

# “Writing About Medicine”: An Exercise in Reflection at Mount Sinai (with Five Samples of Student Writing)

SUZANNE FEIGELSON, M.Sc.<sup>1</sup>, AND DAVID MULLER, M.D.<sup>2</sup>

## Abstract

This paper describes the introduction of a new elective, “Writing About Medicine,” into the Mount Sinai School of Medicine (MSSM) curriculum, part of a new trend of developing humanities programs at medical schools. The paper will first survey two exemplary programs at other schools, and discuss their impact on students. It will then detail the development of “Writing About Medicine,” including its purpose and format. Finally, it will present focus group data evaluating the course and elaborate on its role in the MSSM educational process. Five samples of student writing follow the discussion.

**Key Words:** Humanities, narrative medicine, creative writing, medical education, professionalism.

---

## Introduction

The past decade has seen a systematic effort to diagnose, treat, and discharge hospital patients faster than ever. These changes have left physicians or trainees with little or no time to spend at the bedside, developing the skills of empathic care giving. Therefore, medical schools have been searching for new strategies to teach students how to understand patients better and communicate with them more effectively. The study of the humanities, which holds these skills at its core, provides one promising avenue towards this goal. Medical educators have pursued this path in two ways. First, in recent years, students with limited science backgrounds have been admitted to medical schools in greater numbers. Second, some institutions have begun to integrate humanities courses into their basic science curricula (1–5).

At the many medical schools where they exist, programs in “humanities and medicine” range in both quality and scale, from humanities-based electives (UMass’s “Creative Writing for Medical Students”) to programs that use reading and writ-

ing as part of the standard curriculum (Northwestern University’s second-year course, “The Profession of Medicine”), to Humanities and Medicine or Narrative Medicine Departments (Columbia’s “Program in Narrative Medicine,” [www.narrativemedicine.org](http://www.narrativemedicine.org)). At least 10 institutions have developed these programs or departments, including Northwestern, NYU, Penn State, Columbia, and SUNY Stony Brook.

Although many programs emphasizing patient-centered medical training have established curricula in ethics and “professionalism,” this article will focus specifically on the method of utilizing reading and writing to accomplish similar goals. First, we will provide a brief review of two fully developed programs, at SUNY Stony Brook and Columbia. Then, we will describe in detail the elective “Writing About Medicine” at Mount Sinai, and present data evaluating its effectiveness.

## Columbia College of Physicians and Surgeons

Established in 1998 by Rita Charon, M.D., “Narrative Medicine” is a method of fostering empathy in care by using reading and writing as tools (6). A “narrative” approach seeks to understand the patient in the broader context of his or her story. This involves soliciting the patient’s perception of illness and cultural beliefs, and giving these issues greater emphasis. For example, the social history is taken not simply to establish medical facts (drug

---

From <sup>1</sup>Medical Education and <sup>2</sup>the Department of Internal Medicine, Mount Sinai School of Medicine, New York, NY.

Address all correspondence to Suzanne Feigelson, Mount Sinai School of Medicine, 50 East 98th Street #4F, New York, NY 10029; email: [Suzanne.Feigelson@mssm.edu](mailto:Suzanne.Feigelson@mssm.edu)

use, infections, insurance), but also to understand what the illness might mean to the patient.

According to Dr. Charon, a physician who practices medicine without “narrative competence” risks misunderstanding and alienating the patient, fostering ineffective communication and (ultimately) noncompliance. The Program in Narrative Medicine serves to train students from their second year onward in the skills of reflection and communication. Second-year medical students are required to take a half-semester elective humanities course at Columbia College, for credit.

The most transformative phase of Columbia’s program lies in the third year. For several weeks during their internal medicine clerkship, randomly selected third-year students are asked to keep notes in a “parallel chart” (6). This serves as a reservoir for the students’ subjective experiences with their patients, which are shared in small group settings once a week. Eighty-two percent of participating students said the exercises were beneficial in preparing them for conversations with patients and families. Faculty members concurred that the students were better prepared to interview patients and to assess their needs. Preliminary data show that all the participating students established better connections with their patients and made more coherent case presentations. According to Dr. Charon, reflective writing enables students to review and clarify their experiences and understand the strengths and weaknesses of their care-giving. It also equips them to listen more attentively to their patients’ stories, in the hope of forming more effective doctor-patient relationships (6).

