Carver Across the Curriculum: Interdisciplinary Approaches to Teaching the Fiction and Poetry of Raymond Carver

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CHAPTER THREE

"IT DOESN'T LOOK GOOD": TEACHING END OF LIFE CARE THROUGH CARVER'S POETRY

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The decades-old field of Medical Humanities, which integrates literature and medicine, has been periodically reinvigorated by such theoretical constructs as narrative ethics and narrative medicine.[1] However, in terms of curricular application, we still have much to learn about what happens when medical students sit down to read poetry or short stories. This essay does not provide a critical analysis of Raymond Carver's medically-related work, but describes and analyzes what transpires between students and Carver's authorial voice in a medical education setting. In order to locate the teaching of Carver's poetry in the larger context of medical education, studies on the exposure of preclinical and clinical medical students to issues such as end of life care, prominent in Carver's late poems, will also be explored.

In stories such as "Cathedral," "A Small, Good Thing," and "Errand," Carver deals with blindness, loss, and death—issues of interest to students of medicine. These stories are powerful evocations that question the meaning of disability, how a small human gesture can console in the face of seemingly inconsolable grief, how best to face the moment of one's own extinction, and how to find redemption in the face of the cruelest of losses. In our classes, however, we focus on Carver's poetry. We use four poems—"What the Doctor Said," "Proposal," "My Death," and "Late Fragment"—in a module on "breaking bad news / death and dying," part of a twelve-session elective seminar for first-year medical students on literature and medicine (Patients' Stories / Doctors' Stories). This seminar

[1] See Brody, *Stories of Sickness*, 143-70; Charon and Montello, *Stories Matter*, chapters 15-18; Charon, *Narrative Medicine*, 39-62.

uses poetry, short stories, and readers' theater to encourage students to reflect on psychosocial issues in medical practice such as "taking a history," "the physical examination," "practicing medicine across cultures," "noncompliance," "medical mistakes," as well as "breaking bad news / death and dying." Typical texts used include Margaret Edson's play, *Wit*; short stories by William Carlos Williams and Richard Selzer; and a wide selection of poetry by both contemporary physician-poets (Jack Coulehan, Peter Pereira, Richard Berlin, Rafael Campo, Marc Strauss) and well-known poets such as Adrienne Rich, Donald Hall, Jane Kenyon, Audre Lorde, and Sandra Cisneros. Participating students (ranging in number from ten to fifteen in any given year) meet for an hour over lunch with the faculty facilitator. The focus of the session is a close reading of textual material without significant introduction or context (brief biographical information about authors is included). This instructional approach is designed to elicit students' responses and reactions and to facilitate a group process among participants, with the intention of developing their ability to critically interrogate reflexivity in both emotional reaction and cognitive analysis.

"What the Doctor Said" is also taught in a literature and medicine class, and a creative writing course for medical students. These courses are electives designed for preclinical students, although clinical students occasionally enroll. Some students have extensive backgrounds in the humanities, such as advanced degrees in English, but the majority of them have had limited exposure to humanities courses since leaving high school or Freshman English. Students often find poetry especially intimidating. The value of "What the Doctor Said" for the writing course includes discussion of form: Carver's choices regarding line breaks, vocabulary, narrative stance, repetition, dialogue, punctuation, title, and time-frame. The poem is also used as an example for a writing exercise called "One Moment"—that is, a moment which changes a person, whether that moment is "grand" or not in the usual schemata of life. In both courses, students are encouraged to examine the emotional landscape of the poem as explained below.

