow muscle and fat and made a small motion through it with her knife. A tear as long as her finger and half as deep appeared in an instant in the cold flesh. Jim, a group mate, standing across the body, sliced along the back as confident as a butcher, but Jen worked slow. She didn't want to hurt anything.

She leaned further over to get a better purchase on the hunk of muscle she had in her left hand. For a few minutes she was engrossed in her task: sliced back the thick muscle over and next to the vertebrae, and made a window in the thinner serratus posterior inferior muscle. Jen peeled it off the lower ribs like an orange rind; it made the same satisfying noise. Her nose grew stuffy and started to run, but she kept on cutting. The sooner she was done, the sooner she could leave. The noise in the background increased, as other groups started up other bone saws, and people chattered, fought, discussed, over the cold hard limbs of people who once were. Jen's eyes stung and grew grainy from the

waves of chemicals wafting up out of the body like spirits. But it was only when her lungs started to burn and she felt her chest tighten that she backed away. Taking deep, slow breaths, trying to talk herself out of an asthma attack, she surveyed. Only one layer to go to get to the kidney, she guessed, and the muscle above the spine on her side was completely cut away. Jim, who had more fat to work through, was nearly done with his as well.

He looked up at her and she saw his eyes take in her measured breathing.

"Holy Jeez, Jen," he said, his slight southern accent growing more pronounced with the exclamation. "Take a break! You keep at it the way you've been going, we won't have anything left to dissect." She was about to protest and took a deep breath in to do so, but her lungs squeezed. Wheezing into the crook of her elbow she nodded and sat down on a stool at the edge of the room.

Most of the bone saws had quieted now; they were removing just a small section of the spine. Todd, however, still had his saw switched on, angled deep into the processes between ribs and spine. His goatee, a facial hair choice Jen had wondered about since she first met him, moved down with his mouth in a frown of concentration, and made the beard even more ridiculous. Her asthma attack under control, for the moment, she swallowed a giggle. All of his group members, bored watching a one-man job, had moved off to study radiographs and CT scans and body sections around the room.

He switched off his saw then, and sighed in frustration, wiped his forehead awkwardly against the bottom of his scrubs sleeve and his upper arm. He saw her and his frown deepened. "This sucks."

She waited and after a minute's pause while he looked into the back of his body, he continued. "I swear it, this guy's spine is made out of steel cables. I can't cut through it. "

Continued next page

Jen hopped off her stool and stood next to him, over the body. The man was relatively young, it seemed, his skin still fairly tight, no liver spots, and his back was beautiful. Thick muscles, strong and confident. Even now they hadn't lost their meaning, though they were reflected back and cut away, bare to curious eyes.

"I'm jealous. Our body – you could rip through her muscles with a Q-tip. It's a waste of our time even working on her." Jen peered down again into the man's back, and Todd rested the saw for a moment on the body's scapula. He cracked his knuckles, still gloved.

"What did he die of?" Jen asked. There was a paper posted on each tank giving the cadaver's age and cause of death. Jen's body had been 89 when she died of congestive heart failure and COPD. She was a mess.

"Brain aneurysm. He was like 56." Todd said this without regret, matter-of-factly. He was moving his neck now, side to side, trying to work the kinks out of it.

"That doesn't make you sad?"

"What?"

"He was only 56. That's like the prime of life."

Todd raised an eyebrow at her, cocked his head to one side. "Really? The prime of life?"

Jen glared up, surprised by the anger and disappointment she felt in that tiny moment. "Yeah, well, compare him to our lady. You saw her lungs when we took them out a few weeks ago – all tiny and shriveled up like raisins, and here this guy is, in perfect health, except for the fact that he's dead."

"Why should that make me sad?" Todd asked, taking off his gloves and throwing them with an athlete's grace into the nearest trash bin. "Think about it this way: he never had to go through the hardship of watching his body fail and get weak and sick. He was a man, strong and proud, right through that last second."

