MICHAEL CRICHTON

TRAVELS

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—Kirkus Review

TRAVELS

Michael Crichton

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Preface

For many years I traveled for myself alone. I refused to write about my trips, or even to pla them with any useful purpose. Friends would ask what research had taken me to Malaysia New Guinea or Pakistan, since it was obvious that nobody would go to these places merel for recreation. But I did.

And I felt a real need for rejuvenation, for experiences that would take me away fro things I usually did, the life I usually led.

In my everyday life, I often felt a stifling awareness of the purpose behind everything I di Every book I read, every movie I saw, every lunch and dinner I attended seemed to have reason behind it. From time to time, I felt the urge to do something for no reason at all.

I conceived these trips as vacations—as respites from my ongoing life—but that wasn't ho they turned out. Eventually, I realized that many of the most important changes in my li had come about because of my travel experiences. For, however tame when compared wi the excursions of real adventurers, these trips were genuine adventures for me: I struggle with my fears and limitations, and I learned whatever I was able to learn.

But as time passed, the fact that I had never written about my travels became odd burdensome. If you're a writer, the assimilation of important experiences almost obliges yo to write about them. Writing is how you make the experience your own, how you explo what it means to you, how you come to possess it, and ultimately release it. I found I wa relieved, after all these years, to write about some of the places I have been. I was fascinate to see how much I could write without reference to my notebooks.

There were also some episodes from medical school that I had always intended to wri about. I had promised myself I would wait fifteen years, until they were thoroughly ancie history. To my surprise, I find I have waited long enough, and so they are included here.

I have also included experiences in the realms that are sometimes called psychic, transpersonal, or spiritual. I think of this as inner travel, to complement the outer trave although that distinction—between what is internal sensation and what is external stimulus- often blurs in my mind. But I've found the effort to disentangle my perceptions useful in way I had not anticipated.

Often I feel I go to some distant region of the world to be reminded of who I really ar There is no mystery about why this should be so. Stripped of your ordinary surrounding your friends, your daily routines, your refrigerator full of your food, your closet full of yo clothes—with all this taken away, you are forced into direct experience. Such dire experience inevitably makes you aware of who it is that is having the experience. That's n always comfortable, but it is always invigorating.

I eventually realized that direct experience is the most valuable experience I can hav Western man is so surrounded by ideas, so bombarded with opinions, concepts, ar information structures of all sorts, that it becomes difficult to experience anything witho the intervening filter of these structures. And the natural world—our traditional source direct insights—is rapidly disappearing. Modern city-dwellers cannot even see the stars night. This humbling reminder of man's place in the greater scheme of things, which huma

beings formerly saw once every twenty-four hours, is denied them. It's no wonder th people lose their bearings, that they lose track of who they really are, and what their liv are really about.

So travel has helped me to have direct experiences. And to know more about myself.

Many people have helped me with this book. Among those who read early versions of th manuscript and gave me comments and encouragement were Kurt Villadsen, Anne-Mar Martin, my sisters, Kimberly Crichton and Catherine Crichton, my brother, Douglas Crichto Julie Halowell, my mother, Zula Crichton, Bob Gottlieb, Richard Farson, Marilyn Grabowsk Lisa Plonsker, Valery Pine, Julie McIver, Lynn Nesbit, and Sonny Mehta. Later drafts of th text were read by the participants themselves, who offered valuable suggestions an corrections.

To all these people I am grateful, as I am to my beleaguered travel agents of many year Kathy Bowman of World Wide Travel in Los Angeles, and Joyce Small of Adventur Unlimited in San Francisco.

In addition, certain people have had a major influence on my thinking, although they d not appear much in this book. I am thinking in particular of Henry Aronson, Jonas Salk, Joh Foreman and Jasper Johns.

By design, I have limited the scope of this book. Freud once defined life as work and lov but I have chosen to discuss neither, except as my travel experiences impinge upon them. N have I undertaken to assess my childhood. Rather, it is my intention to write about th interstices of my life, about the events that occurred while what I imagined to be the re business of my life was taking place.

It remains only to say that certain changes have been made to the original text. Names an identifying characteristics of physicians and medical patients have all been changed. And later chapters, some names and identifying characteristics have been changed at the reque of the individuals involved.

MEDICAL DAYS

1965–1969

Cadaver

It is not easy to cut through a human head with a hacksaw.