In the last decade or so, awareness that medical students were often ill-prepared for dealing with terminally ill and dying patients led to the systematic introduction of palliative care, death and dying, and end of life care (EOLC) curricula in all U.S. medical schools; medical training in Canada, the UK, and Europe also typically incorporate EOLC training. These curricula tend to focus on the clinical management of dying patients (e.g., pain control). Psychosocial aspects of these curricula are often

operationalized as specific tasks such as "breaking bad news."[2] Despite these innovations, however, many students still do not feel prepared or supported as they care for dying patients.[3] One study documents discordance between what is taught about EOLC in formal coursework and what actually happens on the wards.[4] Students frequently complain of an absence of appropriate role-modeling and guidance from residents and attending physicians. A study of third year students found that 41% had not observed a physician talking to a dying patient, 35% had never discussed care of a dying patient with their attending physicians, and a large majority had never witnessed a surgeon telling a family that someone had died.[5] In a more recent study, 25% of students who experienced a patient's death as highly emotionally-charged described the amount of support they received from supervisors as extremely inadequate. There was no discussion of the death in 63% of the cases in which the patient was cared for by the student's team.[6] Based on their supervising physician-teachers' responses, students concluded that death and emotions were regarded as negative aspects of medicine.

The extent to which students feel ready to confront end of life issues in patients and to actually put into practice critical, moral attitudes is debatable.[7] Students express a great deal of worry and uncertainty about EOLC,[8] and recognize the importance of receiving guidance in terms of managing their own emotions in response to death and dying and developing appropriate coping strategies.[9] Some evidence suggests that it may be easier to teach students specific knowledge and skills about management of dying patients than to impact their emotional responses to these same patients. For example, after a brief EOLC intervention, students showed significant improvements in competence and knowledge,

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[2] Garg, Buckman, and Kason, "Teaching Medical Students How to Break Bad News," 1161.
[3] Wear, "'Face-to-Face With It,'" 273-75.
[4] Rabow, Gargani, and Cooke, "Do as I Say," 764.
[5] Rappaport and Witzke, "Education About Death and Dying During Clinical Years of Medical School," 164-65.
[6] Rhodes-Kropf et al., "'This Is Just Too Awful,'" 638.
[7] Olthuis and Dekkers, "Medical Education, Palliative Care and Moral Attitude," 930.
[8] Wear, "'Face-to-Face With It,'" 272-73.
[9] Ratanawongsa, Teherani, and Hauer, "Third-Year Medical Students' Experiences with Dying Patients During the Internal Medicine Clerkship," 646; Williams, Wilson, and Olsen, "Dying, Death, and Medical Education," 379.

but not in attitudes toward death and dying.[10] Such findings suggest that we need to seek out innovative methods for addressing these domains. The study of literature, with its emphasis on critical examination of reflexive cognitive and affective responses in learners, is well-suited to meet this need.

Although one study found that student attitudes toward dying patients are typically characterized by attachment, empathy, and advocacy,[11] another study reported a range of student emotions from feeling connected and joyful, to being sad, anxious, frustrated, or perplexed by the struggle to balance emotional connection and distance.[12] Students may also experience feelings of guilt, fear, blame, and impotence in the presence of dying patients.[13] Another paper noted students' tendency to avoid or deny the sadness, hopelessness, and helplessness they associated with dying persons.[14] It is possible to conclude from these observations that EOLC courses need to address both the emotions of patients and of student doctors. Yet the standard curriculum, weighted heavily in the direction of cognitive learning and algorithmic protocols, provides limited opportunity to achieve this goal in anything other than abstract and highly theoretical ways. These limitations open up a potentially rich space to incorporate literature as a path to critically probing student reactions.

One project asked students to visualize their own deaths and write reflective essays about their experiences with death. Analysis of their work revealed that they were concerned about expressing emotions appropriately, dealing with personal grief and emotional detachment, communicating effectively with patients and family members, and shifting the emphasis from curing to caring.[15] Another study utilizing a range of arts-based reflection modalities showed that, with these tools, students explored their own fears of death, their helplessness in the face of the dying process, and,

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[10] Porter-Williamson et al., "Improving Knowledge in Palliative Medicine With a Required Hospice Rotation for Third-Year Medical Students," 780-81.

[11] Ratanawongsa, Teherani, and Hauer, "Third-Year Medical Students' Experiences With Dying Patients During the Internal Medicine Clerkship," 643.