Jen took off her gloves, slick with fat and peppered with dried clots of blood, and her hands, clammy from the latex, were wet in the cold air of the room. Her face blushed and her voice rose in spite of her. "Todd, he only got half a life."

"Jen, it wasn't until recently that people started living to their 80s and 90s. A hundred years ago he would have been considered pretty old. Why are you getting so upset about this?"

"Can't I be sad for the life he didn't get to have?" she countered and stared down into muscle and blood and bone, fat and skin and ligament and all the things that made the man a man, and the smell of the formaldehyde that coated his every cell made her throat close.

"Yes," said Todd, and leaned down to look her in the eye. "But why?" He rested his forearm on top of her shoulder – a fellow's embrace, a somewhat bolstering presence. Jen realized right then how long it had been since she'd been touched by someone. Her throat grew tighter. She cleared it.

"Haven't you noticed?" she asked, her voice quiet against the grinding of the occasional saw and the voices of their classmates. Despite the background noise she felt exposed and naked. "It's starting to speed up. And –and we're in here, using all our time to look at people – I wonder, if they could talk, would they tell us to stay and keep working or to go out and do…something?"

Todd blinked. Straightened up and took his arm off her shoulder. Jen blushed harder. He hadn't expected that, she knew. Shaking her head, she grabbed a fresh pair of gloves from the box in their tank and snapped them on professionally. With the bone saw he had made a deep cut into the vertebrae, but she could see that the angle he was taking was too sharp. He would cut around the spinal cord rather than into it. She pressed her thumb against the knobbly side of a vertebra, not very hard. She heard a sharp snap, like a knuckle cracking, and then the tension in the bone gave way. She almost felt horror rise up in her throat – she hadn't even been trying. Even this perfection of person was so very delicate…

"Please stop mutilating my body, Jen," Todd's voice laughed. "Just cause you're jealous doesn't mean you have to resort to sabotage." He was standing next to and a little behind her now, and she could feel his short laugh through her skin. When she looked up at him she saw his

Continued next page

goatee and mouth smiling. "God – try and not make anatomy lab such a sober place next time, okay? It's hard enough to get through this without having to constantly contemplate our own mortality."

He leaned around her then, and grabbed a pair of gloves from the box and as he did so anchored himself with a hand on her back, his fingers just brushing the bottom line of a shoulder blade.

His hand still reaching for gloves he stopped and his face was right in front of hers. "For the record, though, I think they would tell us to do both. Life and work can happen at the same time, you know." His voice was quiet. She was surprised by how comfortable she felt, even though they were strangers. One of his hands was on her back and the other reached across her and it felt like an embrace. She sunk into it without moving, and she was sure he could feel her muscles relax because he smiled with one half of his mouth and goatee.

"There are a lot of hours in the day," she agreed, and he fished for a pair of gloves and drew away, although his hand stayed cupped on her back for another instant and she shivered when his fingertips brushed her spine as his hand, slowly, left.

"There are a lot of hours in the day," he said, nodding.

"Todd!" a voice called out, startling them both. "What the hell is up with our spine? You done with it or are we going to have to excavate this guy with pick-axes?"

"If you're so impatient, Jeff, why don't you come here and do it yourself?" Todd called over Jen's head. "I was taking a break. My arms feel like I've been jackhammering through concrete."

"Try a different angle," Jen suggested. "I think you're going too deep."

"You're one to talk," he grumbled, but smiled that half smile again, and Jen giggled as she walked away. She knew he was watching. She felt her toes in her shoes, and she felt the soft cotton of her scrub pants shift against her legs as she moved, and she felt the blood surge in her veins, and the sun slanted in the windows to tell them how long the day yet was.

Time of Death

9 o'clock Sunday morning...

"Shouldn't I be in church?"

He just lay there
wondering
while they moved around him
doing their meticulous little routine.

People of sort...
Doctor, technicians, medical students, policemen, photographer...
converged around him
hoping to learn
this Sunday morning.