The blade kept snagging the skin, and slipping off the smooth bone of the forehead. If made a mistake, I slid to one side or the other, and I would not saw precisely down th center of the nose, the mouth, the chin, the throat. It required tremendous concentration. had to pay close attention, and at the same time I could not really acknowledge what I wa doing, because it was so horrible.

Four students had shared this cadaver for months, but it fell to me to cut open the ol woman's head. I made the others leave the room while I worked on it. They couldn't watc without making jokes, which interfered with my concentration.

The bones of the nose were particularly delicate. I had to proceed carefully, to cut witho shattering these tissue-thin bones. Several times I stopped, cleaned the bits of bone from th teeth of the blade with my fingertips, and then continued. As I sawed back and fort concentrating on doing a good job, I was reminded that I had never imagined my life woul turn out this way.

I had never particularly intended to become a doctor. I had grown up in a suburb of Ne York City, where my father was a journalist. No one in my family was a doctor, and my ow early experiences with medicine were not encouraging: I fainted whenever I was give injections, or had blood drawn.

I had gone to college planning to become a writer, but early on a scientific tendenc appeared. In the English department at Harvard, my writing style was severely criticized an I was receiving grades of C or C+ on my papers. At eighteen, I was vain about my writin and felt it was Harvard, and not I, that was in error, so I decided to make an experiment. Th next assignment was a paper on *Gulliver's Travels*, and I remembered an essay by Georg Orwell that might fit. With some hesitation, I retyped Orwell's essay and submitted it as m own. I hesitated because if I were caught for plagiarism I would be expelled; but I was pret sure that my instructor was not only wrong about writing styles, but poorly read as well. I any case, George Orwell got a B− at Harvard, which convinced me that the Englis department was too difficult for me.

I decided to study anthropology instead. But I doubted my desire to continue as a gradua student in anthropology, so I began taking premed courses, just in case.

In general, I found Harvard an exciting place, where people were genuinely focused o study and learning, and with no special emphasis on grades. But to take a premed course wa to step into a different world—nasty and competitive. The most critical course was organ chemistry, Chem 20, and it was widely known as a "screw your buddy" course. In lectures, you didn't hear what the instructor had said and asked the person next to you, he'd give yo the wrong information; thus you were better off leaning over to look at his notes, but in tha case he was likely to cover his notes so you couldn't see. In the labs, if you asked the perso at the next bench a question, he'd tell you the wrong answer in the hope that you woul make a mistake or, even better, start a fire. We were marked down for starting fires. In m year, I had the dubious distinction of starting more lab fires than anyone else, including

spectacular ether fire that set the ceiling aflame and left large scorch marks, a stigmata o ineptitude hanging over my head for the rest of the year. I was uncomfortable with th hostile and paranoid attitude this course demanded for success. I thought that a human profession like medicine ought to encourage other values in its candidates. But nobody wa asking my opinion. I got through it as best I could. I imagined medicine to be a carin profession, and a scientific one as well. It was so fast-moving that its practitioners could no afford to be dogmatic; they would be flexible and open-minded. It was certainly interestin work, and there was no doubt that you were doing something worthwhile with your lif helping sick people.

So I applied to medical schools, took the Medical College Aptitude Tests, had m interviews, and was accepted. Then I got a fellowship for study in Europe, which postpone my start for a year.

But the following year I went to Boston, rented an apartment in Roxbury near the Harvar Medical School, bought my furniture, and registered for my classes. And it was at th registration that I first was confronted by the prospect of dissecting a human cadaver.

As first-year students, we had scrutinized the schedule and had seen that we would be give cadavers on the first day. We could talk of nothing else. We questioned the second-yea students, old hands who regarded us with amused tolerance. They gave us advice. Try and g a man, not a woman. Try and get a black person, not a white. A thin person, not a fat on And try to get one that hadn't been dead too many years.

Dutifully, we made notes and waited for the fateful Monday morning. We imagined th scene, remembered how Broderick Crawford had played it in *Not as a Stranger*, growling t the terrified students, "There's nothing funny about death," before he whipped the cover o the corpse.

In the amphitheater that morning, Don Fawcett, professor of anatomy, gave the fir lecture. There was no corpse in the room. Dr. Fawcett was tall and composed, not at all lik Broderick Crawford, and he spent most of the time on academic details. How the dissection were scheduled. When the exams would fall. How the dissections of gross anatomy would b related to the lectures in microscopic fine anatomy. And the importance of gross anatomy "You can no more become a good doctor without a thorough understanding of gross anatom than you can become a good mechanic without opening the hood of a car."