[12] Ellman, Rosenbaum, and Bia, "Development and Implementation of an Innovative Ward-Based Program to Help Medical Students Acquire End-of-Life Care Experience," 726.

[13] Williams, Wilson, and Olsen, "Dying, Death, and Medical Education," 378.

[14] Block and Billings, "Learning from the Dying," 1315.

[15] Rosenbaum, Lobas, and Ferguson, "Using Reflection Activities to Enhance Teaching About End-of-Life Care," 1189-90.

at times, their discomfort with the kind of medical heroics used to extend life. They often searched for meaning in how patients died.[16]

It is reasonable to assert that, in general, EOLC curricula, while providing essential information to students about death and dying and preparing them in some important ways to care for dying patients, is often limited in emotional scope. Therefore, the use of supplementary sources, such as poetry, can be helpful in connecting students to the emotional experiences of patients in confronting their own mortality, and in facing their own emotions when they must convey a terminal prognosis or participate in the care of a terminally ill patient. In this regard, the four aforementioned Carver poems are especially valuable because they present a patient's trajectory from the initial receiving of a terminal diagnosis to the patient's ruminations literally a few months before death. They also range from an intense one-on-one interaction between physician and patient to a rather casual encounter that includes Carver, his second wife, the poet Tess Gallagher, and a significantly less important doctor. The final two poems have little to do directly with physicians and focus respectively on saying goodbye to friends and loved ones and coming to terms with end-of-life issues. Taken in its entirety, this progression allows students to contemplate how their own roles as future physicians caring for terminally ill patients might evolve along with the patient's priorities and concerns.

As those laboring in the field of medical humanities know, medicine is, in the words of Donald Schön, a practice profession.[17] Despite developments such as the biopsychosocial model, patient-centered medicine, and relationship-centered medicine,[18] medicine, in its clinical expression and its educational preparation, still remains by and large a modernist project—that is to say, it remains reductive and objective in its focus on disease processes and continues to emphasize restitution and cure as the only acceptable outcomes of treatment.[19] Furthermore, at its core, medicine is a discipline that is pragmatic and empirically driven, rather than philosophical. Even when medical education does attend to critical inquiry,[20] such reflection is almost always regarded as a means to the end of better practicing medicine and better caring for the patient. In this

[16] Rucker and Shapiro, "Becoming a Physician," 393.
[17] Schön, *Educating the Reflective Practitioner*, 157-72.
[18] Engel, "The Need for a New Medical Model," 130-35; Stewart et al., *Patient-Centered Medicine*, 33-35; Frankel, "Relationship-Centered Care and the Patient-Physician Relationship," 1163.
[19] Upshur, "If Not Evidence, Then What?" 114.
[20] Branch, "Use of Critical Incident Reports in Medical Education," 1063.

context, the perspectives and aims of medical students who encounter a poet such as Carver may be quite different from those of, say, graduate students in literature: they are more likely to have a very visceral involvement with the text. Naturally, they cast themselves in the role of the physician represented in these poems, and approach such works trying to comprehend what their proper role should be in relation to the patient. Their perspective is often linear and outcomes-oriented, and the literary work may initially be approached rather simplistically as an algorithmic means to a clinical end. They imagine that if they can "figure out" the "message" of the text, it will result in making them better doctors. The teacher has the opportunity to broaden this view while at the same time respecting the need for connecting literary, textual analysis to clinical attitudes, values, and even behavior.

"What the Doctor Said"

"What the Doctor Said" is a widely-used poem in medical humanities circles because it addresses an always highly-charged and potentially problematic interaction between doctor and patient, what in medical education parlance is often referred to as "breaking" or "delivering" bad news (both interesting terms whose connotations are clearly more functional than relational). This task becomes especially problematic in situations such as the one described in Carver's poem, where there is not only diagnostic bad news, but the news that little medically can be offered the patient in terms of cure or remediation. For many physicians, this is the point at which the restitutional view of medicine (find the problem / fix the problem) fails.[21] It is also the point at which literature can provide ways of being present with a dying person that otherwise are discoverable only with difficulty, if at all, in other medical education venues.