### **Stony Brook University**

Stony Brook University introduces its program, “Medicine in Contemporary Society,” in the first year of medical school. Students keep journals and receive a grade for their work (7). They also attend 50 hours of small group discussion on the relationship between medicine and other aspects of contemporary culture. The program continues with another 50 hours in the second year, after which students hand in a creative writing project, either a personal or academic essay on a topic in the medical humanities. In each of their third-year clerkships, students are asked to complete writing projects designed by the clerkship directors in collaboration with in-house Humanities and Medicine faculty. Finally, the fourth year offers an optional sub-internship in “Humanism and Medicine” that further integrates journal writing with clinical practice. Stony Brook’s objectives for narrative training are to foster skills in recognizing so-

cial questions; develop a knowledge base of humanities and social sciences; form attitudes of compassion, curiosity, and collegiality; strengthen analytic skills; improve communication skills; and sharpen learning skills.

### **“Writing About Medicine” at Mount Sinai**

The elective “Writing About Medicine” was started by the authors in an effort to foster reflection among students. Pre-clinical studies can cause students to lose sight of the patient-centered goals that often led them to a career in medicine. The elective, which began with 8 students from the class of 2006 in the winter of their first year, was designed to help students remain connected to the humanistic dimension of medicine. It consisted of seven two-hour meetings, roughly three weeks apart, organized around the following topics: “in ‘doctor’ination,” anatomy, pain, illness, aging, death, and recovery (Table 1). Topics were selected based on those that were most stimulating to students at other institutions with humanities and medicine curricula, according to their program directors. The course was limited to 12 students, a size believed to be most conducive to small-group discussion. Each meeting had four components:

1. **Readings:** Students were assigned readings from a variety of genres, including essays, poems, articles, and short stories.
3. **At-home writing assignments:** For each of the meetings, half of the students were asked to complete a creative writing assignment on the given topic. Students mostly wrote personal essays, but some preferred to write poetry or short fiction. These assignments were handed in to the faculty advisor for review prior to each meeting.
4. **In-class writings:** At the beginning of each meeting, students would write for 20 minutes in response to a question or passage read by the instructor.
5. **Discussions:** To open and support the discussion, students were given the opportunity to read all or part of their in-class writings. The discussion would continue for the first hour, drawing from the in-class writings and the readings, and when the instructor felt it was appropriate, he would hand back a take-home writing to the author to read on the spot. The class would then give the writer feedback on both content and form.

Following the seven sessions, focus groups were conducted by an independent administrator to glean feedback from the participants. Based on this