On another table, next to him, were
his 501's, checkered flannel shirt,
a crushed container of Skoal, the engraved pocket knife
that his wife gave him last Christmas
and...
his favorite gold Timex which read exactly
"Three-thirty-five."

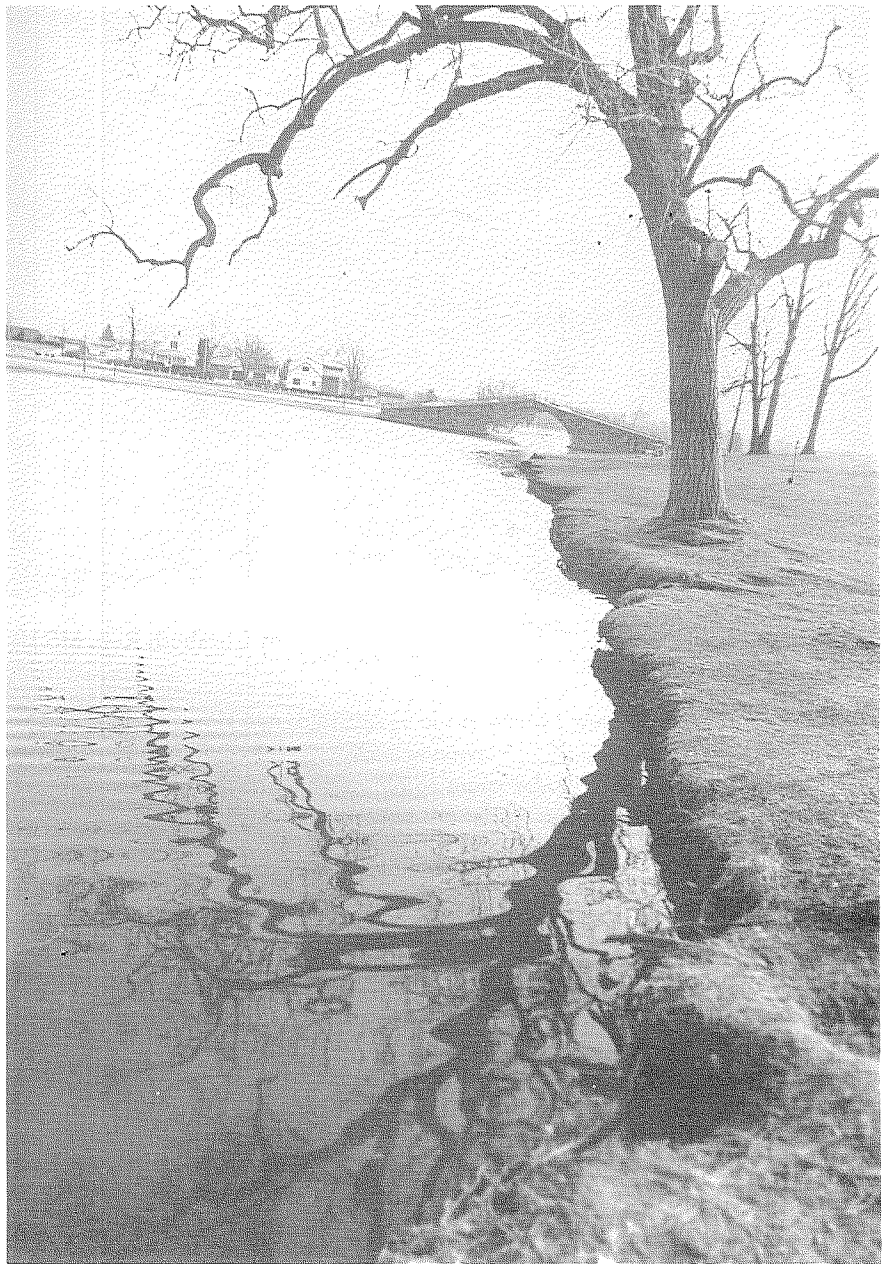
The scenery didn't seem quite right.