Different student readings of the poem emphasize the doctor as an incompetent communicator and fumbler; the doctor as imperfect but empathic; the patient as experiencing primarily despair and ironic anger; the patient as experiencing sincere gratitude; and whether a physician should introduce the topic of faith with terminally ill patients. Since this poem represents a dialogue between physician and patient, close reading can focus on the doctor, the patient (also the narrator), and their interaction.

Medical students tend to be concerned initially with the doctor's performance. As a group, bright, high achieving, competent medical

[21] Frank, *The Wounded Storyteller*, 75-96.

students can be harsh critics, and their judging of this physician's conversation with his patient is no exception. In the students' eyes, the physician's communication is blunt and unvarnished. Sometimes, as other medical educators have noticed,[22] students criticize the quantitative aspect of the transmission, seeing the physician's prioritizing the *number* of cancerous lung lesions as a way for him to distance himself from the patient, hiding behind facts in the face of the unimaginable. Students also often question the doctor's sudden shift to the metaphysical, worried that he is using his authority and power to foist religious belief on the patient, who up to this point does not seem to have defined himself as one of the faithful.

Students' criticism of the physician's performance begins to expand their understanding of what the project of medicine is about. Confronted with the physician's reductive, numerical focus, students experience medicine as cold and unfeeling. Face-to-face with the physician's "prescription" of religious faith, they are made uncomfortable by what they read as a raw, insensitive use of power. When they encounter their profession exclusively as an empiricist enterprise, they quickly become aware of its moral limitations.

Most students, when confronting the concluding lines of the poem, read them as ironic:[23]

> I jumped up and shook hands with this man who'd just given me
> something no one else on earth had ever given me
> I may even have thanked him habit being so strong (*AoU*, 289)

How can the narrator "thank" someone for handing him a death sentence? Isn't this exchange a mordant parody of what happens when someone receives a gift—in this case, death? This interpretation fits well with a patient who has been abandoned by an emotionally callous and fumbling physician, told he needs to turn to prayer because medicine has nothing left to offer him. The doctor-patient encounter ends with a ritualistic handshake that, in line with this general thrust of alienation, students often construe as an empty social formality, devoid of meaning, highlighting the hopelessness and pointlessness of the exchange.

Further discussion, however, can lead to a useful complication of this reading. Without denying the physician's obtuseness or the irony of the final lines, some students begin to explore a more nuanced understanding

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[22] Gianakos, "Commentary," 421.
[23] Shafer, "What Our Patients Say," 96.

of the interaction. What strikes them is the physician's willingness to remain present with his patient. One student who grew up in the Midwest, for example, noted that the exchange about the number of metastatic nodules sounded similar to the way farmers exchange data about the weather. They are laconic and emotionless, men talking to other men about a critical, survival-related issue. This interesting reading opens the possibility that the doctor may be speaking to the patient in his own language, the spare, unadulterated language of people who intimately know (as Carver did) the hardness of life.

From this vantage point, the physician's willingness to move from the quantitative details of lung lesions (numbers being a typically safe refuge for physicians), to the plane of faith and its offer of consolation, is sometimes understood as a significant, potentially life-altering shift initiated by a caring doctor doing all he can to offer his patient succor from whatever source possible: "he said are you a religious man do you kneel down / in forest groves and let yourself ask for help" (*AoU*, 289). This reading invites students to consider that making room for other dimensions of medicine, such as the doctor's relationship with the patient and his willingness to accompany his patient into other, spiritual, realms, may enrich both the patient's experience and their own practice. These students see the shift in the poem not as an arrogant infliction of religiosity by an all-powerful physician on a vulnerable patient, but as a hand reaching out from one helpless, limited person to another. In this interpretation, the invocation of the sacred is an alteration, as Kleppe has noted, from curing to healing.[24] Students may find in this sudden change a gesture of compassion and non-abandonment on the part of the physician. From the standpoint of poem-making, this section is usually viewed as crucial. The poem "opens up" both in vista and possibility with the inclusion of the ambiguity and tension of these lines. Carver denied that he was a religious man, but in the last months of his life he acknowledged openness to miracles and the possibility of resurrection. It may be that the doctor's eloquence regarding faith in the poem is a projection of Carver's own desire, close to death, as he somewhat ruefully comments, to start contemplating the larger, impenetrable mysteries.