But we could hardly listen to him. We were waiting for the body. Where was the body?

Finally a graduate student wheeled in a gurney. On it was a blue denim cloth, and a underlying shape. We stared at the shape. Nobody heard a word Dr. Fawcett said. He move from the podium to the body. Nobody listened. We waited for the moment when he woul pull aside the cloth.

He pulled aside the cloth. There was a great sigh, a great exhalation of breath. Beneath th cloth was a heavy plastic sheet. We still could see nothing of the body.

Dr. Fawcett removed the plastic sheet. There was another, thin white cloth beneath tha He removed this cloth. At last we saw a very pale form. Limbs, a torso. But the head, hand and feet were wrapped in gauze like a mummy. It was not easy to recognize this as a huma body. We slowly relaxed, became aware that Dr. Fawcett was still talking. He was telling u details of the method of preservation, the reason for protective wrapping of the hands an face. He told us of the need for decorum in the dissection room. And he told us that th

preservative, phenol, was also an anesthetic and that it was common to experience numbne and tingling in our fingers during the dissection; this was not a dread paralysis we had caug from the cadavers.

He ended the lecture. We went to the dissection room, to choose our bodies.

We had previously divided ourselves into groups of four. I had given this group choice a l of thought, and managed to link up with three students who all planned to be surgeons. thought budding surgeons would be enthusiastic about the dissection, and would want to d everything themselves. With any luck, I could sit back and watch, which was my fonde hope. I didn't even want to touch the body, if I could help it.

The dissection room was large and, in September, uncomfortably warm. There were thir bodies on tables around the room, all covered with sheets. The instructors refused to let peek under the sheets to choose the bodies. We had to pick one table and wait. My grou chose the table nearest the door.

The instructors gave a lecture. We stood beside our bodies. The tense feelings rushed bac It was one thing to sit high up in an amphitheater while a body was shown. It was another stand close to a body, to be able to reach out and touch it. Nobody touched it.

Finally the instructor said, "Well, let's get to work." There was a long silence. All th students opened their dissecting kits, got out their scalpels and scissors. Nobody touched th sheets. The instructor reminded us we could now remove the sheets. We touched the shee gingerly, at the edge of the fabric. Holding our breath, we pulled the sheets back from th feet, exposing the lower half of the torso.

We had a white female, but she was thin, and very old. The hands and feet were wrappe It wasn't as bad as I had imagined, although the smell of phenol preservative was strong.

Our instructor told us we would begin the dissection with two people on each side of th body. We would begin on the leg. We could start cutting now.

Nobody moved.

Everybody looked at one another. The instructor said that we would have to work quick and steadily if we hoped to keep on schedule and finish the dissection in three months.

Then, finally, we began to cut.

The skin was cold, gray-yellow, slightly damp. I made my first cut with a scalpel, slittin across the area where the thigh meets the body, and then straight down the leg to the knee. didn't cut deeply enough the first time. I barely nicked the skin.

"No, no," said my instructor. "*Cut.*"

I cut again, and the flesh opened, and we began scraping away the skin from the underlyin tissue. That was when we began to realize that dissection was hard work, both meticulou and strenuous. You did most of it with the blunt end of a pair of scissors. Or with you fingers.

As the skin spread apart, what we first saw was the fat—a broad expanse of yellowis tissue surrounding everything we wanted to see. In the heat, the fat was slippery and runn When we stripped away this layer, we found the muscles, enclosed in a milky, cellophan like covering. This was the fascia. It was strong and resilient; we had trouble cutting throug it to the muscle beneath. The muscles looked like what you'd expect: reddish, striate bulging in the middle and tapering at the ends. The arteries were easy: they'd been injecte with red latex. But we had no idea what the nerves looked like until the instructor came ov

and found one for us—white, tough, cord-like.

The afternoon wore on, and took on aspects of a nightmare: everybody working, swe dripping down our faces; the smell, pungent and indescribable; the unwillingness to wipe th sweat away because you'd only coat your face with phenol; the sudden horrified discover that a bit of flesh has been flicked away and landed, sticking, to your face; the ghastl drabness of the room itself, bare, hot, institutional gray. It was a cheerless, exhaustin experience.

Just the names we had to learn were difficult enough: superficial epigastric artery superficial external pudendal artery, pectineal fascia, anterior superior iliac spin ligamentum patellae. All in all, forty different structures that had to be memorized for th first day alone.