They moved around him
doing their meticulous little routine
while he lay there
still as the night.

"Liver: 1800 grams
Spleen: 300 grams
Both severely lacerated.
Brain: 1400 grams... ."

All his thoughts were frozen in time
the moment his Timex had struck
"Three-thirty-five."

[redacted] MS II



Solitude by Nicole Zook, MS III

DOES SHE STEP OUTSIDE TO GAZE UPON THIS SCENE?

Outside the strange room, new machines
whiz their printouts as the morning scuffle begins.
The troops march in, and the bantering gets louder.
Do they think that I can't hear?

The young one with black hair pleads to the air:
"Come on, people, just let her die. . . ."
The bearded young lad cannot think of such things. My lungs are his job.
He faithfully returns to the machine—turning, checking, writing, and suctioning.

Today brings the smiling pulmonologist.
(. . . not the old distinguished one)
His hands and eyes go straight to the clipboard.
(. . . who carefully approaches my soul with soothing penetration)
He quickly talks to the bearded lad, states his plan
(. . . although I cannot speak, he is beginning to hear my wishes)
and leaves the room.
(. . . he holds my hand.)

Outside, the nurses continue the discussion.
The young one has their attention
with pleads of "DNR" (Do Not Resuscitate) and advanced directives.
Others simply nod, hardened from years of days with death.

Their conversation builds, and no one notices the telephone.
"Family of Room D, long distance, line 4."
They quiet and an air of hesitancy and embarrassment ensues.
The young one rises, determined. "Let me handle it," she says.

My feet are full and ashen;
my ankles are wrapped in a strange sling that contracts
mechanically to replace the freedom of youth.

Beside me are the noisemakers that sustain my state.
A high-pitched "fish-sh" releases air from the ventilator
with maddening regularity.

Drops of dew appear along the inside of the clear, blue tubing—
the only things around me that are truly mine.
"Property of Memorial Hospital" lays claim to my distended belly.

The tube snakes along my side, approaching
its target, bending sharply to pierce the saddened face
that sweats futility.

These lips parted once with anticipation of caresses;
they are dried and cracked, bowing
to the blood-stained tube taped upon my face.

Now my hair is thrown up straight and tall.
This peacock spreads its feathers—
not out of pride, but hours of restless still.

"Spilled grape jelly?" Hardly so, young man.
That is bleeding underneath my skin. . . memories of restless acts of passion
when we were out of breath from a different foe!

The vibrant hands (with soft curves) which once held closely
the lips of lovers are moored at my side,
soaked with a blue bogginess from my failing heart (last night's "valiant effort").

The score is even: 6 to 6.
Six tubes enter my body,
Six wires listen to my sorrow.

Looking away, I cringe
at the box of tissue that remains
unopened.

in memoriam:

Agnus Dei qui tollis peccata mundi:
Dona eis requiem sempiternam.

Requiem aeternam dona eis,
Domine, et lux perpetua luceat eis.

Lamb of God, that takest away the sins
of the world: grant them eternal rest.

Grant them eternal rest,
O Lord, and let perpetual light shine upon them.

B. H. (1939–1997)

[redacted], MSIV

CREATION
(Piece by Piece)

He sat within the bed. There was a grey film over his eyes. A curtain that was beginning to fall over a show that had run too long. Within his thoughts there was much going on. Things were being destroyed. Universes were falling.

When he looked up at the light, the Atlantic Ocean was gone. It would never again exist in his universe. It would never be imagined, never thought of, never experienced. Someone walked in the room. As he turned his head, the entire state of New York vanished.

It was his wife. She was still here. She still existed, although most of the world and some of the United States was already gone forever.

She held a damp washcloth to his face. He thought about home, about his parents. That place . . . Idaho, Boise to be exact, well 1134 Plateau Lane in Boise to be very exact, still existed. It was one of the few places that still did. One of the places that he still thought of. That he would ever think of again.