With such ambiguities abounding, some students wonder whether the final lines, while surely containing more than a little irony, may also contain something else as well—sincere gratitude. The patient has received something rare, something that "no one else on earth had ever given [him]" (*AoU*, 289) Perhaps the messenger who brings this monumental

[24] Kleppe, "Medical Humanism in the Poetry of Raymond Carver," 43.

news *is* owed some measure of thanks. Perhaps the narrator truly appreciates the doctor's blunt honesty, his obtuse efforts to heal in the face of approaching death. In this reading, students find that the final handshake is representative of the power and coherence of ritual in the patient-doctor relationship. The gesture becomes moving rather than meaningless, an albeit imperfect bridge between someone whose work is to diagnose death, and someone to whom that death has become devastatingly personal.

"Proposal"

Other issues assume prominence for students in the next poem, "Proposal." Here, the frame expands to include Tess Gallagher who, as Carver faces death, is about to become his wife: the primary focus of the poem is the proposal of marriage between these two people. With "time pressing down...like a vise, squeezing out hope to make room for / the everlasting" (*AoU*, 291), they decide on a quickie Reno wedding and "one / more chance" (*AoU*, 291). In this poem, the role of the physician has receded significantly in importance: instead of being the centerpiece, the interaction between patient, lover, and doctor is relegated to a single stanza. This in itself is an instructive lesson for students, as they must come to terms with the realization that the primacy of their role in some respects diminishes as the patient proceeds with dying. The narrator is less concerned with understanding his diagnosis and prognosis than with completing certain life tasks.

In class discussions, the poem's second stanza is usually considered in terms of the students' initial attraction toward Kubler-Ross's five classic stages of grief (denial, anger, bargaining, depression, acceptance),[25] and the ways in which modernist narratives of restitution and resolution may act to protect the physician in the presence of loss, while he inadvertently abandons the patient. In this stanza, Gallagher, like many loved ones of terminally ill patients, protests Carver's imminent death to the physician: "But he loves his life," I heard a voice say. / Hers" (*AoU*, 290). The doctor, no doubt dealing with his own helplessness at the limitations of his profession, ignores this piece of information. Instead, he attempts to "steer" the devastated couple "away from the veil of / tears and foreboding" (*AoU*, 290)—perhaps an ironic allusion to the "forest groves" and "waterfall" evoked by the more poetic physician in "What the Doctor Said"—toward a simple resolution. This young physician, perhaps

[25] Kubler-Ross, *On Grief and Grieving*, 51-147.

insufficiently seasoned in life's suffering, callously and offhandedly replies that, in the end, Carver will arrive at Kubler-Ross's final stage of the grieving process.

> And the young doctor, hardly skipping a beat, 'I know. I guess you have to go through those seven stages. But you end up in acceptance.' (*AoU*, 290)

Although Kubler-Ross was remarkably nuanced in her analysis of loss and grief, in medical education these stages have a tendency to become algorithmic: it is normal (and therefore not all that interesting) to experience feelings of rage and despair; everything will work out eventually. Constructs designed initially to avoid pathologizing of grief, in the pressured context of clinical interactions, can be used to dismiss and minimize its overwhelming force. Medical students, looking for a safe haven from death, are likely to cling to the death and dying stages as a life raft. How relieved they are that, no matter how angry or depressed their patient seems, these feelings are "normal." What a burden is removed when they can anticipate that eventually their dying patients will find "acceptance" (which also reassures them that they too may find peace even in the face of medical futility). Although researchers and those who work in palliative care medicine are well aware that "stages" are simply a theoretical model, and that patients rarely proceed in neatly predictable steps through them,[26] these nuances often produce anxiety for students. This section of "Proposal" offers an opportunity to explore how "normalizing" grief can also reduce its power. By imagining Carver on the brink of both marriage and death, students can begin to apprehend that "acceptance" is not a simple matter.