We worked until five, and then sutured the incision, squirted liquid over it to keep it mois and left. We hadn't managed to finish the dissection, as outlined in the lab manual.

At the end of the first day, we were already behind.

Nobody could eat much at dinner. The second-year students regarded us with amusemen but we weren't making many jokes in the early days. We were all struggling too hard t handle the feelings, to do it at all.

The autumn heat wave continued, and the dissection room became extremely hot. The f deposits melted; smells were strong; everything was greasy to the touch. Sometimes th doorknob was so greasy that we had trouble turning it when we departed at the end of th day. Even when maggots got into one cadaver, causing the instructors to run around the roo with flyswatters, nobody made jokes.

It was hard work. We were just trying to do it.

The weeks passed. The heat wave continued. We were under terrific pressure to keep pac with the dissection, not to fall behind. The first anatomy exams were getting closer. Tw afternoons a week, we worked in the dissection rooms. And again on weekends, if we had t catch up. We began to make sour, grim jokes.

One joke made the rounds:

A professor of anatomy addresses a woman in the class: "Miss Jones, will you name th organ of the body that increases four times in diameter under stimulation?"

The woman becomes embarrassed, hems and haws.

"There's no need to be embarrassed, Miss Jones. The organ is the pupil of the eye—an you, my dear, are an optimist."

After the first anatomy exam, I got a letter in the mail:

Dear Mr. Crichton:

Although your performance on the recent Gross Anatomy exam was satisfactory, you were sufficiently close to the borderline that it will be to your advantage to talk to me sometime in the near future, at your convenience.

Yours sincerely,
George Erikson,
Professor of Anatomy

Panic. A cold sweat. I was shaken. Then at lunch I discovered that lots of other people ha
received letters, too. In fact, almost half the class. I went to see Dr. Erikson that afternoo
He didn't say much; just some encouragement, some hints on memorization. Talk to yoursel
he said. Say things out loud. Pair up and quiz each other.

Pretty soon everyone in the anatomy lab was talking out loud, repeating mnemonics
help them remember.

"S 2, 3, 4, keeps your rectum off the floor." That told you where the nerves to the levato
ani muscle originate, in the second, third, and fourth sacral segments.

"Saint George Street." For the order of muscles inserting around the knee.

"The Zebra Bit My Cock." For the branches of the facial nerve: temporal, zygomati
buccal, mandibular, cervical.

My lab partner developed a new one: "TE, TE, ON, OM." Two eyes, two ears, one nos
one mouth.

They quizzed us constantly, calling us "Doctor" even though we were first-year students. On
instructor came in and threw up an X-ray of a skull. I'd never seen one before. A skull X-ra
is incredibly complex.

"All right, Dr. Crichton, what would you say this is?"

He pointed to a whitish area on the film. It was near the face, and horizontal.

"The hard palate?"

"No, that's down here." He pointed to another horizontal line, a little below.

I tried again, and suddenly it came to me: "The inferior border of the orbit."

"Right."

It was a great feeling.

Then he said, "How about this?" A small, hook-shaped thing near the middle of the skull.

That was easy. "The sella turcica."

"Containing?"

"The pituitary."

"What is just lateral to it?"

"The cavernous sinus."

"Containing?"

I rattled it off: "The curving internal carotid artery, and the ocular nerves, three, four, an
six, and two branches of the trigeminal nerve, the ophthalmic and the maxillary."

"And this dark space, just below?"

"The sphenoid sinus."

"And why is it dark?"

"Because it contains air."

"Right. Now then, Dr. Martin …" And he turned to another member of the group.

I thought, I'm getting it. I'm finally beginning to get it. I was excited. But at the same tim
the pressure was building. Every day, building.

The jokes got worse. One guy wrote "Al's Body Shop" on the back of his anatomy lab coa
And the cadavers began getting names: The Jolly Green Giant, The Thin Man, King Kong.

Ours had a name, too: Lady Brett.

After two months, on a day when the instructors were out of the room, several people playe football with a liver. “He’s going out, he’s deep in the end zone, the ball is in th air … and … touchdown!” The liver flew through the air.

A few students pretended to be horrified, but nobody really was. We had by now dissecte the legs, and the feet had been unwrapped; we had dissected the arms, the hands, ar abdomen. We could see that this was a human body, a dead person laid out on the tab before us. We were continuously reminded of what we were doing—we could see the for clearly. There was no way to get the necessary distance, to detach, except to be outrageou and disrespectful. There was no way to survive except to laugh.