His children were real. So was the room where he slept. The bed was there, but who knew for how much longer. Funny . . . every automobile had ceased to exist. He would never think of another car, would never imagine or visualize one. They had fallen to the same fate as New York.

He sat up and looked at the walls of the small room in the large house. They were white and very real, as real as anything could be. He didn't want time to pass. He wanted to remember more. But the universe was closing and growing very small.

Over the next few hours it grew smaller. It no longer contained anything outside the room. He looked around. Saw his wife and his children. That was everything now: his wife, his children, one small white room and a bed. Slowly, as things grew hazy, he forgot about the bed.

He held his wife's hand. It was soft. He loved it as much as he loved anything. After closing his eyes, vision was no longer part of his experience. He said good-bye to his children forever. Shortly thereafter, his wife and her lovely hand were gone.

He was alone in everything. His beating heart, his heaving chest, and the chill of sweat on his skin were all that was left. It was so quiet! The thump of his heart echoed softly in his ears. It was going to be very quiet soon.

Most people would think the experience a frightening one. However, since he filled everything, he made up everything that he knew; it wasn't lonely. In fact, the universe was so small that it was crowded even though he was the only thing in it.

And as it passed away, or shrunk away, it was warm and friendly. It was not lonely and he was not scared.

And somewhere, not so far off, in a farm house miles away, a newborn's cry echoed through the evening air. And as the child rose his head from a soft pillow and opened his eyes for the first time . . . a mother was created.

[redacted]
MS III

The Other Side of the Clipboard

[redacted]
MSIII

2nd place, prose

I watched through the dusty gray aluminum blinds as the cold January rain mockingly rapped lightly against the tall office window. Each wave taunting me with an "I told you so" tone reminiscent of how mother would sadly hold my broken hearted 16 year-old body and remind me of her warnings about boys my age. I wish she were here now. I smell her lilac perfume and a fleeting glint of hope and warmth begins to surround me until I hear the hospital paging system remind a certain Dr. Bellows that his nurse is still holding on line two and I am jolted back to the fluorescent light-filled box I am suffocating in. The coarse paper on the examining table. The new, young nurse who had mispronounced my dead husband's first gift to me. The four-month-old magazines on fishing and home re-decorating that seemed so much more inviting six years ago.

Tick. Tick. Tick. I can see John's shrunken physique sitting next to me in the hard plastic chair, clammy hand in mine. How I loved him for explaining what a "lymph node" was and how "cancer" had decided to take up residence in mine. No sir. No family history of cancer. No sir. No tobacco or alcohol use. I was always the healthy one. I had to be since John's first heart attack in '93 had induced a stroke and left him paralyzed on the left side of his body. Now it was his turn to comfort and care for me, of which he did so adoringly until the week of my last chemo treatment. He must have thought I was going to be okay, and that he could finally go home. My family quietly celebrated my remission as we paid our last respects to my dear love, my soul mate, and tried to console me with thoughts of "at least now you have your health." Yes, I suppose I did. But, what good was my health without my heart? I had wept unrelentingly at my good fortune.

In the past four years, however, I had learned to deal with John's passing as I rationalized his advanced years, his debilitating condition and how he had fought till the end to make sure I would make it. The single, thin, gold band on my twisted and swollen left ring finger is all I have of him with me today. Looking past my deformed hand, I notice the doctor has installed new floor tiles. Well, probably not the doctor himself. They look cold. I wonder how they will feel when I collapse onto them, trying to pull them up over my head and hide under them, after he tells me I am dying. No. I will not fall. I will clutch my light blue cardigan tighter around my 94 pound frame and defiantly refuse any further treatment. I am 84 years old. I will lose neither the hair I have spent the past two years growing back, nor my lunch…or any other meal for that matter.