**TABLE 1**  
*Course Syllabus for Writing about Medicine I*

Subject	Reading	Writing
In'doctor'ination	<ol style="list-style-type: none"> <li>1. Rita Charon, "To Build a Case: Medical Histories as Traditions in Conflict"</li> <li>2. Elspeth Cameron Ritchie, "Language Barrier" from <i>Hospital Sketchbook: Life on the Ward Through an Intern's Eyes</i></li> <li>3. Peri Klass, "Learning the Language"</li> <li>4. Two compositions by Mount Sinai residents</li> </ol>	<p>In class: Where are you right now? Start with your immediate physical surroundings and see where it takes you.</p>
Anatomy	<ol style="list-style-type: none"> <li>1. Dannie Abse, "Carnal Knowledge"</li> <li>2. CK Williams, "Dissections"</li> <li>3. Peri Klass, excerpt from <i>A Not Entirely Benign Procedure: Four Years as a Medical Student</i></li> </ol>	<p>At home: Compose a letter to your cadaver, explaining what you did and why you did it.</p> <p>In class: Pick someone you care about and convince him/her either to donate his/her body to science or not to.</p>
Physical Pain	<ol style="list-style-type: none"> <li>1. Elaine Scarry, "Introduction" from <i>The Body in Pain: The Making and Unmaking of the World</i></li> <li>2. Fanny Burney's letter and Richard Seltzer's critique, from <i>Raising the Dead: A Doctor's Encounter with His Own Mortality</i></li> </ol>	<p>At home: Describe an experience of physical pain, either yours or someone else's.</p> <p>In class: Describe an emotionally painful experience.</p>
Illness	<ol style="list-style-type: none"> <li>1. Virginia Woolf, <i>On Being Ill</i></li> <li>2. William Carlos Williams, "Jean Biecke"</li> <li>3. Lorrie Moore, "People Like That Are the Only People Here"</li> </ol>	<p>At home: Describe a time when you experienced illness, either yours or someone else's.</p> <p>In class: You get a letter notifying you that you tested positive for hepatitis C. Write your reaction.</p>
Aging	<ol style="list-style-type: none"> <li>1. Elanor Cooney, "Death in Slow Motion"</li> <li>2. William Dean Howells, "Eighty Years After"</li> </ol>	<p>At home: Describe aging from the point of view of someone who has aged.</p> <p>In class: Which is more difficult: physical or mental decline? Select one and write about it.</p>
Death	<ol style="list-style-type: none"> <li>1. Ernest Hemingway, "A Natural History of the Dead"</li> <li>2. C.S. Lewis, <i>A Grief Observed</i></li> </ol>	<p>At home: Write about death.</p> <p>In class: React to an excerpt (read aloud) from C.S. Lewis.</p>
Recovery	Jack London, "Love of Life" from <i>Stories for Boys</i>	<p>At home: Describe a recovery, either medical or non-medical.</p> <p>In class: React to an excerpt (read aloud) from Jack London.</p>

data, the authors ascertained students' original expectations, their personal "cost/benefit" analysis of the experience, and their ideas of how the course impacted their education (Table 2).

Expectations of the course ranged from professional ("I wanted a 360 degree view of medicine")

to personal ("not to go insane") to intellectual ("I really missed the intellectual and creative culture at college"). As one student said, "I wanted to think about med school things in less of a med school way." The cost/benefit analysis reflected an overwhelming benefit and almost no cost. Students

**TABLE 2**  
*Focus Group Data*

<b>Expectations</b>	<b>Outcomes</b>	<b>Impact of the Course</b>
<ul style="list-style-type: none"> <li>—Establishing a connection with like-minded classmates</li> <li>—Gaining tools for reflection</li> <li>—Rekindling humanities interests pursued in undergraduate training</li> <li>—Having the opportunity and discipline to write</li> <li>—Improving writing skills</li> </ul>	<ul style="list-style-type: none"> <li>—Looked forward to class time</li> <li>—Felt happier in medical school</li> <li>—Felt more satisfied with medical education</li> <li>—Felt more confident in ability to be a good doctor</li> <li>—Course was emotionally challenging, but not distressing</li> <li>—Positive contact with faculty</li> </ul>	<ul style="list-style-type: none"> <li>—Students imagined they were less disillusioned with medicine than they would have been without the course</li> <li>—Students found that reflection and creativity enriched their training beyond what the standard first-year curriculum provided</li> <li>—At the end of the year, students felt a greater connection to their classmates than they would have without the course</li> </ul>

said “it required energy” and “it was emotionally challenging at times...but that was good.” “I think the fact that we all got up at 7 AM to go to the elective—on a couple of separate occasions...and stayed late once, [suggests that] we were definitely into it.” “It was a place where you felt like somebody was watching out for you and cared for you,” another added. Students said they felt happier, more satisfied with their education, better about Mount Sinai, and more confident. When asked, students could not think of any other way they would have rather spent their time, including sleeping, eating, or studying.

The course has continued into the second and third years, following a similar schedule and format in each term. All of the students participating in the first-year course continued into the second and third years. The course has also been offered to the classes of 2007 and 2008. Twelve students enrolled from the class of 2007. This class made minor adjustments to the syllabus and continued with all 12 students into their second year. The course will be offered to the class of 2008 beginning in the winter of their first year.