"My Death"

In the next poem studied, "My Death," Carver imagines his own death—and his reconciliation to that death. This poem allows medical students to explore their feelings about the concept of "readiness to die," and how this may reassure the student while isolating the patient. Students often want an uncomplicated reading of this poem—and of death itself—and find solace in the belief that patients at the moment of death are always ready to say goodbye and are grateful for the lives they have lived. They are eager to read Carver's poem in this straightforward manner, and indeed, given his belief that, after he stopped drinking, he was given the

[26] Wortman and Silver, "The Myths of Coping With Loss," 352-55.

gift of a second life, this is a legitimate way of understanding the poem. From this point of view, the irony of referring in any sense to "luck" in the presence of imminent death—"If I'm lucky, I'll be wired every which way / in a hospital bed. Tubes running into / my nose" (*AoU*, 122)—is seemingly transformed into a genuine appreciation for the possibility of saying goodbye to loved ones, to see them one final time, even to blink in a minimal sign of recognition: "If I'm lucky, they'll step forward / and I'll be able to see them one last time / and take that memory with me" (*AoU*, 122); "I just hope my luck holds, and I can make / some sign of recognition" (*AoU*, 122). Students are reassured and heartened by Carver's apparent reconciliation to his foreshadowed demise.

Like "What the Doctor Said," "My Death" is open to both sincere and ironic interpretations, and the latter usually emerge over the course of class discussions. At some point, students find they cannot ignore details that prevent the poem from remaining in a Panglossian realm of grateful acceptance. For example, the terror of death, which Carver certainly felt, is projected onto friends who are scared and "want to run away / and howl" (*AoU*, 122). Out of love, they will stay with the dying Carver, and they will urge him toward courage, as he must urge himself. But is this loving support a certainty, or only a hope, an expression of wish fulfillment? In this more ambiguous reading, there is as much yearning as conviction. A few biographical notes further complicate the students' perspective. We juxtapose their initial ideas based on sentiments of easy acceptance with Carver's "stupendous grief" at his dying.[27] As Gallagher said at his funeral, if will could have saved him, he would have lived.[28] Finally, by contemplating the metaphor of winning and losing that Carver invokes, coming out ahead or coming out behind, students realize that the narrator is implicitly acknowledging the possibility of death as failure, loss, and defeat.

> But be glad for me if I can die in the presence
> of friends and family. If this happens, believe me,
> I came out ahead. I didn't lose this one. (*AoU*, 123)

He resists this outcome with every fiber of his being. The concept of luck reminds students of the Reno marriage in "Proposal," with its images and sounds of gambling and implications of hitting a lucky winning streak. Carver wants to approach death on his own terms and he wants to feel "lucky." This lends credence to the idea that Carver desired above all to be

[27] Stull, "Biographical Essay," para 12.
[28] Ibid.

the agent and author of his experience, not simply a passive patient in a medical history.[29]

All of this helps students re-evaluate the meaning of the poem, and helps them situate Carver's acceptance within the particularity of his life experiences. They begin to understand that acceptance, rather than being inevitable, must originate in specific circumstances and events. They are also able to incorporate the nuance that acceptance of death is rarely unambiguous, and often exists side by side with many other emotions. Students wonder if the resolved attitude expressed in the poem is an act of will, an act of imagination, or an actual experience, and are likely to conclude that it might be a combination of the three. Students are also cognizant of the fact that physicians are entirely absent from this poem. Indeed, were the poem not situated in a hospital setting, with its array of tubes and syringes, students might have difficulty seeing anything "medical" about it. Although in some cases a wound to students' perception of the centrality of the doctor, the poem helps them grasp that the physician's priorities (to monitor the patient's condition, to intervene when possible, to manage pain, etc.) may be quite different from those of the patient.