There were certain jobs in the dissection that nobody wanted to do. Nobody wanted to c the pelvis in half. Nobody wanted to dissect the face. Nobody wanted to inflate the eyeba with a syringe. We portioned out these jobs, argued over them.

I managed to avoid each of these jobs.

“Okay, Crichton, but then you have to section the head.”

“Okay.”

“You remember, now….”

“Yeah, yeah, I’ll remember.”

The head was in the future. I’d worry about it when I got there.

* * *

But the day finally came. They handed me the hacksaw. I realized I had made a terrib bargain. I had waited, and now I was stuck with the most overt mutilation of all, to divi the head along the midsagittal plane, to cut it in half like a melon so we could see insid inspect the cavities, the sinuses, the passages, the vessels.

The eyes were inflated, staring at me as I cut. We had dissected the muscles around th eyes, so I couldn’t close them. I just had to go through with it, and try to do it correctly.

Somewhere inside me, there was a kind of click, a shutting off, a refusal to acknowledge, ordinary human terms, what I was doing. After that click, I was all right. I cut well. Mine wa the best section in the class. People came around to admire the job I had done, because I ha stayed exactly in the midline and all the sinuses were beautifully revealed.

I later learned that this shutting-off click was essential to becoming a doctor. You could n function if you were overwhelmed by what was happening. In fact, I was all too easi overwhelmed. I tended to faint—when I saw accident victims in the emergency ward, duri surgery, or while drawing blood. I had to find a way to guard against what I felt.

And still later I learned that the best doctors found a middle position where they we neither overwhelmed by their feelings nor estranged from them. That was the most difficu position of all, and the precise balance—neither too detached nor too caring—was somethi few learned.

At the time I resented the fact that our education seemed to be as much about emotions about the factual content of what we were learning. This emotional aspect seemed more lik hazing, like a professional initiation, than education. It was a long time before I understoo that how a doctor behaved was at least as important as what he knew. And certainly I did n suspect that my complaints about medicine would eventually focus almost entirely on th

emotional attitudes of the practitioners, and not their scientific knowledge.

A Good Story

The first part of a student's clinical work involves interviewing patients with various disease The resident on the floor says, "Go see Mr. Jones in room five, he has a good story"- meaning that Mr. Jones can give a clear history for a specific disease. Off you go to find M Jones, take his history, and diagnose his illness.

For a student beginning work in a hospital, there is considerable tension in interviewi patients. You're trying to act professional, as if you know what you're doing. You're trying make the diagnosis. You're trying not to forget all the things you're supposed to ask, all th things you're supposed to check, including incidental findings. Because you don't want come back to the resident and say, "Mr. Jones has a peptic ulcer," only to have the reside say, "That's true. But what about his eyes?"

"His eyes?"

"Yes."

"His eyes, hmmm …"

"Did you check his eyes?"

"Uh … sure. Yes."

"Notice anything about them?"

"No …"

"You didn't notice his left eye is glass?"

"Oh. That."

To avoid these embarrassments, and to make the job easier, all students quickly learne certain interviewing tricks. The first trick was to get someone to tell you the diagnosis, you wouldn't have to figure it out for yourself. Knowing the diagnosis took a lot of th pressure off an interview. If you were especially lucky, the resident himself would let it sli "Go see Mr. Jones in room five; he has a good story of peptic ulcer."

Or you could throw yourself on the mercy of the nurses:

"Where's Mr. Jones?"

"Peptic ulcer? Room five."

Then there might be relatives in the room when you arrived. They were always worth try. "Hello, Mrs. Jones. How are you today?"

"Fine, Doctor. I was just talking with my husband about his new ulcer diet when he go home."

And, finally, the patients generally knew their diagnoses, and they might mention particularly if you walked in, sat down, and said heartily, "Well, how're you feeling toda Mr. Jones?"

"Much better today."

"What have the doctors told you about your illness?"

"Just that it's a peptic ulcer."

But even if the patients didn't know their diagnoses, in a teaching hospital they had a been interviewed so many times before that you could tell how you were doing by watchi their responses. If you were on the right track, they'd sigh and say, "Everybody asks m

about pain after meals," or "Everybody asks me about the color of my stools." But if yo were off track, they'd complain, "Why are you asking me this? Nobody else has asked this So you often had the sense of following a well-worn path.