### **Discussion and Future Directions**

“Writing About Medicine” is Mount Sinai’s first effort to train its students in reflection and “narrative competence” by using reading and writing as its primary tools, as Columbia and Stony Brook have done. Although the methods of “Writing About Medicine” are unique within the Mount Sinai curriculum, its educational objectives are consistent with other efforts of the medical center to train humanistic doctors. Paramount among these is “The Art and Science of Medicine,” spanning the first two years, which includes weekly lectures, small group discussions on ethics, patient-centered care and other non-biological topics within medicine, as well as physical diagnosis

training and introduction to the clinical encounter. Course offerings during the third-year intersession and fourth-year electives include reading and discussion groups that explore students’ reactions to medical training. The Visiting Doctors program for internal medicine residents also devotes several sessions to this type of activity. In addition, student groups have organized lecture series dedicated to humanism in medicine.

A unique expression of Mount Sinai’s commitment to humanism in medicine is its program “Humanities and Medicine,” which provides a path to medical school offering maximum flexibility in the undergraduate years for students to explore their interests in humanities and social sciences without having to take the MCAT or complete the standard premed course load (8). The program has been remarkably successful in recruiting diverse, nontraditional premed students. Columbia and Stony Brook, while more advanced in the development of humanities and medicine curricula at their institutions, do not have comparable programs that solicit and nurture humanities students in the undergraduate years. “Writing About Medicine” has the potential to become an excellent complement to the Humanities and Medicine program, by reinforcing its values once graduates of the program have begun their medical training. For students with more traditional premed backgrounds, the course helps to enhance verbal communication skills and provides training in reflective practice.

Frederic Hafferty, in “The Hidden Curriculum,” writes that students learn the core values of medicine not in lecture halls or on medical rounds, but in more informal, unsupervised settings where reflection takes place. By allowing students the opportunity to reflect on their shared experiences in the presence of a faculty member, “Writing About Medicine” presents an opportunity to integrate this more personal realm into medical students’ formal training (9).

To build on the positive effects of “Writing About Medicine,” we will continue to develop forums that include reading and writing for trainees at every level of medical education. In the long run, our goal is to design a curriculum similar to those offered by Columbia, Stony Brook, and other institutions, a curriculum that will span the four years of medical education and involve the entire student body. We also plan to offer programs for the rest of the medical community in close collaboration with the Humanities and Medicine program.

#### References

1. Hatem D, Ferrara E. Becoming a doctor: fostering humane caregivers through creative writing. *Patient Educ Couns* 2001 Oct;45(1): 13–22.
2. Ahlzen R. The doctor and the literary text—potentials and pitfalls. *Med Health Care Philos* 2002; 5(2):147–155.
3. Reifler DR. Early patient encounters: second-year student narratives of initiation into clinical medicine. *Pharos Alpha Omega Alpha Honor Med Soc* 1996; 59(1):29–33.
4. Reifler DR. “I actually don’t mind the bone saw”: narratives of gross anatomy. *Lit Med* 1996; 15(2):183–189.
5. Hawkins A, McEntyre M, editors. *Teaching literature and medicine*. New York: The Modern Language Association; 2000.
6. Charon R. The patient-physician relationship. *Narrative medicine: a model for empathy, reflection, profession, and trust*. *JAMA* 2001; 286:1897–1902.
7. The Institute for Medicine in Contemporary Society. [www.uhmc.sunysb.edu/prevmed/mns/imcs](http://www.uhmc.sunysb.edu/prevmed/mns/imcs) [accessed 2/11/05]
8. Rifkin MR, Smith KD, Stimmel BD, et al. The Mount Sinai humanities and medicine program: an alternative pathway to medical school. *Acad. Med* 2000; 75(10 Suppl):S124–S126.
9. Hafferty F, Franks R. The hidden curriculum: ethics teaching and the structure of medical education. *Acad Med* 1994; 69:861–871.

## Phone Call

JUDITH GOLDFINGER  
MSSM '06

---

THEY HAD BEEN ON THE PHONE for nearly an hour, and her reserves of kindness were nearly dried up.