A final benefit of such discussions is that they facilitate, first, student reflection on what might help a patient feel "content" with his or her life, and second, speculation about what they themselves might need in their professional lives to feel "lucky" when a patient's death occurs. In particular, students have the opportunity to rethink the heroic role of medicine in the presence of Carver's simultaneous resistance and acceptance. Rather than define the death of a patient as a failure, they may begin to adopt Carver's own view that it is both a devastating loss and an inevitable occurrence. Like him, they may think about fighting hard for their patients, but also about learning to facilitate "a good death"[30] when necessary. They may more clearly understand that medicine involves expert instrumental action on behalf of the patient, but also, at times, a willingness to accept "what is."

"Late Fragment"

The last poem of the sequence, "Late Fragment," further encourages students to reflect on the final summing up of life, what is valuable in others' lives and in their own. This poem, composed a couple of months

[29] Cf. Kleppe, "Medical Humanism in the Poetry of Raymond Carver," 45.
[30] Field and Cassel, *Approaching Death*, 24.

before Carver's death, uses the second person voice, which engages the students in an intimate, unavoidable way. "And did you get what / you wanted from this life, even so?" (*AoU*, 294). Carver is speaking to himself. But his question is also addressed to us. This causes students to reflect about what *they* want from life. Most want to be able to answer, as Carver does, "I did." The phrase "even so" helps students reflect on the fact that life is not always "fair," that sometimes people die even though, like Carver, they have cleaned up their lives, conquered their addictions, and are ready to do great work and enjoy great love. Students comment on this imbalance to help them re-evaluate their initially rather naïve and judgmental views of patients who make "bad" lifestyle decisions, as did Carver in terms of heavy chronic drinking and smoking. They often have the simplistic idea that, firstly, these patients in some sense get what they deserve, or deserve what they get, because they have brought their problems on themselves. Secondly, the students like to think that, if only these patients would reform, their lives will have happily-ever-after endings. Carver's own life, as well as this poem, helps to show them the limitations of this tidy equation. The poem also helps them consider what matters most in people's lives, and to reflect on Carver's unadorned yet profound conclusion that it is the knowledge and acknowledgement of being loved: "to call [oneself] beloved, to feel [oneself] / beloved on the earth" (*AoU*, 294).

Students find Carver's work accessible, we think, not only because of his straightforward and unpretentious language, although this quality certainly makes his work comprehensible to poetry-phobic medical students, but because of his pervasive compassion and humanism.[31] In all of the aforementioned poems, whilst Carver appreciates the mordant humor of gazing at the face of his own death, he never relies purely on irony. His compassion includes himself, but extends to devoted, albeit sometimes horrified, friends; and even encompasses stumbling, fumbling doctors whom he nevertheless recognizes are trying to do the right thing by their patients.

Medicine as a practice profession is still strongly rooted in empirical, reductive, objectivist assumptions. The aims and orientations of medical students in approaching poetry often reflect a similar bent. They may view a poem as merely another mechanism for telling them what is right and what is wrong, in, for example, attitudinal and behavioral domains. They may search for answers in terms of how to "break bad news," or how to

[31] On this subject, see Brown, "Raymond Carver and Postmodern Humanism," 126-27.

prepare a patient for death. They may come to a medically-themed poem with the expectation that the physician will always play a central role. They may anticipate a clearly linear, causal chain—the "right" answers will produce the desired outcome. And they may want difficult situations (impending death) to have tidy, clean resolutions (straightforward acceptance). Teaching the work of Carver and other poets can counter these assumptions, and lead to a more nuanced and complex appreciation of the journey toward death as experienced by patient, family members, and doctors. It is even possible, although far from certain, that critical interrogation of accepted norms in medicine may ultimately lead to greater awareness of the dimensions and impact of their clinical interactions with future patients.

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