I suppose when they had said there is a chance it will return, the cancer that is, that I would have preferred it if they had been a little more clear. Thirty percent chance. Well, does that not leave a 70 percent chance that it will not? That seemed like a lot of percent until last week when I had walked to the mailbox to collect the post, trying to ignore my ever-increasing breathlessness, and returned to the house only to cough up a handful of blood. Fresh. Candy apple red like my first tube of lipstick. I hadn't felt right for months, but that is what brought me here four days ago and prompted a pleasant array of poking, prodding, and testing. I had just finished rinsing my teacup this morning when the nurse phoned. Of course I could come in this afternoon. Her tone of voice was similar to that you would expect of an invite to luncheon with the ladies or a friend's birthday party. Some party this was going to be. I had left the water in the sink running a good 15 minutes before the incessant beeping of the disconnected phone line reminded me of my RSVP.

Now, I sit and wait. Confused. Resigned. Proud. I am relishing how I have come full circle and am ready to strongly face this alone when there is a knock at the door. A solitary tear silently emerged from my right eye and plotted a course over my freshly rouged cheek and to the corner of my
quivering wrinkled mouth.

Pink Fluffy Slippers

[redacted]
Class of 2009

His brow wrinkles again, ever so slightly. He doesn't want her to see his concern, she might get worried, even more so than she already was, he didn't want that for her. He looked into her eyes and gave a smile. He couldn't feel it in his heart, but it seemed to calm her anyways as her eyes fluttered closed again, briefly, he knew. He turned around again and took her small hand in his. They had been waiting here in the hallway of the ER for almost half an hour. Of course to him it seemed like days, his beloved needed to be seen and quickly. She didn't like feeling exposed to all the prying eyes, and lying here in this hallway in a bed by the corner outside of room Q in the ER was about as exposed as it got. He knew it bothered her, it was why she kept her eyes closed most of the time they had been waiting here. They were closed again, but he knew she wasn't sleeping. He felt her fingers flutter slightly in his large palm, and he looked down again at her small hand, almost half of his, delicate as a butterfly, and he remembered that first night he had asked her to dance, and she had placed that same small hand in his large one. He had felt then as if his hand had engulfed hers and had said so, embarrassed. But she had told him later that she loved the way her hands disappeared in his and he never let her go again. They had been dancing since then, sixty amazing years. He looked quickly again at her face, it was her low moan that had pulled him back from his reverie, lost in long, slow dances, the angst and joy of labor, four children, their wedding day.

"It's okay my darling, they'll find us a room soon I'm sure." He smoothed her forehead tenderly with his hand. Her lips were a little pale and her eyes fluttered open again. Her other small hand rested atop her abdomen, the source of her current distress. Still she smiled. A small smile. He knew it was for his benefit, just for him, and the realization brought choking tears to his eyes which he struggled to hold back. He looked away hurriedly and tried to compose his voice. "I'll be right back," he said simply and stepped away to speak to the girl standing at the glass observation window where a sea of doctors and nurses and other hospital staff seemed to watch the patients and going ons like they were fish in a fish bowl. "Excuse me, nurse, please..."

"Please, sir, we are doing everything we can. There are a lot of patients coming in right now. We will have a room for you as soon as one opens up."

"Thank you I understand you are working very hard, and I thank you, but my wife, she, really doesn't feel well and lying out here in the hallway just makes it so much worse.."

"I understand that sir, but there is nothing to do now but to wait till something opens up."

"Thank you ma'am..." But she turned away almost immediately and was gone before he could ask her the question. He glanced again at Hattie and hurried back to her side.