But even if you figured out the diagnosis, there was always an exciting uncertainty abo interviewing patients. You never knew what would happen. One day the resident said, "G see Mrs. Willis, room eight; she has a good story of hyperthyroidism."

I walked down the hallway, thinking, Hyperthyroidism, hyperthyroidism, what do I kno about hyperthyroidism?

Mrs. Willis was a thin thirty-nine-year-old woman, sitting up in bed, chain-smoking. He eyes were bulging. She was edgy and appeared unhappy. Her dark tan highlighted the man slashing scars on her arms and face, presumably the result of a bad automobile accident.

I introduced myself and started to talk to her, focusing on thyroid questions. The thyro regulates general body metabolism and it affects skin, hair, voice, temperature, weigh energy, and mood. Mrs. Willis gave me all the right answers. She couldn't gain weight n matter how much she ate. She was always hot and slept with the covers off. She had notice that her hair was brittle. Yes, yes, yes, everybody had asked her these things. She was quic and impatient in her responses. She often seemed on the verge of tears.

I asked her about her suntan. She told me she had been staying with her sister in Alabam It was all right because her sister's apartment was air-conditioned. She had been with he sister in Alabama for three months. Now she was back in Boston.

Why was she in the hospital?

"For my thyroid, it's too high."

What had brought her to the hospital?

A shrug. "I came and they said I had to stay. Because of my thyroid."

"How did you get the scars on your arms?"

"Those're cuts."

"Cuts?"

"From a knife, most of them. This one here's glass."

The scars seemed to be of different ages, some recent, some older.

"Yes. This one is about five years old, the others are newer."

"How did they happen?"

"My husband."

"Your husband?" I proceeded cautiously. She seemed close to tears now.

"He cuts me. When he's, you know, drinking."

"How long has this been going on, Mrs. Willis?"

"I told you: five years."

"Is that why you went to your sister's?"

"She says I should call the police."

"And have you?"

"Once. They didn't do anything. They came and told him to stop it, is all. He was *mad* aft that."

And she burst into great sobs, her whole body shaking, tears streaming down her face.

I was confused. Emotional lability is characteristic of hyperthyroidism; patients frequentl burst into tears. But this woman appeared to have been seriously abused by her husband.

talked to her some more. She had initially come to the hospital because of her wounds. Th doctors had admitted her for hyperthyroidism, but that was clearly an excuse to get her awa from her violent husband. She was safe enough in the hospital, but what would happen onc she was discharged?

"Has anybody talked to you about your husband? A social worker or anybody like that?"

"No."

"Do you want somebody to talk to about your husband?"

"Yes."

I said I would arrange it, and I left, filled with outrage.

In those days, physical abuse within a family was not really acknowledged. Everyon pretended that wives and children weren't beaten. There were no laws, no governme agencies, no homes, no mechanisms at all to assist these people. I felt strongly the injustice this situation, and this woman's dangerous isolation—sitting alone in a hospital bed, waitin to be sent home to her husband, who would stab her again.

Nobody was doing anything about it. The doctors might be treating her thyroid, but nobod was dealing with the real, life-threatening problems she faced.

I went back to the resident.

"Listen, did you see Mrs. Willis's wounds?"

"Yes."

"Those are knife wounds."

"Yes. Some of them." He seemed calm.

"Well, here we are treating her hyperthyroidism and it seems to me she has a much bigg problem."

"All we can treat is her hyperthyroidism," the resident said.

"I think we can do more. We can take steps to keep her away from her husband."

"What husband?"

"Mrs. Willis's husband."

"She doesn't have a husband. What did she tell you?"

I told him the story.

"Listen," he said, "Mrs. Willis was transferred here from a private sanatorium in Alabam Her family is well-to-do, but her husband divorced her years ago. She's been in and out institutions for a decade. All those cuts are self-inflicted."

"Oh."

The resident said, "Did you ask her whether she'd ever been in any mental institutions?"

"No."

"Well. You should have asked. She's not that crazy. She'll tell you, if you ask."

Another time, the resident said, "Go see Mr. Benson; he has a good story of duodenal ulcer."

I went to see Mr. Benson, first stopping at the foot of his bed to read his chart. This wa another trick. The bedside chart contained only nurses' notes on fluid intake, things like tha but it could still be helpful. Also, it made you look professional if you came in and read th chart first.