The woman was lying on the floor, sometimes on her stomach, sometimes on her back. She began the conversation with the phone in her right hand. When that arm and elbow got stiff, she switched hands. Soon enough, her left ear reddened from the pressure of the receiver, and she switched back. As the call reached the hour mark, she tried to calculate how many times she had switched the phone from ear to ear, and she realized that she could not get more precise than an estimate of four to six.

"Four to six, foor too seeeks," the woman repeated over and over in her mind until the words had lost all meaning, like an object whose lines begin to blur when stared at for too long.

She mentally reviewed the call. Male caller, undergraduate, stressed over his grade on a recent test. The caller was feeling overwhelmed and anonymous in the large college. He was having trouble making friends and he missed his long-distance girlfriend. This was a typical call, a variation on a theme that she had visited and revisited numerous times. Of course, for the caller these problems were intensely personal, special, and even unique.

The woman had played the role of counselor well on this call, she decided, as she switched the phone to her other ear. Was that ear switch number five or seven? Back to the call: plenty of non-verbals, "uh-huh," "hmmm," and "yeah." She had validated every feeling he expressed. "It is totally understandable for you to feel overwhelmed. The workload can be really considerable." "It can be really hard when you are here, and your girlfriend is so far away, and you just really want to be with her." "It sounds like you are feeling really alone right now, which can be really difficult." "It is always hard to come to a new place and meet new people."

The woman was proud of her performance. She had empathized and commiserated. She suggested clubs related to his interests, as potential

meeting places for new friends. She recommended peer tutoring and potentially helpful meetings with deans. She gave him phone numbers and email addresses, never pushing, always just suggesting, even as she emphasized how vital these measures could be. And he took them all, wrote the numbers and email addresses somewhere on his side of the phone line, and then repeated them back to her to make sure he had them right. It was very rewarding for the woman, the counselor, that he did this. So many times she had tried to give a phone number to other callers, perhaps had spent a minute or so explaining how useful the resource could be, only to hear these callers say, "Oh, that's OK, I don't really think I need *that*." Or, "Well, not *now*, if I decide that I need it, I guess I can just call back at a different time."

This caller was different. She felt him responding to her attempts at sincerity, felt the rapport grow between them.

Then the man said, "I'm sorry." And she was momentarily taken aback, confused, thought perhaps she had said aloud, "Six or eight," as she switched the phone yet again. And he said, "I feel that I have been taking advantage of your compassion."

The woman thought, this is not compassion. I am the counselor and I am doing what I have been taught, and you are responding to studied words and phrases. You are calling an anonymous and confidential hotline so you can share your thoughts and feelings with someone who does not know your face or story, who is not tired of hearing your grumbling, and who sees you only as you choose to present yourself. This is a forum where I will judge you in my own mind, but you will never know it or even sense it, and you will see me as nonjudgmental.

Then the woman surprised herself and said, "Well actually my ear hurts." The man responded "Um-hmmm" encouragingly, and she could not stop herself from thinking, good non-verbal. She found herself wanting to explain about the worn-out couch and the shag carpet on the floor. She

looked around and saw the faded posters tacked on the walls of the small room, for past conferences about domestic violence and eating disorders.

Then the woman realized what she had said, and she amended her complaint. "Not that my ear hurts from listening to you, no, no, just that the actual phone is pressing on my ear, you know?" And the man said "Um-hmmm" again and then he said, "I find that it helps to switch ears."

"I have been doing that," she said. "It does help. Somewhat."

"Or try lifting your eyebrows," he said. "Try doing it in a way that kind of stretches your ears out."

The woman realized that the caller would never know if she, on her side of the phone call, was taking his advice or not. Just as she would never know what the caller was doing with the phone numbers and her advice, whether he followed through.

"I am doing it," she said. "Lifting my eyebrows, I mean. And it is helping. It really is. Really."

"It's a good trick," he said. "I keep doing it. Otherwise your ears fall asleep, which is pretty uncomfortable. And then you can barely even concentrate on what is going on, because you are so conscious of your *ears*. And switching the phone a hundred times is ridiculous."