"My darling, it's coming soon, we'll be in a room, don't worry sweetheart." He tried to keep his voice light and spoke almost in a whisper. He touched her shoulder lightly and held her open hand with his. "Oh Arnie, I just wish it didn't hurt this much," she whispered softly. "I know my angel, i'm sure the nurse will bring something any minute." He felt teardrops flowing, but his face was dry, inside he cried. He was afraid, she was 77 and she hadn't been eating for the past two days. What if she was really sick, what if it was … no he couldn't think that. Lord God please, my Hattie he screamed, yet his lips uttered not a word. He smiled and she smiled back at him, or tried to. Then he saw it, ever so softly — her lips trembled. That only happened when she was really cold, yet trying to be so strong like she was always wont to do. He had needed to ask that lady for a blanket for Hattie. Hattie always had chills and she'd told him before, when he'd asked her, that she was cold. He rubbed her arm "I'll keep you warm my dear," he said "just give me a moment." He pulled out the green bag the tech had

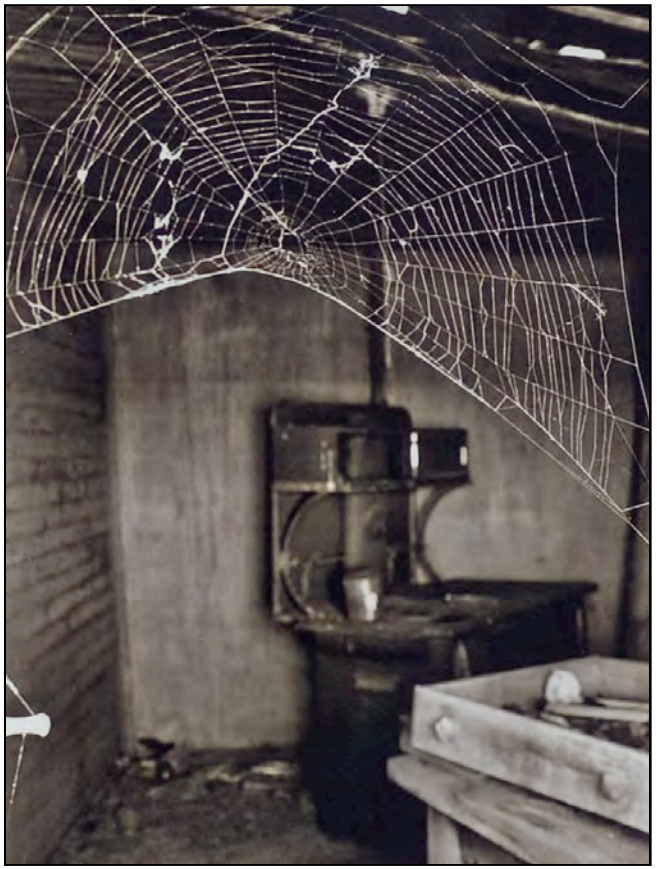
given him when they first came in, and began to rummage around inside it.

"It has to be here, I know we packed it because we were scared she might have to stay this time." he muttered to himself. "I'm sure I put it in there, they're her favorite, always give her a sense of being home, I ... aah." He pulled it out ever so gently and placed the green bag at the bottom of the stretcher she'd been conveyed in upon. He moved to the end of her bed where her little feet stuck out from the thin solo blanket she had covering her.

A girl walking past was struck by the image of an old man standing at his wife's feet, sliding fluffy pink slippers onto each tiny foot. A visible look of relaxation came upon the old woman's face accompanied with a smile. The man was watching the old woman's face, and bore the same look of happiness at bringing comfort to his beloved.

untitled

[redacted]
M.S. Student



Hospital Room

[redacted], M.D.
Department of Neurology

Strange town
hospital gown open in the back
IV drip by drip

A wall clock measures
time she is away
from herself... and him

The flowers empty their vase
before she answers
to her name

or opens her pretty eyes
to a light kiss.
One look

and she is gone again,
naked on an ice float,
farther from the river banks

than she has ever been.
He fears losing her,
at her side useless,

from thoughts of her startled
by the intercom announcing baby John.
A stranger mops linoleum at his feet

[why now—can't she see?]
The food tray comes and goes untouched,
winter sun makes its journey

on the off-white wall
then,
nightfall

White Dove of the Desert

[redacted]
Community