"Ah, Mr. Benson, I see you're in your second day of recovery from surgery." Thinking th if he had had surgery for his ulcer, it must have been severe.

"Yes."

"And putting out good urine, I see."

"Yes."

"How're you feeling, any pain?"

"No."

I thought, Just two days after surgery and no pain? "Well, you're making an unusu recovery."

"No."

For the first time, I really looked at him. He was sitting in bed wearing a bathrobe, a sma precise, tense man of forty-one. He had the detached look that many postoperative patien have, when they turn their focus inward to heal. But it was different in his case, somehow.

"Well," I said. "Tell me about your ulcer."

Harry Benson spoke in a flat, depressed voice. He was an insurance adjuster from Rhod Island. He had lived with his mother all his life. She was sick and needed him to take care her. He had never married, and had few friends outside work. He had had severe ulcer pai for the last five years. Sometimes he vomited blood. Sometimes a lot of blood. He had bee in the hospital six different times for this pain and blood. He had had several transfusions fo blood loss. He had had a barium swallow that showed the ulcer. The doctors told him la year that they would have to do surgery if the medication didn't heal the ulcer. The bleedi continued, so he came back to the hospital and underwent surgery two days ago.

That was his story.

As the resident promised, it was a classic story, and after so much medical attention, M Benson told it clearly. He even knew physicians' jargon, like "barium swallow" for an uppe GI series.

But why was he so depressed?

"Well, given your history, you must be glad to have the operation over with."

"No."

"Why not?"

"They didn't do anything."

"What do you mean?"

"They opened me up, but they didn't do anything. They didn't do the operation."

"Mr. Benson, I don't think that's right. They did an operation to remove part of th stomach."

"No. They were going to do a partial resection, but they didn't. They took one look an then closed me up again."

And he burst into tears, holding his head in his hands.

"What have they told you?"

He shook his head.

"What do you think is wrong?"

He shook his head.

"You think you have cancer?"

He nodded, still sobbing.

"Mr. Benson, I don't think you do." He had no swollen glands, no history of weight loss, n pain in other parts of his body. And I was pretty sure they wouldn't send a student to talk somebody who had just found out he had inoperable cancer.

"Yes," he insisted. "It's carcinoma."

He was so upset I felt I had to do something immediately. "Mr. Benson, I'm going to chec on this right away."

I went back to the nursing station. The resident was hanging around. I said, "You kno Benson? Did they do a gastric resection?"

"No, they didn't."

"Why not?"

"When they opened him up, his blood pressure went to hell, and they decided they couldn go through with the procedure. They just closed him up as fast as they could."

"Did anybody tell him that?"

"Sure. He knows."

"Well, he thinks he has cancer."

"Still? That's what he thought yesterday."

"Well, he still thinks it."

"He's been told specifically," the resident said, "that he does not have cancer. I told hir the chief resident told him, his own doctor told him, and the attending surgeon told hir Everybody's told him. Benson's a weird guy, you know. Lives with his mother."

I went back to Mr. Benson. I said I'd checked with the resident, and he did not have cance

"You don't have to kid me," he said.

"I'm not kidding you. Didn't the chief resident and the other residents come to see yo yesterday?"

"Yes."

"And did they tell you you didn't have cancer?"

"Yes. But I know. They won't tell me to my face, but I know."

"How do you know?" I said.

"I heard them talking, when they thought I wasn't listening."

"And they said you have cancer?"

"Yes."

"What did they say?"

"They said I had nodes."

"What kind of nodes?"

"Aerial nodes."

There was no such thing as aerial nodes. "Aerial nodes?"

"That's what they called them."

I went back to the resident.

"I told you he was weird," the resident said. "Nobody ever said anything about nodes t him, believe me. I can't imagine how he—wait a minute." He turned to the nurses. "Who's i the bed next to Benson?"

"Mr. Levine, post-cholecystectomy."

"But he's new today. Who was in that bed yesterday?"

"Jeez, yesterday …"

Nobody could remember who had been in the bed the day before. But the resident wa insistent; records were pulled and checked; it took another half-hour, and still more tall with Benson, before the story finally became clear.

On the day after his operation, Mr. Benson, worried that no surgery had been performe had feigned sleep while the residents made rounds. He had listened to what they said, and h heard them discussing the patient in the next bed, who had a cardiac arrhythmia involvi the sino-atrial nodes of the heart. But Mr. Benson thought they were talking about him, a his "aerial nodes." And he had been in enough hospitals to know that nodes meant cancer.