*Yes*, she thought, *yes*, exactly. And now she had to regain control of the conversation, reestablish their respective roles. "So when you called tonight, one of the things that you mentioned was that you were lonely, that it is hard for you, because you came from a small high school where everyone knew everyone else. And one of the things that we talked about was you getting involved in clubs or activities on campus to try to meet some new people, and feel more a part of things. And so I gave you some numbers, and you took those numbers, which was really great, because it can be hard, you know, to take the initiative and try to do something for yourself. To try to make things better for yourself. That is really great. And I want you to promise me that you will call. For yourself."

And the woman realized that she desperately needed to know that he would call one of those numbers. She knew that she had another hour on the hotline, and then she would go home and go to sleep. In the morning, she would wake up and be one of the thousands of nameless people on the large college campus. She would spend the whole day thinking about a lonely man who thought her compassionate and had been, for at least a moment, truly concerned about her ears.

# The Tale that We Spun

LAURA PILAR GELFMAN  
MSSM '06

I EXPERIENCED HIS ILLNESS over the telephone. The diagnosis, the symptoms, the treatment and eventually his death, all over the telephone over a three-year period, one twelve-year-old confiding in another. Many days it was more than I could bear, but most days I had little capacity to connect the symptoms and the treatments with the prognosis. I did not know that it was a bad sign when one of his lungs filled with fluid, or the day when he began another round of an experimental chemotherapy, or when he began spending less and less time in Miami and more and more time in Houston getting treatments. I did not realize how willingly I believed in his stories and I did not realize how much he needed me to believe in the myth that he had created for me. It was a story that he wove for me each day and each day a story that I digested. He needed me to believe that he was going to be okay, just as I needed to believe that I could help make him okay. I learned the language of his illness with a vocabulary of a twelve-year-old.

As the treatments continued and the days he spent in school became fewer, I came to rely on his voice as a means to gauge his illness. His words were telling, but the tone, the candor, the energy of his voice grew more meaningful. Looking back on our almost daily phone conversations, I spent most of my time listening closely to his voice. I would replay our conversations in my head, still unaware that he was going to die, focused on what I could grasp, worried that he felt lonely, that he had a sad day, that he felt far from home, that he felt tired and dizzy from the treatment, all things that I believed that I could improve. I could make him feel close to his friends, I could keep him company over the phone as he lay in the hospital bed, and I could make him feel like a fourteen-year-old. I tried to keep him connected with homework assignments and letters from classmates and videos of our friends. He graciously accepted all of my attempts to save the part of him that I could understand, sustain the part of him that I connected with, to keep him believing in the hope of returning to the lifestyle from which he grew more distanced.

For the most part, I did not realize that behind the tale that he spun for me, that he was facing his death. We even spoke of death on a few occasions, and he convinced me that he was not afraid, once again reassuring me of the very thing that I had quickly dismissed. He made confessions to me

about his family's troubles and shared the things that he hoped to do one day. I never saw the connection between his reflections, confessions and worries, but instead believed in his health, his power to recover, the power of medicine, his treatment, the false hope that he would be cured. All the while, I tried to manage the tragic circumstances that he faced in the only way I knew how. In many ways, I never experienced his illness; instead, I experienced the absence of his illness, a space without his illness, which we created together. For the most part, no illness existed over the telephone.

The day that the phone rang and his sister told me that he had died, I was stunned. At that point, after three years of phone conversations and reports on the status of his health, my parents had tried to prepare me for what they recognized as the end of his life. Once again, over the phone, his sister reported to me that he was paralyzed when he died because the cancer had spread to his spine and strangled the spinal cord. His sister shared with me his last secret, something that he actively concealed from me. She told me his secret with the hope that it might be easier for me to deal with his death, knowing how difficult it would have been for the talented soccer player to live paralyzed. As I listened, I felt as if I could not breathe and again, as I write, I feel the same crushing sensation, that he could not tell me his last secret, that he could not break the harmony, that he could not shatter the tale that we spun together even as we spoke the day before his death.

I cannot help but wonder how much he knew about his illness, how much I needed to play into his tale, and how much he wished that he could have told me the truth. Today, I cannot help but wonder how much my new vocabulary of medical school would have revealed to me about his illness, how I would have treated him differently, how I would no longer be able to believe his tale, but now I would have to prepare him for what seemed inevitable.

This time I would be seeing the illness, hearing the illness, watching the illness, understanding the illness, and I would no longer be given the chance to create the tale, to share the tale that he needed to create and I needed to believe. I could no longer participate in the tale spinning; instead, this time, I would have to dismantle the tale, shatter the tale, and stare at the illness directly.

## A Private Visit

JONATHAN DWORKIN  
MSSM '06

---

"I'M STARVING," I admitted. A. grinned from under his hat. Then he reached into his coat, a loose beige blazer, and pulled from some secret compartment a tangerine. There was no pause from the driving, his attention remained fixed on the road.

It took some fumbling to peel the fruit, which squirted and resisted until I settled the matter by sinking my teeth in. There were no napkins in the car, so I licked my fingers as best I could. All the while A. drove on, eyes fixed ahead, probing as much for gaps in his own attention as for ice patches or deer crossings. The trip entered its fifth hour, the signs still pointed north.

In a town outside Bangor we passed a complex of smokestacks that bellowed enormous gray plumes into the overcast sky. There were no workers or even cars visible from the road, and the place seemed to run on some kind of autopilot. It felt odd seeing it there in the middle of nowhere, like bumping into an awkward acquaintance on a camping trip, but we passed the stacks and hardly said a word about it.

Sometime later we drove over a bridge. The water below curled like black glass around a mountain, and large chunks of ice perforated its surface and swallowed passing clumps of earth and driftwood. Around us a frozen drizzle made for miserable conditions, but the panorama of the creek winding through the woods snapped us out of our mental spaces. A. stretched his back and gestured towards the radio. This motion possessed a kind of conserved energy, as if his power grew through the exercise of banal tasks. I inserted a cassette and smiled with satisfaction as the fierce piano of Schubert's *Erlkonig* filled the silence of the car. We kept on like that, feeding on the tension of music and forest, until we reached our cabin.

After I gathered my supplies from the car we entered the cabin together. I expected to come across a somber scene, but instead everyone assembled seemed relaxed. Two friends hung over a chessboard while a few others tended to the patient. Someone had taken the trouble to hang white curtains along a broad back window overlooking the woods. The patient rested in bed under some carved bookshelves and a soft reading light. A pale hue clung to him, but when he recognized me he brightened noticeably. Knowing that my work here would be secondary, I took plenty of time to catch up before beginning my exam. He told me of a recent performance in Boston, and though he was too weak to stand, his expressiveness showed that his humor was preserved. He quizzed me on my work, and then on my play. Only after teasing me about the latter did he seem satisfied to undergo the exam.

I continued the light talk through the vitals, and only when I removed his shirt did his decline strike me. He was hollowed out, completely cachectic, and his pallor spread to my face as well. His disease was consuming him from the inside, and no facility invented by man could preserve him any better than our little cabin. I draped him in blankets and called out to A., who helped me reposition him in a chair.

There in the woods, some way north of Bangor, we spent the evening retelling old stories and giving them new twists. There was sadness, but little open grief. A fire burning in a corner hearth provided light and warmth. A. cut some potatoes and stuck them on skewers. This delighted our friend, who insisted on roasting his own. He was all dignity as we began to eat.

## Aging

KATHERINE KRAUSKOPF  
MSSM '06

THE HOUR I STARTED TO AGE was fifty years ago.  
Normal December 16<sup>th</sup>, nine days before my  
birthday,  
slush-coated galoshes rested on their rubber mat  
at the front door  
and an orange gauze of winter sun clung above  
my patch of park  
outside the window.  
In the bedroom,  
I began to change for dinner  
before that same crack in the closet mirror  
with the same pot of violets on the sill for company.

I began to change for dinner,  
pulled dress and slip over my head,  
even tossed them onto the edge of the bed.  
Turned back to the mirror  
to steal a glance at myself before forty became  
forty-one  
and saw the dimple in my skin.  
A tiny leaf-shaped dip  
moving with each breath,  
just above the line cut by my bra across my left breast.  
The closer I moved to examine it, hoping for a  
trick of the fading light,  
hoping it would diminish to a figment of the win-  
ter day,  
the closer I moved, the bigger it became.