And that was why he was so sure he was dying.

Everybody went back and talked to him. And he finally understood that he did not hav cancer, after all. He was very much relieved.

Everybody went away. I was alone with him. He beckoned to me. "Hey, listen, thanks," h said, and he gave me twenty dollars in cash.

"Really, that's not necessary," I said.

"No, no. Give it to that guy Eddie in room four," he said. And he explained that Eddie wa a bookie, and he was placing bets for everybody on the floor.

"Put it on Fresh Air in the sixth," he said.

That was the first sign that Mr. Benson was on the road to recovery.

"Go see Mr. Carey in room six; he has a good story for glomerulonephritis," the resident sai My elation at being told the diagnosis was immediately tempered: "In fact, the guy's probabl going to die."

Mr. Carey was a young man of twenty-four, sitting up in bed, playing solitaire. He seeme healthy and cheerful. In fact, he was so friendly I wondered why nobody ever seemed to g into his room.

Mr. Carey worked as a gardener on an estate outside Boston. His story was that he had ha a bad sore throat a few months before; he had seen a doctor and had been given pills for strep throat, but he hadn't taken the pills for more than a few days. Some time later h noticed swelling in his body and he felt weak. He later learned he had some disease of h kidneys. Now he had to be dialyzed on kidney machines twice a week. The doctors had sa something about a kidney transplant, but he wasn't sure. Meanwhile, he waited.

That was what he was doing now, waiting.

He was my age. I talked to him with a growing sense of shock. In those days, kidne dialysis was still exotic treatment, and kidney transplantation more exotic still. The statisti were not encouraging. If the transplant worked at all, the average survival was three to fiv years.

I was talking to a doomed man.

I didn't know what to say. For a while we talked about the Celtics, about Bill Russell. H seemed happy to discuss sports, glad to have me there. But all I wanted to do was run fro the room. I felt panicky. I felt I was suffocating. What could I *do* here? I was a medic student faced with somebody who was going to die, just as surely as the basketball seaso would end in a few weeks. It was inevitable. It didn't seem like there was anything I cou say.

Meanwhile, he seemed so pleased to talk to me. I wondered how much he knew. Why wa he so calm? Didn't he know his situation? He must know. He must be aware that he mig not walk out of this hospital again. Why was he so calm?

Just talking away, sports. Baseball season. Spring training.

Eventually I couldn't stand it. I had to leave. I had to get out of that room. I said, "We

I'm sure you'll be up and around in no time."

He looked disappointed.

"What I mean is," I said, "you're definitely on the mend, you'll probably be out of here in week or so."

He looked *very* disappointed. I was saying the wrong things. But what should I be saying? had no idea.

"So cheer up, I'm sure they'll be arranging for you to leave any day now. I've got to g now. Rounds, you know."

He looked at me with open contempt. "Sure. Fine."

I fled, closing the door behind me, blocking out the view of this man my own age who wa close to death.

I went back to the resident. "What're you supposed to say to someone like that?"

"That's a tough one," the resident said.

"Does he know?"

"Yeah, sure."

"So what do you say?"

"I never know what to say myself. It's a bitch, isn't it?"

In retrospect, it seems inconceivable to me that in four years of medical education, noboc ever talked to us, formally or informally, about dying patients. Arguably the most importa item on any medical curriculum, death was never even mentioned at the Harvard Medic School. There was no consideration given to how we might feel around a dying person—th panic, the fear, the sense of our own failure, the uncomfortable reminder of the limits of ou art. There was no consideration of what a dying patient went through, what such a patie might need or want. None of this was ever discussed. We were left to learn about death o our own.

When I think back, I imagine the horrible isolation that young man must have felt, sittin day after day in a room that nobody wanted to enter. Finally some poor medical stude comes in, and this young man has a brief chance to talk to another human being, and he delighted. He would like to talk about what is really going on in his life. He's worried abo what will happen to him. He wants to talk—because, unlike me, he can't avoid the realities. can run from the room, but he can't. He is stuck with the fact of his impending death.

But instead of talking about it, instead of having the strength to stay with him, I merel mumbled platitudes and fled. It was no wonder he finally regarded me with contempt. wasn't much of a doctor: I was far more worried about myself than about him, but he was th one who was dying.

I was still pretending that I was somehow different—that he wasn't like me—that it woul never happen to me.