The flurry followed—a trip to the doctor, a trip to  
the specialist, a trip for a second  
opinion and then a trip for a third. Of course there  
was medical treatment—primitive by today's  
computer screens and machines to image the  
impossible I imagined on my own.  
Time passed. I still pride myself on forgetting its  
simplest details.  
Then two surgeries and less many lymph nodes  
later, I was deemed in remission.  
I was forty-one.

Forty years of before and fifty years of after.  
We became comfortable old friends, my remis-  
sion and I.  
Each testing the other's limits  
Until enough time passed, and we knew to trust in  
the silence.  
And yet, despite this dependence,  
each morning, still smelling of soap and shower,  
before I dressed for the day  
I would look for another leaf.

I am dying now, although no one knows.  
I sit in my white chair, in that same room,  
blue and white sheets on that same bed.  
Even the violets, which I will give to my daugh-  
ter, grow.  
I sit in my chair across from the closet with its  
door swung open  
so that I am reflected back: white head, round face,  
left hand curled and still in my lap—  
the more visible scar from surgery,  
a small peace of mind  
paid for with a bundle of sentinel nodes  
and the drowning of my writing hand in pools of  
edema.

Of course, over time my knees began to creak,  
And my spine curved as if obeying laws of tro-  
pism for the earth.  
Sure my walk slowed and glasses thickened.  
And yes these things made me act my age,  
matched me with my peers at the coffee shop  
on the corner.

Yet at forty-one—body relatively lithe, strong  
calves and hair dark and thick,  
At forty-one I knew what I would see across the  
room tonight.  
Since then, I have known what to expect from  
that mirror in the door.

## Privacy

ALISSA KAHN  
MSSM '06

---

ALONSO OFTEN SAT ALONE IN THE SHADE, staring off into the distance as if contemplating a secret. When I had a rare, quiet moment during the day, with nothing to do and no children climbing on me with mango-sticky hands or clamoring for me to begin a game, I would sit down next to him. He would rest his hand gravely on my arm or his head heavily on my shoulder, but he rarely said a word.

I thought I knew what he was thinking. Unlike most of the other children there, abused or neglected, Alonso was a real orphan. I imagined that while his vivacious seven-year-old sister Graciela was too young to remember their mother and could contentedly spend her days planning her dancing career and avoiding homework, Alonso, at eleven, thought of his mother always, perhaps remembering their poignant last moments together or the texture of her caresses.

That week, I had done my best to avoid the missionaries visiting from Arkansas. When not complimenting me on my “really good English,” they were apt to be inviting me to their prayer circle, reminding each other not to drink the (perfectly good) water, or asking me to translate to the children that if they didn’t see them again, they would surely see them in heaven. Nonetheless, when on their last day a couple came to me to inquire about adopting Alonso and Graciela, I was pleased.

Earlier that day, another woman had asked me about Lourdes, a dark, dimpled demon who

spent much of her time after kindergarten hiding in the bushes trying to catch and kill butterflies. But Lourdes could not be adopted—the state was still fighting her parents in court. So it was with more hope that I translated for this couple as they asked the orphanage director about Alonso and Graciela.

But the answer was no. “Why?” “I don’t know,” I explained. “She says that they have a disease they inherited from their mother. They’re not suitable for adoption.” Agitated about the kids, I asked for more information, but that’s all she would say. “Maybe some sort of genetic disease?” I weakly offered the missionaries, to which they responded, “Oh, is that why they’re so pale?” I tried my best to patiently explain that not all Latin American children have the same exact brown skin color, but I was quite relieved when the missionary group finally left.

I went back to ask again what was wrong with them. Alonso and Graciela were among my favorite children there. But the director was no more forthcoming than before, insisting that she could not tell me any more. I kept repeating my question. Finally, she whispered to me, “Es que tienen el SIDA. Sus padres murieron del SIDA.”

So they would never be adopted. Perhaps Graciela would not live to become a dancer—or to not become a dancer. And Alonso would remain alone, carefully considering his secret.